

'Icarus Allsorts'

Many years ago, before anybody outside the US military used email, a typed message was delivered to members of the anaesthetic department (eight consultants and a handful of trainees). Reading like something out a Poirot mystery, it produced a huge amount of interest. If Joanne, the secretary, knew anything about the purpose of the meeting she disguised it very well.

'I have something of great importance to discuss with you next Thursday. Please assemble at six pm in the seminar room.'

In those days there were no evening 'waiting list initiatives'. Had there been such opportunities for overtime they would have been spurned. Come Thursday evening a silence settled over the hospital and the neighbouring Nuffield as the anaesthetists withdrew to hear what it was all about.

The author of the cryptic message, consultant anaesthetist and former medical director Miles Rucklidge, addressed the attentive audience with a potted version of the history of aviation. His thesis was that progress was not linear. Montgolfier's balloon, the Wright brothers' aeroplane and Frank Whittle's jet engine were examples of very brief groundbreaking brilliance interspersed with decades of stagnation.

Just as the baffled meeting was about to give up and decant to the Waterwitch, he got to the point.

The Trust was building a new hospital and he was commissioning the piped gas system. Why not give up using nitrous oxide as an anaesthetic gas and omit nitrous oxide pipelines? Nitrous oxide was destined to become an obsolete drug, its presence in the hospital demanded standards of oxygen monitoring, and costs, that were higher than would be required if we didn't have it. We could abolish the risk of hypoxic gas mixtures by not putting nitrous oxide pipes into the new hospital. Furthermore, and this was the important bit, the Trust would be to be first in the UK to get rid of the stuff.

It was clearly a groundbreaking thing; and a tempting one at that.

The reaction was a mixture of wonder and outrage. Wonder at the sheer brilliance of the idea, excitement that a small organisation in a little known corner of Lancashire could come up with a national 'first'. It was my predecessor, the late Phil Allen, who led the counterattack, with characteristic pragmatism. It would require, at a stroke, the abandonment of time-honoured techniques and was a huge restriction of the old principle of clinical freedom. He was not going to be pushed into new fancy techniques just to be seen to be first. Miles's great idea (in those days consensus ruled) never had a chance.

A generation later, the organisation has another groundbreaking opportunity to become a national 'first'. In the meantime there has been some change. The anaesthetic department has tripled in size. 'Clinical freedom' has been replaced by NICE guidance and Drugs and Therapeutics Committees. Clinical 'leads' no longer need consensus.

But the electronic patient record (EPR) dwarfs them all.

The EPR has arrived, and we are its privileged standard bearers. But we don't know how it will affect practice. Here are a few suggestions as to what we might expect.

Access to an EPR will be restricted to those who have the legitimate right to it. Unauthorised access can be traced and will be followed up. It will be very dangerous to attempt to establish mother-in-law's prognosis, a prospective child minder's sanity, or the details of a sick colleague's scan. What used to be wrong or illegal can now be put right.

This is obviously a good thing. But are there drawbacks to a system where individual staff have to be granted access to records rather than walk into a ward and pick up a set of notes? Nurses working a single ward and consultants who 'own' beds need access to the records of their patients. But will they get the whole record or just their specialty specific record? What about staff who visit, or multidisciplinary teams? They will need to establish a formal and legitimate access by means of a referral. Referrals will be traced as having occurred at a particular time – no more faxes with illegible signatures sitting in in-trays awaiting the weekly ward round! Link this system with an electronic version of the duty rota (automatically checked for compliance with the 48-hour week?) and there will be a clear record of who can visit, when the visit should occur and whether it did. It will be possible to establish whether there really are inpatients who do not see a doctor for three days, and if there are, who is making the decisions on behalf of the doctors. Those decisions, whether they be for investigations or prescriptions, will be, naturally, subject to 'permissions' granted by pathology or pharmacy overseers acting according to published protocols: 'we don't cross match for hip replacements', 'we don't do costa-lot-ozole'. Clinical information of the sort that used to be exchanged over lunch is as out of date as the consultants' dining room: the EPR has no place for informal, off the record, wisdom. It all sounds too good to be true.

There was one aviator that we didn't discuss on that memorable evening – Icarus. Icarus was, if you remember the myth, the pioneer aviator who got it wrong. Didn't read the manual or attend the training course, tried to push the technology too hard in pursuit of his dream, flew too close to the sun and melted the wax that held the feathers on his wings.

As they say in anaesthesia, high flying is all very fine, but low flying is actually more exacting and satisfying. Doing the job well and consolidating the ground is as important as being the being the first and breaking up the ground (see pages 35-38). Learning from others' mistakes (see pages 39-42) saves us from the hubris of Icarus. And if you read the small print (see pages 50-54), you will see that nitrous oxide is fashionable again.

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