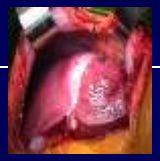
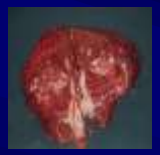
Working with Surgeons Team Dynamics in the Operating theatre

Dr Alex Yeo Sow Nam


Lahore
Mt. Everest
(highest point in Asia
and the world, 8850 m)
HIMALAYAS
Chengdu
Wuhan
Shanghai
New
Delhi
NEPAL
Kathmandu
BHUTAN
Thimphu
Chongqing
East China
Sea
Okinawa
Kānpur
Taipei
BANGLADESH
Dhaka
Ahmadābād
Kolkata
(Calcutta)
Mandalay
BURMA
Pyinmana
Hanoi
Hong Kong
S.A.R.
Macau
S.A.R.
Taiwan
Luzon Strait
INDIA
LAOS
Vientiane
Gulf of
Tonkin
Hainan
Dao
Mumbai
(Bombay)
Hyderābād
Rangoon
Bay of
Bengal
PARACEL
ISLANDS
THAILAND
VIETNAM
Manila
Bangkok
South China
Sea
ANDAMAN
ISLANDS
(INDIA)
CAMBODIA
Bangalore
Chennai
(Madras)
Phnom Penh
Ho Chi Minh City
Andaman
Sea
Gulf of
Thailand
SPRATLY
ISLANDS
Laccadive
Sea
Colombo
SRI
LANKA
NICOBAR
ISLANDS
(INDIA)
Bandar Seri
Begawan
BRUNEI
Male
Kuala
Lumpur
Medan
MALAYSIA
Celebes Se
DIVES
Singapore
SINGAPORE
SINGAPORE
INDON
Jakarta
Java Sea

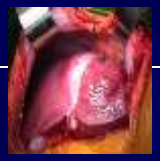
CEO , Orchard Surgery Centre, Paragon, Singapore
300 surgeries/ month
120surgeons
30staff(nurses/ancillary)
24 Hour stay

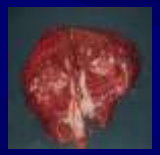






Why Surgery ?

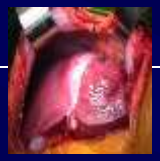
- Quick answer
- Almost immediate results
- Permanent solution
- Reasonable risk of morbidity/mortality
- Short term “side-effects”
- Transient limitation of ADL

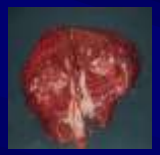






What Can Surgery Do ?

- Remove tumour
- Bypass a luminal blockade
- Stent a luminal blockade
- Create stability
- Restore function/mobility
- Stop bleeding




