Saying "No" when it is important:

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Medical profession is an ancient noble profession well governed by a set of sound ethical principles and regulatory injunctions enunciated by the Medical Council of India. Long years of training coupled with inculcation of a spirit of service during the formative years of medical education firmly establish a rooted tendency to unfailing observance of these ethical principles and compassion and sensitivity towards the suffering of fellow human beings. Indeed, the physician who says "No" to a patient's call is the exception rather than the rule.

Refusing to honour a patient's call besides being unethical is not entirely without consequences detrimental to the physician's interests. The opportunity to manage a clinical problem and to gain knowledge and experience thereby is irretrievably lost; not to mention the pecuniary losses occasioned thereby.

Therefore, in the practice of medicine including clinical anaesthesiology, the need to say "No" to a patient's call ought not arise at all. Perhaps, the dubious distinction of being the only specialty to occasionally deny patient's need of its services belongs to the field of clinical anaesthesiology. Lest I am misunderstood, I must hasten to add that the denial is not out of evil designs to aggravate the patient's suffering; but with the noble and laudable objective of safeguarding the patient from danger of the stress of anaesthesia itself superimposed upon the already existing combined risks of his disease and surgery.

This unpleasant and unsavoury situation falls to the lot of practicing anesthesiologist for the following reasons:

1. An anaesthesiologist always works as part of the surgical team. If the surgical brethren fail in their duty to carry out their part in the preparation of the patient for surgery or if they fail to provide ideal conditions for the administration of anaesthesia, potentially dangerous situations may arise; proceeding with the administration of anaesthesia unmindful of the dangers would amount to criminal negligence on the part of the anaesthetist. The prudent anaesthetist who wishes to save his patient from such dangers should either attempt to correct the situation or where it is not possible he should have no qualms in withdrawing from the case even at the risk of appearing diffident.

2. The practice of clinical anaesthesiology especially its free-lance version is a surgeon dominated field. Surgeon is the medium through which the patient obtains anaesthesia services and vice versa. Hence, in isolated cases, anaesthetic aspects of surgical

management of the patient suffer neglect rendering the process of anaesthesia riskier than usual.

3. The practicing anaesthesiologist is always in a weak position in the event of anaesthetic mishaps inside the operating theatre. Patient and relatives of the patient find it easier to believe the surgeon who enjoys the rapport and confidence of the patient rather than the anaesthetiologist who is a relative stranger. Therefore the prudent anaesthetist should always be on his guard to steer clear of dangerous situations caused by surgeon's neglect or carelessness even at the risk of appearing non-cooperative and the only way to achieve this objective lies in not anaesthetizing patients if there are sound reasons to do so.

4. The practicing anaesthetist seldom gets the opportunity to achieve ideal conditions for the administration of anaesthesia. Anaesthesia is administered outside of the public gaze within the four walls of the operating theatre which is under the possession and/or control of the surgeon. Unsatisfactory conditions prevailing in the theatre itself and/or in the proper preparation of the patient justify denial of anaesthesia services in such cases.

CLINICAL SITUATIONS OF "POTENTIALLY DANGEROUS ANAESTHESIA".

Described below are some clinical situations in which the anaesthetist should exercise care and circumspection before proceeding to the administration of anaesthesia and if deemed safe and indicated, withdraw from the case to prevent anaesthesia induced adverse events. The list is only indicative and illustrative but not exhaustive.

1] Anaesthesia without pre-anaesthetic / airway examination of the patient:

This is a common clinical situation encountered in obstetric emergencies. By the time anaesthetist reaches the O.T., he finds the patient already on the table, sometimes even draped and ready for the scalpel. Generally a request to proceed immediately with the anaesthesia is made by the surgeon in view of the dire emergency setting. Nothing could be more dangerous than complying with this request. The unsuspecting anaesthetist who proceeds to administer anaesthesia would be shocked to encounter a difficult airway situation which in isolated cases may lead to CICV situation with disastrous consequences. Lesser degrees of airway difficulty may end in unpleasant and troublesome complications leading to morbidity and even mortality.

At the least a cursory physical examination of the vital systems with special attention to the airway is indicated in all patients, no matter how bad the emergency is. Saying "No" to

anaesthesia without pre-anaesthetic examination of the patient should be a guiding principle of all anaesthesia practitioners.

2] Acute respiratory infection in paediatric patients posted for general anaesthesia:

A not uncommon clinical situation in paediatric anaesthesia is to come across patients with signs of acute respiratory infection on the day of surgery. The patient would be otherwise normal and surgery a relatively minor one and the temptation to proceed with anaesthesia is strong.

Inducing general anaesthesia in such patients invites a host of problems to the anaesthetist. The acutely inflamed air passages with increased mucous production are hypersensitive and instrumentation of the airway would lead to a high incidence of bronchospasm and laryngospasm; besides the small calibre endotracheal tube is easily blocked by tiny blobs of the mucous making ventilation difficult leading to hypoxia. All these potentially dangerous complications could be avoided if the prudent anaesthetist says “No” in this situation. There is nothing to be lost and everything to be gained by postponing such cases until the lungs are clear.

