Deaths and anaesthesia

With all the recent talk about audit formal large-scale investigations of current practice remain rare. An investigation of deaths associated with anaesthesia in five NHS regions commissioned jointly by the Association of Anaesthetists and the Nuffield Provincial Hospitals Trust is therefore welcome —despite its having provoked newspaper headlines claiming that "anaesthesia could cost 900 lives each year."

What the survey showed was that 6 in 1000 of patients died within six days of operation but that only one in 10,000 died totally as a result of anaesthesia. To extrapolate from these deaths to the whole of Britain, around 280 deaths each year would be totally attributable to anaesthesia (though some of those would be in patients with other life-threatening disease). Anaesthesia would play some part in 1800 deaths. In both categories avoidable anaesthetic errors could be identified.

The picture that emerges from the report is depressing. Half the deaths occurred in the ward on the day of operation, which suggests that selection of patients for care in recovery rooms was poor. In nearly 10%, of the deaths the anaesthetist had not made a preoperative assessment of the patient, which implies that each year in Britain 300,000 patients are anaesthetised without meeting their anaesthetists.

In contrast to the Confidential Inquiries into Maternal Deaths in England and Wales the report did not highlight and comment on the clinical problems most commonly associated with death. Nor did it look at anaesthetic disasters which may be just as serious: those in which a patient is left permanently handicapped from a prolonged period of anoxia. To some extent there are problems of scale—the sheer numbers of deaths made detailed analysis impossible.

Despite its lack of clinical detail, however, the report has drawn attention to the inadequate facilities and lack of monitoring equipment in some hospitals (20%, have no recovery rooms), yet further evidence of the current underfunding of the NHS. It has also pointed to the failure by some anaesthetists to identify patients at risk long enough before operation for the necessary plans to be made. Trainee anaesthetists are too often left unsupported; medical assistants, clinical assistants, and general practitioner anaesthetists may either not feel at liberty to call for consultant help or have a false belief in their own competence.

In refuting some of the explanations advanced for these findings, Professor J P Payne pointed to some of the particular problems faced by anaesthesia: largely because of its rapid expansion, it is still a shortage specialty and it relies too much on junior doctors for routine services, with a lack of opportunity for proper instruction. Few would disagree, however, that anaesthetic deaths need to be investigated within the profession with the same vigour as maternal deaths have been studied for half a century. That means collection of reliable comprehensive data nationally and more effort locally. Indeed, audit should ideally identify specific failings and quickly bring them to the attention of the clinicians concerned. These aims are probably best achieved at regular "deaths and disasters" meetings in individual hospitals, with only those directly concerned attending. A balance can be drawn between the plain speaking that is necessary and any hint of a self-appointed kangaroo court; the outcome must be seen to be non-punitive. Public concern will be allayed only so long as professional efforts to make audit acceptable are seen to be effective. But that concern should also extend to correcting the underfunding of the National Health Service; until this is done the people of our country cannot be provided with the standards of care to which they are entitled.