ORIGINAL PROF-696

ETHICAL ANESTHETIC PRACTICE;
WHAT WE MUST LEARN FROM THE WEST

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Physicians need to be more up to date regarding the latest developments in the medical field. I will narrate here general outline under different headings what I have experienced in the west.

World is changing very fast but is not changing equally at all places. In England it is generally said that if you go for a coffee break during a procedure, you should not be surprised that on your return back to the case a new guideline may have come and old one may have been cancelled.

Patients are much more aware about their disease and the surgical procedure now a days. "What about permanent neurological damage, doctor?" used to be the question from the patient, whenever I intentionally omitted this complication while explaining epidural to the patient, for the simple reason of not frightening them too much. Explosion of information technology has made even an average patient wise enough to alert the treating physician to be careful while encountering the patients or the attendants.

ATTITUDE

Medical treatment should be taken as a service not as a favour.

This will change the approach to the patient. In favour you give whatever you want to give but in service you offer whatever is at your discretion.

Some time must be spent with the patient preoperatively in calm and cool environment, at a place specially designated for this purpose. Pre anesthetic check up is such a mandatory issue in the west, that the nurse I/C of the ward will not send the patient to operation theater, unless an anesthetist has seen the patient. It is rightly so because it is this visit when we can check up the fitness of the patient for the procedure, order relevant investigations, order premeditation and prepare ourselves for untoward events.

Patient dignity and privacy should be maintained all the time. The patient coming for any procedure is under great mental and emotional stress. They should be comforted and assured according to their condition. This builds a repo with the patient and confidence in the physician. One should never lose contact with common community.

Anesthetist and surgeon are not answerable to each other in the course of discharge of their duties. But both are accountable for their action to the patient.

PROFESSIONALISM

Practice of anaesthesia has changed dramatically over the past few years. This has changed basic old concepts about patient doctor relationship.

Concept of the captain of the ship has been readdressed. The surgeons are supposed to decide

about suitability of the procedure for the patient, the decision of suitability of patient for the procedure is left to the anesthetist. This puts great responsibility on shoulders of the anesthetist for looking after overall condition of the patient throughout the perioperative period. Anesthetist is responsible for safe out come from any procedure and it leaves the surgeon to concentrate with full peace of mind on technical aspects of the procedure itself.

When deciding about any procedure, the anesthetists commonly use two approaches to reach the final conclusion.

- My rule
- Court of law

MY RULE

This rule is slowly getting out of favour .The physician asks himself what I would have done if this patient could be my brother or sister and so on .This gives a time for a second thought and enhances the safety of the intervention. This rule works very well in ordinary circumstances. Major draw back with this rule is that it is never possible to measure affiliation of any body to a member of his family. There is no standard, which could be helpful in deciding 01 against any procedure.

COURT OF LAW

If I am going to do any procedure, is medical expert in court of law going to support and justify my technique?

This approach, which can be judged by common practice prevailing at the moment, can also be assessed by various guidelines and protocols. No body will come to your help when you are in trouble. Only your actions/documentation will support you or otherwise.

MONITORS

Royal College of Anaesthetists and Association of Anaesthetists of Great Britain and Ireland are two bodies in U.K which keep on issuing guidelines regarding monitoring in different procedures. Final decision is that of the anesthetist undertaking the care, but he has to justify and give reasons for not using a monitor or otherwise. It is unthinkable in U.K that any OT would be without any of the following monitors.

- ECG
- NIBP
- Pulse Oximeter
- Oxygen analyzer
- Capnograph
- Facility to monitor BP and CVP invasively

These monitoring equipments are well beyond the recommendation of the above two regulation bodies. According to the guideline, no anesthetist will carry out any routine procedure, which involves intubation unless capnograph is available. These guidelines become binding for the department to maintain at least minimum standard of monitoring.

It is very encouraging to see that standard of monitoring in our country is growing much better than it used to be about five years ago. But it is still short of Western standards. Every department is managing its monitoring needs locally and in its own way. The financial constraints apply most to the provision of better healthcare facilities. Further, there is no central body regulating this practice. There should be instructions/guidelines from the higher echelons, which should ensure availability of minimum level of monitors wherever general anaesthesia is administered.

I would suggest following as minimum

1. ECG
2. NIBP
3. Pulse oximeter

These should be available in each operating theater in B class hospital. A class hospital should have even better equipment and staffing that matches their class.