Concepts

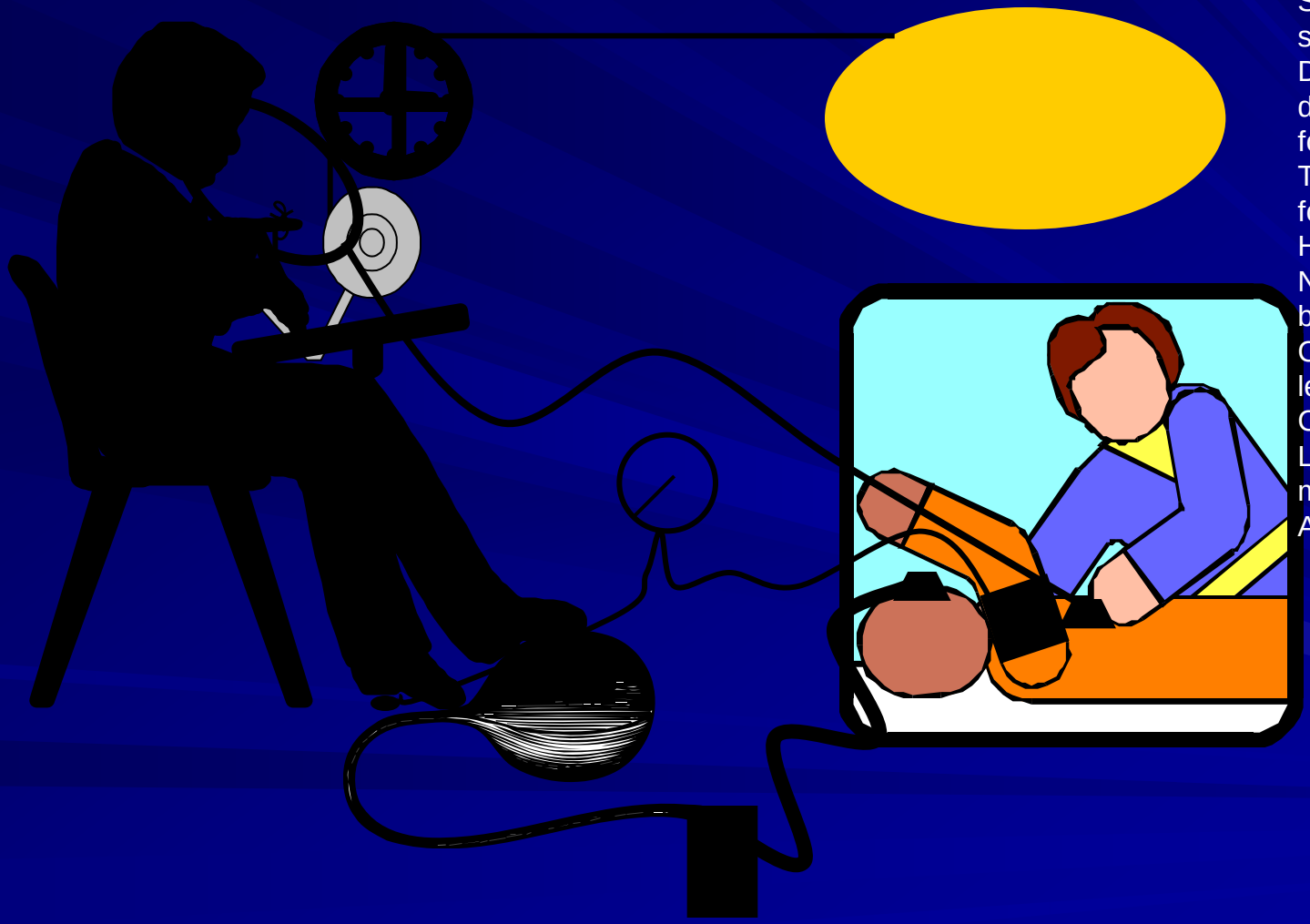
- Need not be last resort
- Need not be radical but may be major
- Could always be considered as an option
- Results of operation must be good before embarking on this option – choice of surgeon
- Do No More Harm

Team Dynamics and Mindsets

- Constant communications and no compromise on standards and safety
  - ASA status
  - Preop, IntraOp, Postop
  - Cost vs preop investigations/ referrals vs intraop monitoring devices vs postop ICU care
  - Professional relationships with staff and Surgeons and Social Relationships and Academic Research
  - Comanaging complications

THE “NEEDLE MAN”

