

## President's Letter – June 2004 Multidisciplinary Working – The Anaesthesia Team\*

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### THE ANAESTHESIA TEAM

**A**LTHOUGH staff from many different disciplines contribute to the work of the anaesthesia team, the main contribution is made by anaesthetists, nurses and operating department practitioners (ODPs). There is also the prospect of a new grade of staff, probably to be called the anaesthetic care practitioner (ACP), being introduced as part of the team. I shall take a brief look at the history and evolution of the different disciplines working in the areas of anaesthesia and recovery, and how they have developed their expertise, before moving on to consider the areas of overlap and the areas of difference. Finally, I shall consider the elements required for true multidisciplinary working.

### ANAESTHETISTS

It might be argued that the very first anaesthetist was Jehovah, when he put Adam into a deep sleep before removing his rib to create Eve. Following that, there was a long hiatus in the history of anaesthesia. Surgery was avoided wherever possible, and when that was impossible, various soporific or intoxicating drugs, such as opium or alcohol were used to try to deaden the pain.

The first modern anaesthetists were dentists. Horace Wells used nitrous oxide in 1844, and William Morton used ether in 1846. The first ether anaesthetic in London was given by a dentist, James Robinson, on 19 December 1846. Just 5 days later, Robert Liston, Professor of Surgery at the University of London, performed an amputation under ether anaesthesia. The anaesthetic on that occasion was given by William Squire, a medical student.

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The first professional anaesthetist in England was John Snow, and the surprisingly controversial use of anaesthesia gained respectability when he administered chloroform to Queen Victoria for the birth of Prince Leopold in 1853.

For many years thereafter, most anaesthetics were given by general practitioners. The first formal qualification in anaesthesia was the Diploma in Anaesthesia (DA), initiated in 1935. This was expanded in 1948 into a two-part examination, at a time when the NHS was being formed, and anaesthetists were recognised as consultants.

The current specialist diploma is the FRCA – Fellow of the Royal College of Anaesthetists.

### NURSES

Mankind has always required nurses, although their status in society and their degree of professionalism has varied. At the time of the first anaesthetics, in the mid-19th century, the image of the nurse was personified by Sarah Gamp in Dickens' 'Martin Chuzzlewit': dirty, drunken and dangerous. The image, and indeed the reality, were improved beyond recognition by the likes of Florence Nightingale.

Local and informal training gave way to formal instruction, and State Registered Nurses. Nurses now require either a diploma or a degree granted by a university.

### ANAESTHETIC NURSES

During World War I, nurses often administered anaesthesia. However, their current role as anaesthetic nurses involves (in the UK) assisting the medically qualified anaesthetist. Initially, there was only 'on the job'

training, and the duration and standard varied from hospital to hospital.

Joint Board courses were established in the 1960s, to be superseded by qualifications recognised by the English National Board (ENB). Currently, universities run degree or diploma courses under the overall authority of the Nursing and Midwifery Council (NMC).

## RECOVERY NURSES

Initially, recovery from anaesthesia was accorded little attention. There were certainly accidents and fatalities, but the death rate from surgery was so horrendous pre-anaesthesia that this reduced death rate looked, relatively speaking, like an improvement. Recovery from ether anaesthesia was slow, messy, and often accompanied by vomiting. Small wonder, then, that it was often left to the most junior members of the nursing staff.

Dedicated recovery rooms were introduced in the United States in the 1940s, but rather later in the UK. With the development of a specialised area, grew the need for specialist skills. The ENB ran courses, which have now been taken over by universities under the aegis of the NMC.

The recovery room has developed into the Post-Anaesthesia Care Unit (PACU), and these have proved fertile ground for the development of the new Nurse Consultants.

## ODPs

ODPs probably have the most colourful history of all. They started life as 'handlers', the large men employed at surgical operations to hold the victims down. These evolved into 'box carriers' and 'surgeymen', men employed by the surgeons to look after and carry instruments.

Hospitals also employed beadles and porters to man the gates, deciding who should be admitted, and maintaining order, not only amongst the patients, but also amongst the medical students.

During the First World War, men were employed as attendants in operating theatres, and they went into civilian operating theatres after the war. During the Second World War, now called theatre technicians, they received more formal training and became assistants to the anaesthetist.

The Lewin Report in 1970 established the grade of Operating Department Assistant (ODA). In 1998, ODAs, became ODPs – Operating Department

Practitioners, reflecting a change of status from assistants to practitioners.

The training of ODPs has evolved from local and non-standard training at the outset to the current Diploma in Operating Department Practice. There is now a voluntary register for ODPs, and registration is a requirement for employment within the NHS.

## ANAESTHETIC CARE PRACTITIONERS (ACPs)

This is a grade of staff so new that not even the name has been finally decided upon.

The shortage of anaesthetic personnel has led to a search for new ways of delivering anaesthesia. It is envisaged that this new breed of practitioners will be trained to anaesthetise fit patients under the supervision of a medically qualified anaesthetist. The potential sources of recruitment include existing nurses or ODPs, but there is already a shortage of these valuable members of staff. It is hoped that the grade will attract science graduates who would not otherwise be working in health care.

The qualification will be a Master's degree awarded by the NHSU in conjunction with a provider university. Standards will be set by the Royal College of Anaesthetists, and a multidisciplinary group, with representatives from all the members of the anaesthesia team, is planning the curriculum.

## THE PATIENT JOURNEY

The patient journey, with regard to surgery, can be broken up into the following components:

- preoperative assessment,
- preoperative optimisation,
- the operating theatre itself, with subdivisions into induction of anaesthesia, maintenance and emergence,
- recovery and
- postoperative analgesia.

It is immediately apparent that all members of the team participate in these steps, but that different members take the lead at different stages.

Preoperative assessment is increasingly nurse-led, while preoperative optimisation is under the guidance of the anaesthetist.

Induction of anaesthesia, maintenance and emergence are led by the anaesthetist, but the skilled assistant, whether anaesthetic nurse or ODP is a *sine qua non* of this process.

Recovery has traditionally been led by nurses, although ODPs are increasingly employed in PACUs. Pain teams are often led by nurses, and all require senior nurse input to be effective.

It is intended that the ACPs will be able to participate in most or all of the processes outlined above. It will be interesting to see how the role evolves.

## MULTIDISCIPLINARY WORKING

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Multidisciplinary working is the current buzz word, and, as with all buzz words, there is a real danger that it will become meaningless. It should certainly not mean that all members of the team are jacks of all trades, and masters of none. Rather, I take it to mean that members of the team will genuinely work together, each contributing their expertise while respecting the expertise of others. There will inevitably be areas of overlap of skills, and these should serve to make the team more robust and more flexible in its response to the unexpected.

For a multidisciplinary team to work successfully there should be a clear definition of the competencies expected of each member, in the three key areas of knowledge, skills and attitudes. There should be a clear

definition of roles, and of responsibilities, although these should not be so rigid that they prevent a flexible response to a crisis. Indeed, flexibility might be regarded as one of the hallmarks of a successful team.

Good communication, of course, is vital. So, too, is consideration for one another. A little kindness between team members goes a long way.

But the most vital thing of all, perhaps, is trust. Without it, the team will not function, since each member will be constantly watching the others. True trust, which can only be built up by familiarity and repeated practice, will build team competence and confidence to a level which will not only safeguard the patient but also make the working environment a happier place for the staff.

## ACKNOWLEDGEMENTS

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