3] DIFFICULT AIRWAY SITUATION WITHOUT SPECIAL AIRWAY GADGETS:

If difficult or compromised airway is detected during the pre-anaesthetic examination of the patient, availablity of special airway gadgets must be ensured before contemplating GA. A number of special airway gadgets are now available and management of the difficult airway is poised to become a separate sub-specialty by itself. The conscientious anaesthetist should be confident of his expertise in tackling the difficult airway found by him in his patient with the aid of the required airway instruments available to him. Adopting blind techniques with misguided hopes of **somehow** achieving successful airway management is clearly unacceptable in these days of bounding medico-legal litigation. Unless and until ideal airway gadgets are made available, the anaesthetist should say No to general anaesthesia in patients with difficult or compromised airway.

4] GENERAL ANAESTHESIA IN PATIENTS SUFFERING FROM PARTIAL RESPIRATORY OBSTRUCTION:

Patients suffering from partial airway obstruction whether due to inflammation, growth or foreign body, are likely to be extremely restless and uncooperative for surgical intervention. A request to ‘quieten’?! the patient to enable the surgical procedure often proceeds from the surgical colleague. Administration of any sedative/ hypnotic/ intravenous anaesthetic or neuromuscular blocking agents is fraught with dire consequences unless the airway has been secured. A careful examination of the airway is mandatory in these patients and attempts must

be made to secure the airway first before surgical intervention could begin. Until the airway is secured, request for general anaesthesia / sedation should be firmly refused.

5] PATIENTS "UNFIT FOR ANAESTHESIA"

A busy practitioner is occasionally likely to come across very severely ill patients with multiple physiological derangements and anaesthetic problems making anaesthesia very difficult and risky. If the anaesthetist forms the opinion that patient would not be able to stand the stress of anaesthesia or if the anaesthetist does not feel confident in handling such a patient, no time should be lost in saying so and refusing to proceed to anaesthesia. The care of such patients should be entrusted to members of the profession who have the expertise in dealing with such patients. Proceeding with anaesthesia despite misgivings merely because surgeon wants to operate on the patient is a disservice to the profession. Anaesthetist should not be a party to seemingly fruitless surgical adventures.

It is pertinent to mention here that such negative attitude does not detract from his standing in the profession as is commonly believed; rather they enhance the good will he has earned and reinforce the confidence in him assuring of his dependability to the surgical colleagues.

6] LACK OF BASIC INVESTIGATIONS/MONITORS/ACCESSORIES/REQUIREMENTS:

Deficiencies in the preparation of the patient and basic investigations and other such infrastructural defects are sometimes found in some surgical establishments. The prudent anaesthetist who wants to serve his patient does his best when he gracefully withdraws from giving anaesthesia in such situations. Alternatively such deficiencies and their implications should be discussed with the patients and relatives and their consent should be obtained if the clinical situation does not permit delay.

The clinical situations described herein do not represent a complete list of situations in which the anaesthetist is expected to say no. The instances could be easily multiplied. The individual anaesthetist should evaluate each case thoroughly keeping in mind the basic objective of anaesthesia is to bring about an improvement in the clinical condition of the patient. It should not be converted into a tool to precipitate morbidity and mortality.

LEGAL PERSPECTIVES:

Today litigation against the doctors by the patients is increasing day by day. A recent development in medical jurisprudence is the concept of "criminal negligence" which entails imprisonment with or without damages. Taking a risk knowingly with mistaken hopes that nothing would happen or gross indifference to a risk which exists constitutes criminal negligence. In the clinical situations described above, a risk is present which needs to be

eliminated. This may require the cooperation of the surgeon which if not forthcoming, is an indication to the anaesthetist to extricate himself from the clinical management of the patient. Not doing so would amount to criminal negligence. Blaming the surgeon for the inadequacies would not be acceptable as defence. In short, it may be safely stated that Law expects the anaesthetist to say "No" when it is so indicated and not otherwise.

Conclusion: The prudent anaesthetist who wishes to ensure the safety of his patient and of his own reputation should never hesitate to say No if, in his opinion, circumstances exist which render the process of anaesthesia an unacceptable risk or danger to the patient. Anaesthesia is a potent weapon and it can bring about great benefits to the mankind. If not properly applied, it can wreak havoc with the life of the patient. Therefore caution should be the watchword of every practicing anaesthesiologist. It is better not to anaesthetize and harm the patient than to anaesthetize and precipitate accidents and complications. The following poem by Dr.Samuel Johnson expresses the same sentiments.

IT IS THE FATE OF THOSE WHO TOIL AT THE LOWER

EMPLOYMENTS OF LIFE;

TO BE EXPOSED TO CENSURE WITHOUT HOPE OF PRAISE;

TO BE DISGRACED BY MISCARRIAGE OR PUNISHED FOR NEGLECT;

WHERE SUCCESS WOULD HAVE BEEN WITHOUT APPLAUSE

AND DILIGENCE WITHOUT REWARD;

AMONG THESE UNHAPPY MORTALS IS THE ADMINISTRATOR OF ANAESTHETICS,

AND HE MUST COVER HIMSELF IN EVERY WAY POSSIBLE."

Concluded.