THE CLASSIC “PERFECT” ANAESTHETIST

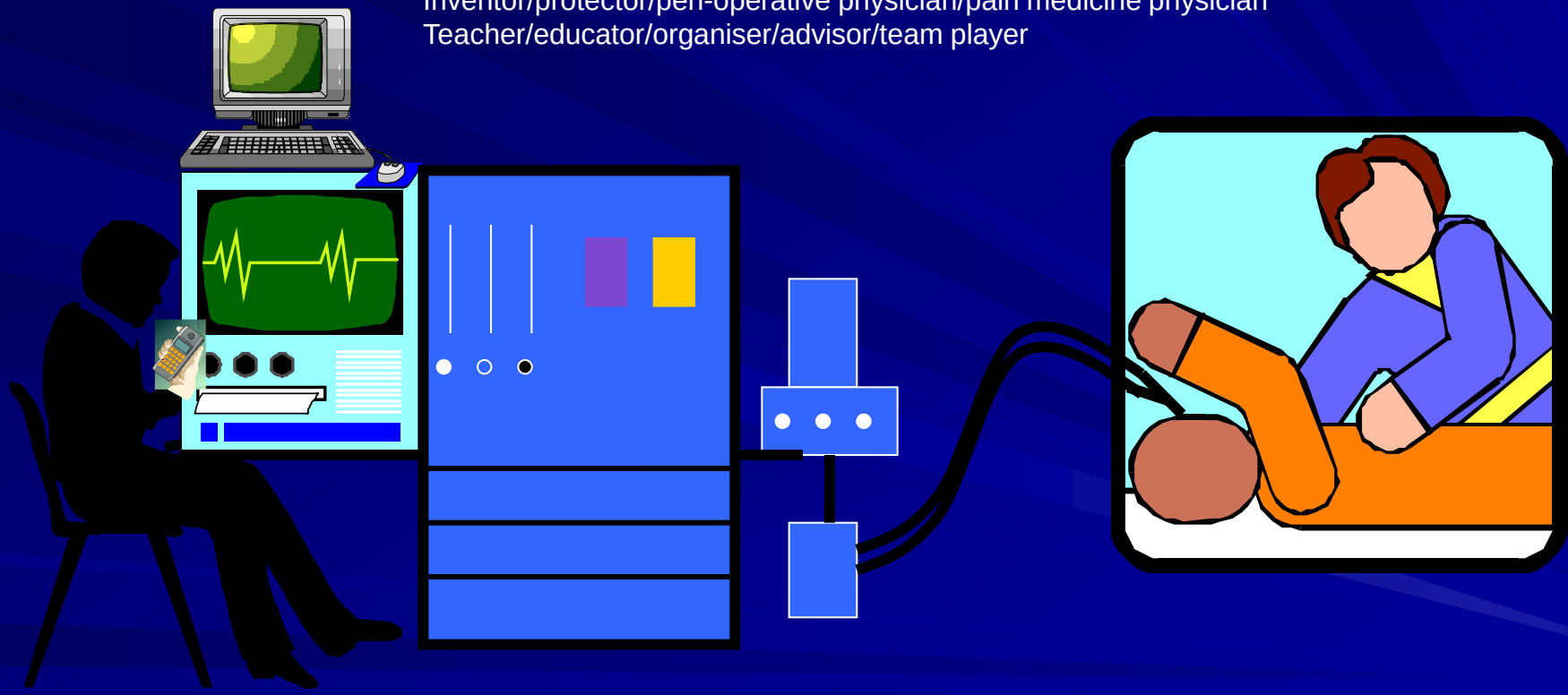


Never speaks unless spoken to
Sits in the corner away from the sterile field
Does not use ventilator as it disturbs the surgeon, uses left foot
Takes blood pressure with right foot
Has a 10 gallon bladder
Never eats or take coffee breaks
Controls the theatre lights with left hand
Charts with right hand
Listens to heart beat with modified stethoscope
Able to mop surgeons brow

