

Taking Anesthetic Practice Few Steps Higher: A Personal Prospective

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Abstract

Anaesthesia today made it possible to trespass on the physiological and health of individual to mend what is wrong with the human body by complex and lengthy procedures. Gone are those days when the surgeon does his surgery in few minutes to spare the patient the torture of invasive brief surgery. So if he escaped from death at the time of management he would face it again due to sepsis and loss of blood. Many physicians would consider anaesthesia as one of the blessing to mankind. Antisepsis, antibiotics and blood transfusion made a hue revolution the medical progress. Anaesthesiologists are considered the Unknown Soldiers in the hospital. The author put in his article the few important aspects which make the voice of the physician who care about the patient in the time of surgery in a more positive presence in the area of high technology and more safe environment in operating theatre (OR). It goes in favour of more patient safety. From his personal prospective he represent his generation of builder practitioner who witnessed the time of trial and error stage to methodological research to the era of evidence based medicine.

INTRODUCTION

One reads with fascination the history of Anaesthesia, [1, 2, 3] and the unique rate of progress that anaesthesia speciality in medical world had no resemblance, In the last 50 yr, advances in perioperative care, especially intraoperative anaesthesia, have helped to increase the safety and capability of delivering anaesthesia effectively to very fragile patients (i.e., ASA Class III and higher), who are often undergoing complicated procedures. Advances in technology, pharmacology, and training, have facilitated our ability to successfully meet these anaesthetic challenges [4]. Pioneers anaesthesiologists taught the art and dedicated few had promoted it in a very skilful manner with regard to equipments, Then Scientist promoted the speciality to a modern era of moving from art to science, They established the scientific bases of anaesthetic agents and promoted it in search for newer agents more selective, Digging so deep into applied physiology and pharmacology studying pharmacokinetics and dynamics, Caring about physiological trespass and improving monitoring equipments. Progress then went along studying patho-physiology of different forms of illnesses that necessitates surgical interference and excelled in the science of optimizing patient's conditions preoperatively leaving nothing to chances.

THE ROLE OF SCIENTIFIC METHOD

Nowadays thousands of dedicated researchers working in a fascinating wide areas of researches' some to establish the precise mechanism of actions of the anaesthetic agents, Some searching at the molecular level identifying Channels in the cell wall and recognising channelopathies (Disturbances affecting the mechanism of transfer across cell membrane at the molecular level), anaesthetic machines and monitoring are improving by the hour. In 1992, this state of affairs was outlined [5]. These outlines would make the ideal safe anesthesia practitioner. This safe anesthetist (using the term in the correct traditional sense to mean anyone who administers anesthesia: physician, nurse, or other) is an intelligent, vigilant individual who is experienced and well rested. He/she uses appropriate monitors at appropriate times. His/her anesthesia machine is up-to-date and well maintained, having been checked personally by him/her. He /she consistently prepares for the unexpected and he/she actively participates in the quality assurance process.

Anesthesia providers can aspire to and attain this ideal, thanks to the efforts of those clinicians, researchers, and lawmakers whose respective concepts, studies, and legislation advanced patient safety to the forefront in the field of anesthesia. The document outlining these definitions was a result of extensively reviewed literature (142

references from the United States and the United Kingdom). The summaries and discussions of this information are well organized and informative.

Subtopics include: The epidemiology of accidents, monitoring standards, checking anesthesia machines, the selection of anesthetists, detection of anesthetic mishaps, the end of flammable anesthetic agents, fatigue, accountability and audit, competence to practice, product liability, and The Anesthesia Patient Safety Foundation. These discussions demonstrate the wide range of issues underpinning the field of anesthesia safety as well as the fact that the struggle to improve patient safety is ponderous, often painful, and still ongoing [5].

These outlines point out that incredible progress has been made in ensuring the safety of patients undergoing surgery. This progress has not occurred 'by accident,' as anyone who reads this review will appreciate.

THE STATUS OF THE ANESTHESIOLOGIST

Amazing thing is the status of this speciality Generations after generations had lived up to the magical phrase the Unknown Soldier, Well to me as practicing Anaesthetist for 37 years. I am growing very confident that anaesthetist is A master rather than soldier and is indeed very well known some look with regard and majority with the mystery and fear should they go under Anaesthesia.

The negative impacts on anaesthesiologist of remaining Unknown Soldier are serious. There is only one speciality in medicine that could claim awareness and skills and comprehension of preoperative problems and how to handle it. Preoperative physicians would be a truly descriptive term to a qualified Anaesthesiologist. Several other physicians may and do get consulted about perioperative care, to name a few: Cardiologist, Pulmonologist, Paediatricians ...etc. But does any of them ever claim knowledge of what would the patient go through peri-operatively, Would any of these other colleagues be able to see the big picture about operative managements from the establishing the diagnosis and need for surgery to the moment of complete recovery of the patients and the pleasure of having no painful squeal to surgical services..

