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Are we too focused on blocks, to care, for the patient as an individual who needs holistic care?

"Work is love made visible"
Khalil Gibran

We feel very contented, useful and happy when our patients are safe and comfortable in the perioperative period. Learning new techniques and implementing fresh ideas add a lot of meaning and zeal to our daily work. Keeping abreast with the latest and honing skills at any given opportunity makes daily work enjoyable. Regional anesthesia (RA) is one such aspect that constantly demands grooming. The scope and play of RA are ever increasing. Certainly, because this is one of the best tools to treat perioperative pain with least amount of changes in the patient's physiological milieu. RA is evolving more than ever before. With different techniques, modalities, equipment, drugs and yes, attitude. Well thought of workshops, skill courses, fellowships, etc., offer precise and vigorous teaching to hone these skills. Text books, internet, etc., keep adding to the existing knowledge. Introduction of ultrasound-guided regional anesthesia (USGRA), with its promises, has made all of us take a rightful note of it. We all want to travel over the learning curve of USGRA to make the most of this tool and why not! USGRA has made RA objective and the dual modalities are nullifying the failure rates. Yes, we are steadily marching towards an era where regional blocks and GA may almost have equalled the success rates!

Being an ardent RA enthusiast, I understand the focus, practise and dedication required to perfect these skills. Although this is true, it is high time we ponder on issues that we might miss by being too focused on technical aspects! Apart from dexterity few other skills are required for a successful conduct of RA.

To sum up and introspect on the most pertinent aspects that matter while performing RA is the main reason for penning down this editorial.

Is the preprocedural communication with the patients adequate?

The onus of communication and reassurance is much more on us while conducting a case under RA than otherwise. The RA procedure should be explained adequately. The various other options including sedation should be discussed. The benefits of RA should be explained with a clear emphasis of it being a 'business class in post-operative pain management'. It would be thoughtful to communicate in advance about the insensate and numb extremity post-operatively if the block is expected to remain 'dense'. In our experience, adolescents and school-going children seem to be most affected by this. Sedation and occasional conversion to GA if the block fails could be mentioned, especially if such a question is asked. A well-informed patient is more likely to be cooperative.[1]

Is consent specific to RA taken? And have we documented any previous neurological deficits in the area which the block shall render temporarily insensate?

Fundamentally, we require consent for any procedure. Zarnegar *et al.*[2] in their survey pointed out the inadequacy in this area. Their results showed that the recall of surgical risks was overall significantly better than recall of brachial plexus block risks. We need to improve our understanding of the consent for RA. The *Academy of Regional Anesthesia (AORA)*, India (Annexure 1), suggests a consent form with a specific mention of RA and its related aspects. Readers would find this form at the end of this editorial.

Is the Anesthesiologist–Patient interaction before wheeling the patient inside the operation theatres (OT) given its due importance?

The quality of anesthesiologist–patient interaction matters a lot. Surveys have shown that it improves the quality of PNB, and moreover, the willingness of patients to undergo repeat PNB.[3] The anesthesiologist in the OT and pre-anesthesia check-up may be two different people. A quick self-introduction is an etiquette we owe our patients irrespective of the set up. A reassuring tone, positioning the fractured extremity in the least painful position, administration of IV analgesics or sedation[4] go a long way. All this shall set a correct attitude of the patient to the RA procedure, which is shown to influence results.[5] The most crucial time points are shifting through the corridors, from the trolleys to the operation table and back.

Is the checklist seriously looked into?

It is mandatory to keep our resuscitation carts, intralipids and routine anesthesia equipment checked. RA is never an excuse for taking safety for granted.

Is an effective and liberal skin infiltration with local anesthesia our normal practise?

The fear and complaint of needle puncture is the greatest negative factor for RA. Are we so engrossed on visualising

the needle on the ultrasound screen that the wincing of the patients faces on repeated adjustment and passes don't strike us? Have we given a thought to the pain elicited by the end motor response of a fractured limb? We need to answer this to improve patient satisfaction which shall go a long way in making RA more acceptable.

Do we communicate with the patients while we give blocks?

We understand it will come with time once the dexterity is mastered but that should be the goal. As awake patient is the best monitor to pick up LAST. Of course, there is no such luxury in pediatric population!

Do our surgical colleagues know our anesthesia plan?

This is team work, and functions the best when well-coordinated. Besides, they know what to expect especially in post-operative interpretations.

Have we planned patients position for the surgery?

A cold operation theatre, uncomfortable position on the operating table, surgical drapes, a full urinary bladder, etc., can add up to a lot of discomfort for an awake patient despite an effective RA. Warmers, reassurance and sedation can ease out these difficulties.

To sum up, RA is a fascinating subject. It imparts lot of safety. It is almost evangelising due to the profound pain relief it offers. But a perfectly placed block can be a nightmare to the patients if we don't take a holistic approach towards it.