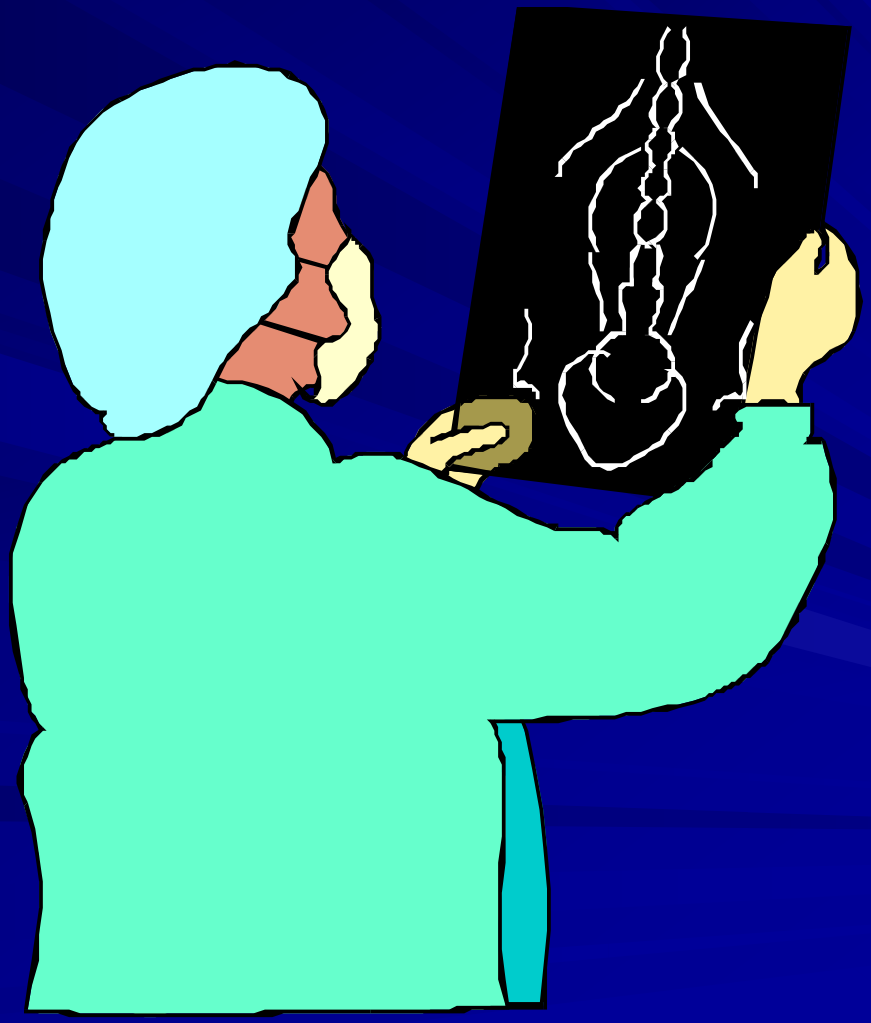
THE PROFESSIONAL CONSULTATION

THE NEW ANAESTHETIST

Computer literate
Able to interpret complex rhythms
Can manage list/personal calls/stockbroker by mobile phone
Able to operate a complex anaesthetic machine
Inventor/protector/peri-operative physician/pain medicine physician
Teacher/educator/organiser/advisor/team player