COMMUNICATION

The most important factor in safe patient management is communication. Communication should be in all directions. Communicate with your colleague regarding patient management: you may be missing something. Discuss with your senior colleague especially in higher risk and complicated cases ensuring that your plan for the patient is really safe. Communicate with your patient giving reasonable explanation of the procedure and the risks involved.

In troublesome cases it is better to have third party present when you are explaining the risk. That third party can be another physician, operation theater sister or al least a member of the operation theater staff. Worries regarding patient should be conveyed to the treating surgeon and in selected cases, the patient should be discussed with medical specialist for optimization of the patient condition.

After all this work, best time for the patient to undergo surgery should be decided & all communication should be documented in the patient notes.

I have observed that some anesthetists and surgeons inform the hospital administrator regarding poor condition of the patient. This I personally feel is not a professional approach, when your are not decisive or have concerns regarding patient condition, get advice from senior colleague of your own specialty or your advisor/director will be pleased to help you.

By seeking advice from the hospital administrator, one is exposing himself to dual damage:

1. The hospital administrator will not be able to offer the best advice.

2. The administrator may have very strong yes or no system. If for any reason you feel that his advice is not safe for the patient, your are likely to have sore relationships with your administrator.

3. Administrators are there to give you administrative support and rescue you from non-professional pressure which can interfere with your patient management.

I will repeat again: communicate to keep your patient safe as well as yourself.

INDEPENDENT WORK

Though it is taken as a plus point if some one has a chance of working independently and in our military medical services it is a routine matter to post a single anaesthetist at remote field area. This practice is not without its adverse consequences. In the western world they get scared and start doubting about the safely of that anaesthetist. Their view is that no body has observed him what he has been doing. Physicians, who are single anaesthetists at any place need to be more vigilant and should make habit of discussing their routine cases with another anesthetist colleague. The recent induction of Passcom communication system in the army and the mobile sets all over the country have made it so simple that nothing should be left to chance or human omission now. Other physicians working at different grade should realize that what they are upto.

General system about different grades of specialists, which is being followed in the West, is as follows;

SHO (senior house officer);
must always work under direct supervision.

REGISTRAR (SPR1,2);
can perform routine surgical cases and treat routine complications.

SENIOR REGISTRAR;
can treat all possible complications.

CONSULTANT;
avoids complication.

The golden rule to be followed is the complications are better avoided than treated. Think about consequences and the cost of failed intubation, asystole, VF and pulmonary oedema. The cost can be very expensive for the patient, society and the physician as well. While avoiding above complications by a reasonable monitoring system and a more vigilant physician may save a life or prevent a prolonged and needless morbidity.

If physician is to be blamed for any thing going wrong with the patient, he has all the right to demand for equipment which might help in detection of the consequences of equipment failure, human error, omission or the disease process itself, such monitors may enable him to react within reasonable time to take appropriate measure. Your need for equipment should be well registered with the administrators, so that they should realize their administrative duties.

Tragedy in our part of the world is that the professionals are being blamed for professional as well as administrative failures.

TRAINING

In this modern world of information technology there is flood of information on internet and there is no limit of books available in the market. The old style teaching has gone into disrepute, as it is pointless to deliver lectures to half asleep and mentally absent class. It is wastage of time of the teacher and the student.

This is an era of interactive teaching. It is generally thought that one session a week is enough for classroom type teaching. A session covers a 4 hours period in which a trainee presents an already selected topic for about 45 min, which is followed by a presentation by the consultant on same topic for about 30 min, interrupted by a cup of tea or coffee.

On other days it is teaching in OT with the patient, and there is one to oi.d discussion, it gives a good practice for viva, and the trainees pick up points of importance. Of course there is adequate anaesthesia staff to carry out routine work along with the instructional job. In spare time students are encouraged to go to libraries for self reading.

DOCUMENTATION

Importance of documentation is that one only sees the documents. Every step taken must be well documented, and every drug given must be endorsed in the papers of the patients. It is generally agreed that a step which has not been mentioned has not been taken, and a drug which has not been entered, is not given.

Good documentation leads to good defense, poor documentation to poor defense and no documentation to no defense. A fragmented document leaves you nowhere.

It is prudent to spend some time and make a habit of clearly documenting various steps, including risks explanation to the patient and condition of the patient while shifting from O.T.

In selected cases post-operative visit should be documented in the notes.

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