We shall miss the point totally if we have a perfectly acting block but an uncomfortable and dissatisfied patient. Our patients should be happy enough to be our ambassadors.

Are our patients really satisfied with RA? should be our main concern today because success rate is something, we are more conditioned to think about and pretty much close to the target.

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ACADEMY OF REGIONAL ANESTHESIA OF INDIA

Informed Consent form for Anesthesia (Including Blocks)

Name: …… …….Age/Sex:……..

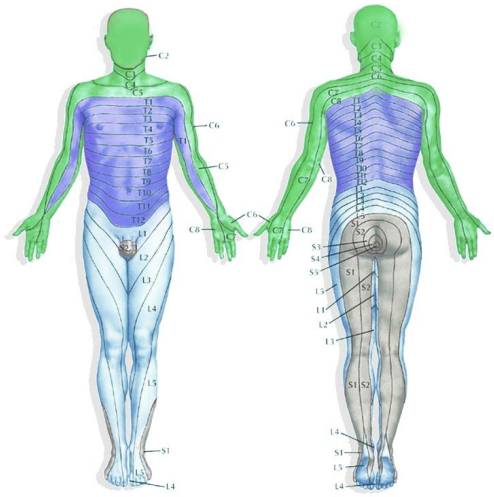
Hospital I.D:……Date:……

It has been explained to me that all forms of anesthesia involve some risks. I am aware that the plan of anesthesia is decided according to the my medical condition(s), my preferences, surgery, discussion with my anesthesiologist & the and surgical team.

General Anesthesia	Technique and expected results Risks	Unconsciousness by giving injection in to blood,/ breathed in to the lungs ± tube in windpipe Hoarseness, Mouth/ teeth injury, Nausea, Vomiting, aspiration, awareness, pneumonia.
Spinal or Epidural Anesthesia/ analgesia With Sedation Without Sedation	Technique Expected result Risks	Drug injected through a needle/ catheter placed into the fluid of the spinal canal; or immediately outside the spinal canal Temporary decreased/ loss of feeling and/or movement of lower part of body Headache, blood vessel injury, persistent weakness, residual pain, backache.
Nerve Block/ Fascial Plane Block With sedation Without Sedation	Technique Expected result Risks	Drug injected near the nerve by needle/catheter that provides sensation to the area of operation. Temporary decreased or loss of feeling and/or movement of a specific limb or area of body Persistent numbness, weakness, residual pain requiring additional anesthesia, blood vessel injury, nerve injury
Intravenous Regional Anesthesia With sedation Without Sedation	Technique Expected Result Risks	Drug injected into vein of arm/leg, while using an inflated tourniquet proximal to vein Temporary loss of feeling and/or movement of a limb Persistent numbness, blood vessel injury, convulsion
Monitored Anesthesia Care Without sedation With Sedation	Technique (with sedation) Expected Result Risks	Drug injected in the blood vessel/ breathed in to the lungs Reduced anxiety, pain with partial amnesia Vital signs measurement, availability of anesthesiologist Unconsciousness, awareness, depressed breathing.

Past or existing medical problems may increase the risk during and after surgery eg: Heart problem (Heart attack, angina, blood pressure, valvular heart disease), Lung problems (Asthma, chronic obstructive pulmonary diseases, infection) and other diseases like diabetes, kidney diseases, liver diseases, thyroid, alcohol, blood thinning medications.

In the event of sudden unexpected critical condition, I am aware that all the necessary measures as per the requirement and resources available will be done.



Neurological Deficit Already present:
Sensory:…….
……
……
Motor:……
……
……
Other Medical Conditions:
……
……
……
……
ASA status:…..…….

Anesthesiologist's Declaration:
Thorough preoperative evaluation done and patient/ Relatives (Relation……...) are well informed about the procedure and the associated risks. They were given enough time for discussion of the regional anesthesia plan and possible adverse outcome.

Doctor's name:…… ……..Signature: …….

Date:……..Time:……

Surgical Procedure:……

Regional Anesthesia procedure planned:……..

Modality Planned: Ultrasound / Peripheral nerve stimulator/ Landmark guided

Patient's Declaration:
The benefits and risks of various modes of anesthesia have been discussed and explained in detail, in a language that I comprehend, and I have understood. The contents of this form have been read carefully by me and I confirm that I have had the opportunity to discuss and ask questions. I understand the importance of providing a complete medical history, medications, addictions, past anesthetic complications and they must be disclosed to the anesthesiologist. I consent to the anesthesia plan discussed and checked above. I also consent to the alternative type of anesthesia, if necessary, as deemed appropriate by the anesthesiologist.

Name of patient: ……Age/ Sex:……..

Signature of patient: ……Date: ……..Time:……..

Signature of Guardian (if patient is minor):……

Signature of the witness: …….

Relationship to patient: ……