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Empty theatres

Looking at part of the problem provides only part of the answer

Last year the National Audit Office took a long hard look at the use of operating theatres in five district health authorities and concluded that they were busy for only a little over half of the available time, with cancelled sessions and overruns accounting for most of the disuse. The report claimed that much tighter administration, unconstrained by historical allocations of theatre time to individual specialties and consultants, was needed for improvement to occur.^{1,2} These observations, which most clinicians would accept as an account of reality however much they might divorce themselves from the remedies then proposed, were lost in the more general crises that affected NHS funding and resources in the ensuing months.

The Committee of Public Accounts has now given its approval to the audit office's opinion on the need for change. It endorses the view that underuse is mostly due to three items: "traditional practices and habits, framed for the convenience of consultants and staff"; scheduled and unscheduled absence of medical staff; and the absence of—and consultant resistance to—the provision of locum cover.³ In regard to the last the committee makes one statement that is hard for those at the sharp end to accept and does not give the public much cause for comfort when it says (para 34) that, in keeping operating theatres running, "it is unacceptable that the quality of locums should be a factor."

Surgeons might be forgiven a sense of déjà vu. No one likes the long waiting lists, almost exclusively surgical, that have characterised the NHS since its inception. But both the original report and the comments of the Public Accounts Committee make the mistake of looking at the use of theatres in isolation. This has led them to underestimate the difficulty of arranging the smooth progress of a routine surgical patient through a system plagued by bottle necks of many kinds and by recurrent crises of funding. (In the case of my own hospital

these financial crises reduced the provision of beds for months on end and led to a doubling of the waiting time for routine surgery.)

The vexatious matters of having enough beds and flexibility of theatre allocation to deal with an inevitably and almost randomly fluctuating case load were described in detail in the *BMJ* recently by surgeons from the Whittington Hospital.⁴ These observers also spelt out the fact that increasing the use of operating theatres will also increase costs—anathema to most managers in 1988. This conclusion will not please politicians making capital from the report.

Throwing at the problem requests for tighter administration and for more disciplinary action against a minority of poorly performing consultants is unlikely to result in radical improvements. Norms for theatre performance need to be established not in isolation but against a background of the overall function of hospital services. We might then see that rather than having what seem to be underused theatres we need more provision to deal with fluctuating and essentially unpredictable demands in an unstable health delivery system. Certainly the accounts committee is being too certain of its remedies on the basis of facts that form only part of a complex issue. Some would argue that this approach is characteristic of political comment about the problems of the NHS.

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