THE PERI-OPERATIVE PHYSICIAN

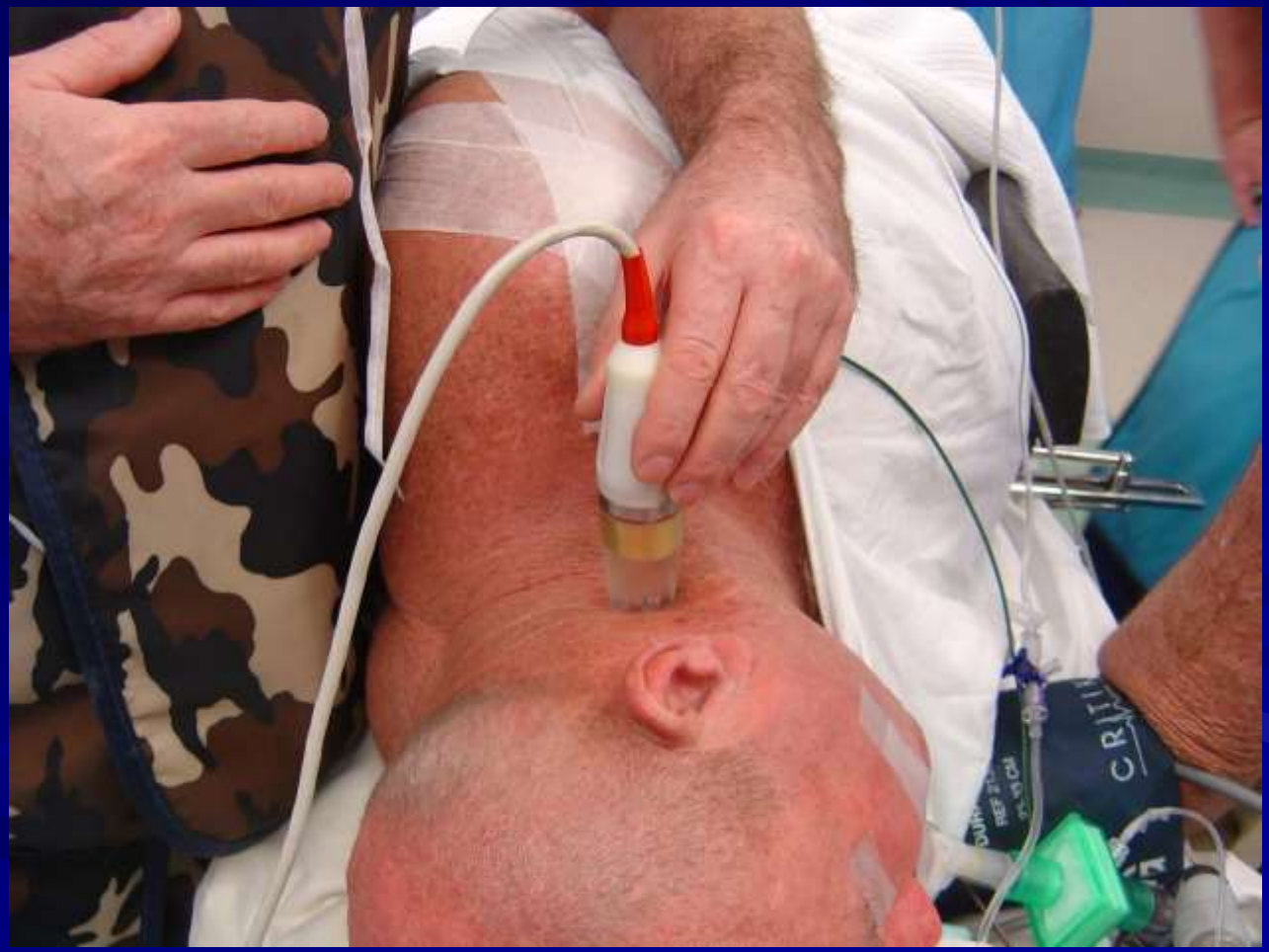


THE PROTECTOR

ACUTE PAIN MANAGEMENT

THE INVENTOR/ ADVISOR

EQUIPMENT



5-10MHz, 9cm depth, 38mm Linear/Curved Array

Nerves, Musculoskeletal

↑ Frequency, ↑ resolution

↓ Frequency ↑ penetration

THE CART

THE EQUIPMENT

THE ATTACHMENTS

THE REFINEMENTS

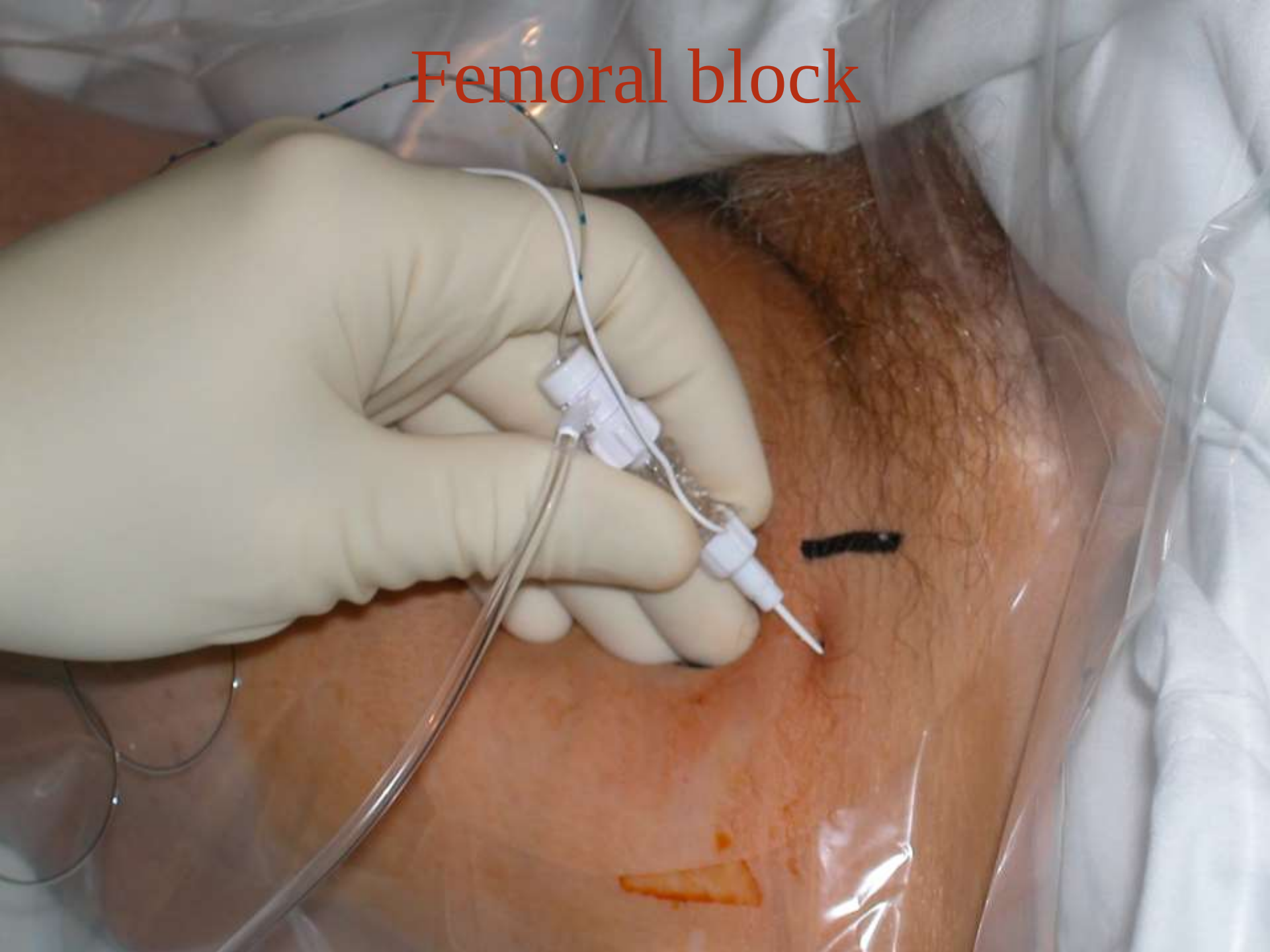
THE SAFEGUARDS

Persistent postsurgical pain is a common but under-recognized problem