If the anaesthesiologist remains shy and behind, that would not help the surgical patients anymore and I may outline that as follows

1-Failing to elucidate every significant details about patients

health, Various systemic functions, Various system reserves, Medications Allergies Family history Anaesthetic history psychological makeup.

2-Reviewing medications what to stop what to keep what to complement up to the day of surgery consequently what drugs to prepare for the time of surgery and for the post operative period

3-Considering as one whole big task of the perioperative patients affairs as one continuum linking preoperative medical and psychological status with minute by minute of what happens during surgery and the immediate postoperative phase then providing for post operative comfort and safety.

4-Judging the exact need for laboratory studies and limiting them to what is really relevant and mandatory, saving perioperative waste and preserving resources.

One may argue on the bases of reviewing different medical colleges' curriculum that, surgical and various medical training programs have actually extended their programs to let their trainee increase their comprehension of perioperative knowledge, but is it enough? To be enough; they would have to be a trained anaesthesiologists too ! That is not practical and surely not realistic or else surgeons would have to be in training until they would be ready to retire.

SPECULATIONS ABOUT THE FUTURE OF ANESTHESIA

The core of this paper is a speculative future look to what steps anaesthetic practice should clime to realise what is expected of the anaesthetist based on their through comprehension of Perioperative patients' affairs and welfares

- Operative departments and operative masters
- Operating theatre compounds with two wings annexed
- Preoperative wards
- Post operative wards

The analogy would be much like a labour ward in a modern obstetric practice with the Antenatal and Postnatal wards.

PRE OPERATIVE WARDS

Receive three categories of patients

1. Patients who had previous appointments for scheduled surgical procedures
2. patients referred from surgical or medical wards
3. patients admitted for day surgery

That part of the compound would be the only site with privileges of liaison with the operative department control of what surgical procedures are going to be performed on the day or the day after

Here patients would be received with their single relative by the clerical services and by the preoperative nurse to complete the detailed questionnaire

Anaesthetic registrar backed by a consultant anaesthetist (Operative Master) to assess patients as soon as they were admitted, Order what may be deemed necessary of complementary investigations and or referral to other specialities

By early hours it would be absolutely clear to the operating room administrators who would be admitted for surgery and when

Liaison with the postoperative ward would pave the way for safe and secure place for post operative sound care in the specialised beds of the postoperative ward in surgical general or special ICU units

MERITS

- Avoiding the erratic coordination and organization, which renders some patients come to OR without having been examined thoroughly, or lacking some investigative requirements, or still need to be referred to other specialist physicians.
- Establishing a routine that leaves little room for mishaps
- Reducing the need for manpower if to the contrary every single surgical department would do these tasks separately
- Reduce the time and effort resident anaesthetists have to spend chasing patients around the hospital for pre operative assessment
- Limit the huge number of unnecessary laboratory tests that is ordered routinely by the admitting residents indifferent surgical departments, Limited

to what is absolutely necessary according to IPPS

- Avoiding delays of surgical schedule and eliminating surprises

POST OPERATIVE WARD

- Ideal patients care with staffs that is aware of the patients exact needs
- Easy managements of PCA and neuro-axial analgesic techniques in a safe atmosphere
- Better management of immediate and delayed postoperative complications
- Improving the turn over on hospital beds and early discharge of patients who were better cared for in this ward
- Availability of resident anaesthesiologist who better care for Central Venous Lines (CVL) Arterial Lines (AL), Archiving homeostasis of arterial gases, fluids and electrolytes balance.
- Eliminating risk of sudden serious complications Cardiovascular, Respiratory...etc
- Availability of CPR, ACLS and ATLS Personnel, Equipments and Drugs immediately when it is needed
- Saving time and efforts of moving patients all day along hospital corridors
- Limiting infection spread and reducing chances of contaminations
- Better management of postoperative Blood and blood products transfusion
- Better post operative care for diabetics
- Providing an excellent area for training medical students interns and nurse on a wide spectrum of post operative surgical managements

Last but not least Anaesthetic practice would keep the Anaesthetist knowledgeable skilful and truly classed as Operative Master.

Figure 1

Glossary of abbreviations used in the text	
CVL	Central Venous Line
AL	Arterial Line
CPR	Cardio-Pulmonary Resuscitation
ACLS	Advances Cardiac Life Support
ATLS	Advances Trauma Life Support

Figure 2

Figure 1: Continuous medical education (CME) is vital part of the today practice. Dr Hamalwy in this picture was about to deliver a talk on anaesthesia and surgical challenges of ruptured aortic aneurysm at the anaesthesia department in KFMC-Riyadh



Figure 3

Figure 2: Modern Anaesthesiologist working in a safe environment monitoring the patient in order to control his physiological parameters and delivering oxygen and aesthetic agents in controlled method. [Dr Adulbaset Maghirah and Mr Abdul Kader Abu sini in KFMC theatre]



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