

KEY PRINCIPLES OF ANAESTHESIA

KEY PRINCIPLES OF ANAESTHESIA

Optimum patient care is dependent on a collaborative approach by the anaesthetic and surgical teams. The importance of multidisciplinary collaboration has been clearly demonstrated by national audits such as the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) and the Confidential Enquiry into Maternal Deaths in the UK. These audits have led to changes in clinical and non-clinical practice to improve morbidity and mortality. The use of a safety checklist in operating theatres in the form of the World Health Organization's (WHO) 'WHO Anaesthesia'; the name was suggested by Oliver Wendell-Homes, first appeared in Bailey's William Thomas Gren Morton, 1819-1868, dentist who practised in Boston, MA, USA. Horace Wells, 1815-1848, Harvard, CT, USA, dentist who pioneered the use of nitrous oxide anaesthesia to prevent pain during dental procedures. Sir James Young Simpson, 1811-1870, Professor of Midwifery, Edinburgh, UK. John Snow, 1813-1858, general practitioner, London, UK, was one of the pioneers of anaesthesia. Humphrey Davy, 1800, suggested that nitrous oxide inhalation might be used to relieve the pain of surgical operations and named it 'laughing gas'. Henry Edmund Gaskin Boyle, in 1917, got his gas-oxygen machine, which became the first 'Boyle apparatus'. The first examination for a Diploma in Anaesthesia was held in London in 1935. The First Chair in Anaesthesia: Ralph Waters, Wisconsin, USA, in 1933 and RR Macintosh in Oxford, UK, in 1937. During the First World War Sir Ivan Magill and Stanley Rowbotham. Sir Magill is also remembered for his laryngoscope, Magill attachment and laryngeal forceps. Surgical Safety Checklist' has shown a reduction in the incidence of perioperative untoward events. - The role of the modern anaesthetist has evolved from just - being responsible for the patient in the operating suite into a 'perioperative physician' who optimises the patient for surgery, assesses and minimises risk, cares for the patient during the operation and then manages both pain and homeostasis in the postoperative period. Summary box 23.1 Ground rules for anaesthesia /uni25CF /uni25CF /uni25CF /uni25CF -

Local and regional anaesthesia techniques • The management of chronic pain and pain from malignant • disease Safe surgery is achieved by close teamwork between the surgeon and the anaesthetist Safety checklists ensure that things are not forgotten Risk assessments allow the best strategy to be chosen Anaesthetists are extending their care into the pre- and postoperative phases

KEY PRINCIPLES OF ANAESTHESIA

Optimum patient care is dependent on a collaborative approach by the anaesthetic and surgical teams. The importance of multidisciplinary collaboration has been clearly demonstrated by national audits such as the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) and the

Confidential Enquiry into Maternal Deaths in the UK. These audits have led to changes in clinical and non-clinical practice to improve morbidity and mortality. The use of a safety checklist in operating theatres in the form of the World Health Organization's (WHO) 'WHO Anaesthesia'; the name was suggested by Oliver Wendell-Homes, first appeared in Bailey's William Thomas Gren Morton, 1819-1868, dentist who practised in Boston, MA, USA. Horace Wells, 1815-1848, Harvard, CT, USA, dentist who pioneered the use of nitrous oxide anaesthesia to prevent pain during dental procedures. Sir James Young Simpson, 1811-1870, Professor of Midwifery, Edinburgh, UK. John Snow, 1813-1858, general practitioner, London, UK, was one of the pioneers of anaesthesia. Humphrey Davy, 1800, suggested that nitrous oxide inhalation might be used to relieve the pain of surgical operations and named it 'laughing gas'. Henry Edmund Gaskin Boyle, in 1917, got his gas-oxygen machine, which became the first 'Boyle apparatus'. The first examination for a Diploma in Anaesthesia was held in London in 1935. The First Chair in Anaesthesia: Ralph Waters, Wisconsin, USA, in 1933 and RR Macintosh in Oxford, UK, in 1937. During the First World War Sir Ivan Magill and Stanley Rowbotham. Sir Magill is also remembered for his laryngoscope, Magill attachment and laryngeal forceps. Surgical Safety Checklist' has shown a reduction in the incidence of perioperative untoward events. - The role of the modern anaesthetist has evolved from just - being responsible for the patient in the operating suite into a 'perioperative physician' who optimises the patient for surgery, assesses and minimises risk, cares for the patient during the operation and then manages both pain and homeostasis in the postoperative period. Summary box 23.1 Ground rules for anaesthesia /uni25CF /uni25CF /uni25CF /uni25CF -

Local and regional anaesthesia techniques • The management of chronic pain and pain from malignant • disease Safe surgery is achieved by close teamwork between the surgeon and the anaesthetist Safety checklists ensure that things are not forgotten Risk assessments allow the best strategy to be chosen Anaesthetists are extending their care into the pre- and postoperative phases

KEY PRINCIPLES OF ANAESTHESIA

Optimum patient care is dependent on a collaborative approach by the anaesthetic and surgical teams. The importance of multidisciplinary collaboration has been clearly demonstrated by national audits such as the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) and the Confidential Enquiry into Maternal Deaths in the UK. These audits have led to changes in clinical and non-clinical practice to improve morbidity and mortality. The use of a safety checklist in operating theatres in the form of the World Health Organization's (WHO) 'WHO Anaesthesia'; the name was suggested by Oliver Wendell-Homes, first appeared in Bailey's William Thomas Gren Morton, 1819-1868, dentist who practised in Boston, MA, USA. Horace Wells, 1815-1848, Harvard, CT, USA, dentist who pioneered the use of nitrous oxide anaesthesia to prevent pain during dental procedures. Sir James Young Simpson, 1811-1870, Professor of Midwifery, Edinburgh, UK. John Snow, 1813-1858, general practitioner, London, UK, was one of the pioneers of anaesthesia. Humphrey Davy, 1800, suggested that nitrous oxide inhalation might be used to relieve the pain of surgical operations and named it 'laughing gas'. Henry Edmund Gaskin Boyle, in 1917, got his gas-oxygen machine, which became the first 'Boyle apparatus'. The first examination for a Diploma in Anaesthesia was held in London in 1935. The First Chair in Anaesthesia: Ralph Waters, Wisconsin, USA, in 1933 and RR Macintosh in Oxford, UK, in 1937. During the First World War Sir Ivan Magill and Stanley Rowbotham. Sir Magill is also remembered for his laryngoscope,

Magill attachment and laryngeal forceps. Surgical Safety Checklist' has shown a reduction in the incidence of perioperative untoward events. - The role of the modern anaesthetist has evolved from just - being responsible for the patient in the operating suite into a 'perioperative physician' who optimises the patient for surgery, assesses and minimises risk, cares for the patient during the operation and then manages both pain and homeostasis in the postoperative period. Summary box 23.1 Ground rules for anaesthesia /uni25CF /uni25CF /uni25CF /uni25CF -

Local and regional anaesthesia techniques • The management of chronic pain and pain from malignant • disease Safe surgery is achieved by close teamwork between the surgeon and the anaesthetist Safety checklists ensure that things are not forgotten Risk assessments allow the best strategy to be chosen Anaesthetists are extending their care into the pre- and postoperative phases

Revision #1

Created 2025-12-31 15:11:09 UTC by Omar Ayman

Updated 2025-12-31 15:11:09 UTC by Omar Ayman