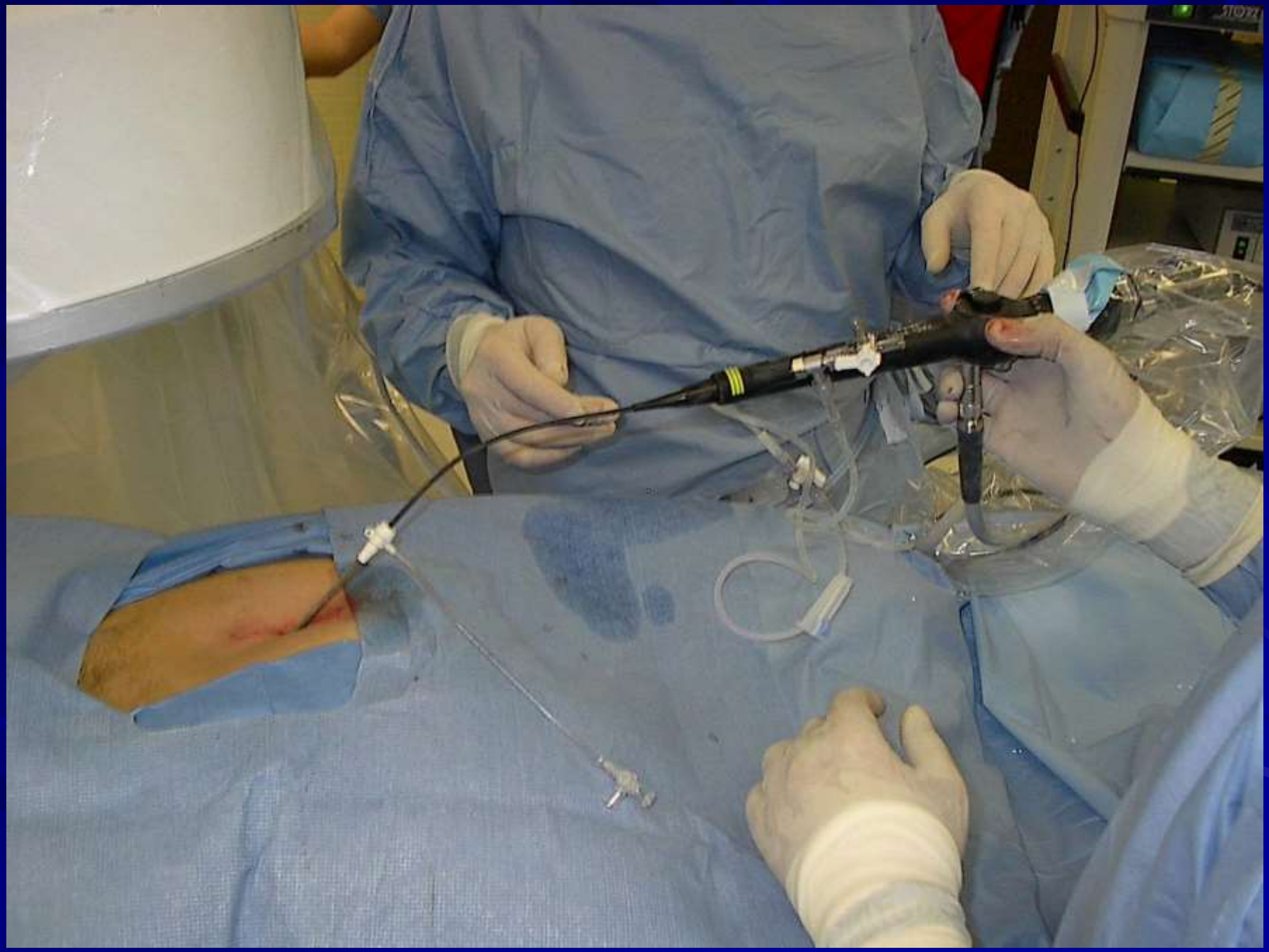
	Estimated incidence of persistent postsurgical pain	Estimated incidence of severe (disabling) pain	Estimated US surgical volumes (1000s)
Inguinal hernia repair	10%	2–4%	600
Lower limb amputation	30–50%	5–10%	160
Breast surgery (lumpectomy or mastectomy)	20–30%	5–10%	480
Thoracotomy	30–40%	10%	200
Total knee arthroplasty	12%	2–4%	550
Coronary artery bypass surgery	30–50%	5–10%	598
Caesarean section	10%	4%	220

