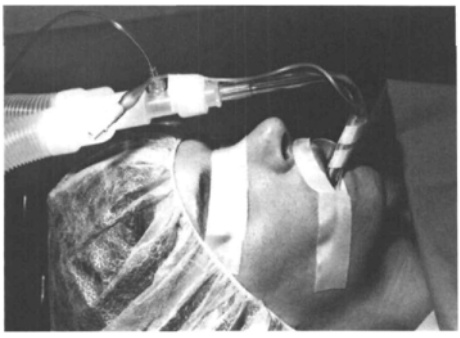

FIGURE

This technique has been used in both paediatric and adult patients without complications.

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Obstetric anaesthesia: informed consent

To the Editor:

The Department of Anaesthesia at Mount Sinai Hospital prepared a brochure to provide parents-to-be with an introduction to the obstetric anaesthesia service. The brochure was mailed to all obstetric patients six to eight weeks before admission for childbirth.

We selected, randomly, 62 patients in our delivery room in July and August, 1988 to determine if they had received the brochure and their response to it. We included only those patients who satisfied the criteria below.

1 ASA I or II
2 BP <140/90
3 Age 18–35 years
4 Gestational 38–42 weeks
5 Intention of vaginal delivery
6 Contractions >3 minutes apart
7 Comfortable between contractions
8 No sedation or narcotics given

Only 33 of 62 patients recalled receiving the brochure. All these patients read the brochure but only 23 remembered what it concerned and all thought that it was clear about the various methods of pain relief available.

We asked directly if the brochure provided enough information to give an informed consent about receiving an anaesthetic. Four patients felt that the brochure gave too little information and six were unsure if it gave enough information to give informed consent. This illustrates one of the problems of obtaining "informed consent" prior to obstetric anaesthesia.

In our hospital, there are numerous physicians who might obtain informed consent from the obstetric patient who may or may not be in labour. We have no standard routine, and discussion is left to the individual doctor. We are not aware of any guidelines that would ensure a legally acceptable consent. We speculate that guidelines established by our national bodies might help satisfy all concerned parties that a thorough attempt had been made to provide patients with sufficient information to make a reasonable decision regarding their anaesthetic care.

It is not possible to ensure that enough patients receive or understand a brochure such as we have distributed. Information sent in this manner will not eliminate the need to give more information on a one-to-one basis at the time of hospital admission. Perhaps the most useful feature of such a brochure is that it enables informed consent to be obtained more readily in some patients at the time of admission.

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Obstetric epidural analgesia in remote hospitals

To the Editor:

Dr. Palahniuk's editorial[1] regarding obstetrical epidural anaesthesia in remote hospitals underlines the challenge facing uncertified anaesthetists in small communities across the country. Dr. Palahniuk states emphatically that the GP anaesthetist must be prepared to stay in the hospital throughout the duration of an epidural anaesthetic. Quite apart from the fact that such a rule would eliminate the availability of epidurals for labour in community hospitals in Northern Ontario where I practise, this rule is clumsy and indirect in achieving its purpose.

The "Availability Rule for Epidurals" should be stated in terms of response time to the bedside rather than building location of the anaesthetist if it is to be of any help to those of us in remote communities. In my small town distances are short and the three anaesthetists all have response times of five minutes from either home or office to any bedside in our hospital. Intermittant "top-ups" are used and the anaesthetist is always at the bedside for these. The physical presence of the anaesthetist in the hospital, if he is tied up in the OR and unable to respond to his epidural patient, is about as useful as the moose pellets which litter the ground in this part of the country.

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REFERENCES

1 *Palahniuk RJ*. Obstetric epidural analgesia in remote hospitals. Can J Anaesth 1988; 35: 448–50.

REPLY

Dr. Blount correctly points out that the response time to the bedside is the key issue in safely providing continuous epidural analgesia in any community. Since life-threatening complications can occur suddenly, ready availability of the anaesthetist (GP or certified) is mandatory. Even then, the nursing staff must be taught to recognize the complications and initiate proper management while awaiting the arrival of the anaesthetist. Obviously, the sooner this arrival, the safer the care of this patient will be.

It would be as difficult for me to comment on the speed of Dr. Blount in responding to an urgent call from the nursing unit as it would be to comment on the potential usefulness of moose pellets, since I have never seen either.

The "in the hospital rule" implies that the anaesthetist is accessible to the nursing staff and readily available to attend to the patient. I stand by this recommendation as a minimum standard of safety in the provision of epidural analgesia.

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Avoiding nosocomial infection in anaesthesia

To the Editor:

Current trends are leading to increasing numbers of outpatient anaesthetics and same-day admissions for surgery. Larger numbers of short procedures are being performed serially in one operating room during the working day. A rapid patient turnover, lack of nausea and vomiting, cost effectiveness and a short duration of postoperative CNS depression and outpatient stay are important goals in this modern practice.

Often, only portions of single-dose ampoules of multiple drugs are given to each patient during anaesthesia, i.e., midazolam 1–2 mg, droperidol 0.625–1.25 mg, d-tubocurarine 1 mg, sufentanil 5–10 μg. Increasingly, one notices colleagues who carry syringes with them, which are used to portion out the medications to successive patients throughout the day. Cost containment mitigates against wasting excessive amounts of unused and expensive drug. Changing the needle after each patient seems convenient and often adequate if no reflux into the syringe occurs and needles are indeed changed. This is unlikely in my experience with most average personnel and even the most compulsive person will falter occasionally.

Recently, it has been shown that needles introduced into IV tubing pose a threat of infection, even if no blood was given through the tubing and no blood contamination was apparent.[1] The use of stopcocks in IV tubing systems was recommended for incremental drug injections to prevent "needle stick" autoinfection. *Excluding* the use of needles during injection into patient IV lines further eliminates contamination of multiple use vials from patient-contaminated needles as syringes connected to IV lines are routinely discarded. Fractionation of drugs into multiple syringes before approaching the patient is feasible, cost effective and hygenic and highly desirable.

The increased number of laryngoscopies occurring each day has not been associated with an increased number of larngyscope blades available to each theatre. Although all other endoscopes are routinely subjected to high-level disinfection between patients, and this level of disinfection is prescribed for all blood- or secretion-contaminated instruments, one finds a laryngoscope blade returned to duty after a rinse with water and perhaps soap or Polyvidone-iodine. The lack of documentation of nosocomial infection secondary to anaesthetic practice most likely reflects a long incubation period and lack of follow-up, combined with a low incidence. The changing demands anaesthetic practice should not compromise common sense principles of hygiene and reemphasis appears warranted at this time. Single use items should be used on one individual and disinfection of multi-use instruments should be appropriate to the degree of contamination and patient penetration.

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