I guess that's why they call it 'The Blues'

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We continue our series in which Consultant Interventionist Dr Michael Norell takes a sideways look at life in the cath lab… and beyond. In this column, he considers surgical outfits.

Over the years they have been white, green, pink, lilac and even a rather unpleasant shade of yellowy-brown, reminiscent of vomit. I refer, of course, not to the various shades of automobiles I have gone through since my first car (a Morris Minor, *circa* 1972 – a dark green, D reg, 'jelly-mould' as they were affectionately referred to), but to the myriad of coloured theatre and catheter lab attire donned by yours truly over nearly four decades of invasive medical procedures.

The first question must be, why? What is the rationale behind such clothing needing to be of any particular tint? I guess it starts with having to discriminate our day-to-day, outdoor clothing from that more suited to the sterile, aseptic and more disciplined environment of an operating theatre of any sort.

The significance of colour

The emotional significance of what we do – let alone its psychological impact – would be lost if, for instance, your spleen was removed by a surgeon wearing a pinstripe suit, or your left main bifurcation was stented by someone in a T-shirt and Bermuda shorts. Like any other costume it adds to the whole ritual, significance and power of all things theatrical.

A slightly dark green is the traditional hue, presumably because of its relaxing and stress-reducing influence, together with the more practical quality of becoming nearly black when covered with blood.

It also marks out the wearer as an individual whose rank and status will not be immediately apparent to the observer. That said, he or she will clearly have a role of significance in an area in which the private, intimate and interior domains of a vulnerable patient are in some way entered, exposed and instrumented by medical staff. So, regardless of appearance, a modicum of respect is, therefore, due, don't you think?

Location

The whole infection control argument is an easy win. Ensuring that the outer garments, worn during procedures in which contagion may occur, can be easily identified and cleaned in a controlled way, sounds very sensible but then raises an often-asked question.

What then is the logic of allowing such a uniform to be worn outside the boundaries of potential sepsis? We are now familiar with cath lab garb being sported on wards, in the Accident & Emergency department and in other hospital areas that are more social, such as clinics and refreshment stops.

On one memorable occasion I was at a regional meeting in a hotel, which, among others, was also attended by a colleague from a neighbouring unit 20 miles away – wearing his cath lab kit! I fully appreciate that such a practice must save on ironing bills for shirts, and on laundry expenses for trousers, but it does drive a coach and horses through even the most lax of current microbiological recommendations.

This particular issue is skirted around in some institutions in which 'blues' are permissible in non-sterile parts of the hospital, while scrubs of a different colour are then donned when the wearer moves into aseptic areas, such as the cath lab or theatre.

Style

As for colour, there are only two underlying principles; they have to stand out and ideally not show the odd drop of spilled haemoglobin as an impressive and unavoidable streak of scarlet. When choosing their particular design of theatre-wear it is predictable that Hospital Trusts will be focused more on purpose, practicality and price rather than colour, fashion and style.

Scrubs, like school uniforms, are the great leveller; they ensure that all of us are dressed in the same way regardless of any financial advantage or familiarity with the catwalk. Nevertheless, there are still some fortunate souls who just seem to look good in such clothes (like George Clooney for instance), and other mere mortals (like me, obviously) who just pull on the nearest, baggiest and most unflattering top-and-bottom and have done with it.

A few modify their appearance by turning up the short sleeves even higher and tucking the trouser bottoms into their socks. This might have some practical value (I struggle with that one) but it still does nothing to improve things and – unfortunately – gives the distinct

impression that they have just stepped off the Starship Enterprise.

Branding

Regardless of colour and style it seems to me that any garment of this sort needs a logo, sign or printing of some form or other in order to identify the hospital – and ideally the department – to which the wearer is attached, as it were. A typical example might be 'Royal Nether-on-the-Wapping Acute Trust; Operating Department' neatly embroidered over the breast pocket in a subtle shade, which, nevertheless, contrasts with the overall colour of the cloth.

In addition to emphasising the idea of the things being a uniform, it reminds us as to which institution we actually belong and thereby provides a sense of *Esprit de Corps*. It also ensures that the owner is unlikely to filch the things and use them as casual beach attire next time they go to the south of France. Why one should wish to look a pillock in such gear anyway I cannot imagine, but one would certainly be less inclined to strut along the Promenade des Anglais in Nice with the words 'Property of Hospital Mortuary' emblazoned on your front and back in the largest possible font size.

I now realise that in penning this column, I am running a little late and am due to attend my weekly clinic half an hour or so behind schedule. But … no worries. I will change rapidly into my trusty cath lab blues (suitably crumpled and stained), tie on a mask to dangle loosely over the top of my chest and pop on a blue theatre hat at a rakish angle. The final flourish is to attach my stethoscope around my neck and, as long as I arrive in the outpatients department in a slightly breathless state, any irritation will turn rapidly to sympathy.

I promise you; it works every time

Wit and wisdom from all Michael Norell's regular columns are online at www.bjcardio.co.uk

Correspondence

A gap between training and provision: a primary-care based ECG survey in North-East England

From Mr Dev Katarey

Dear Sirs,

I read with interest the recent publication by Wolff *et al*.[1] which looked at ECG training in general practice in the North-East of England, and felt that their conclusions were ill-advised. The authors report that general practitioners had low levels of confidence in diagnosing common ECG abnormalities and suggest trained staff should record and interpret ECGs. However, these conclusions are not externally supported.

Regarding the low level of confidence in ECG interpretation, under 70% of GPs with in-house ECG recording and interpretation felt comfortable diagnosing left ventricular hypertrophy (LVH), according to this study.[1] This is in clear contrast to neighbouring Scotland, as most GPs in a cross-sectional study of 123 were able to accurately identify left ventricular hypertrophy (LVH) from assessment of ECGs, a more accurate method of determining association than using confidence.[2] In fact, 57% of GPs achieved a 90% sensitivity of correctly diagnosing LVH on an ECG.[2] Given the training for general practice is identical in Scotland and England, there are unlikely to be major differences in ECG interpretation between GPs in Scotland and those in North-East England.

This letter with a response from Dr Andreas Wolff continues online.

Optimised beta blocker therapy in heart failure: is there space for additional heart rate control?

From Drs Danny Lim, Alyson Tiernan and Raj Mohindra

Dear Sirs,

We undertook a similar audit to Russell *et al*.[1] within the heart failure service of a district general hospital auditing the case notes of 96 patients attending over three months. Applying the SHIFT inclusion and exclusion criteria, we identified only seven patients (6.7%) eligible for ivabradine.

Using the SHIFT dataset the number needed to treat to prevent a single hospitalisation due to heart failure was 22.[2] Extrapolating our data, over 12 months, we would expect to identify approximately 28 suitable patients. Treating 28 patients would result in 1.3 less hospitalisations over one year. Achieving this reduction would cost £14,672 a year (or £524 per patient per year[3]). In contrast, the average hospitalisation for heart failure would cost £2,231; making it unlikely to be cost-effective.[4]

This letter with a response from Dr Stuart Russell continues online.

The full text of this correspondence is available at www.bjcardio.co.uk