1. Kehlet H, et al. *Lancet* 2006;367:1618-1625;
2. Durkin B, et al. *Expert Opin Pharmacother* 2010;11:2751-2758.

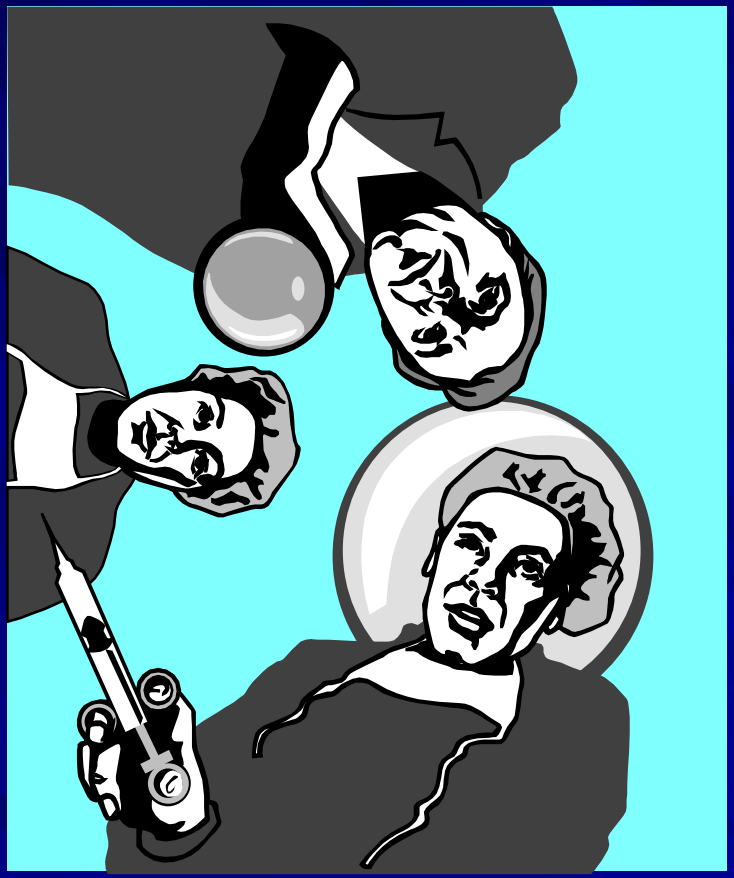
Femoral block



AAOS Washington



STILL THE “NEEDLE MAN” BUT MUCH MORE



Thank you

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