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The pursuit of quality in anaesthesia

The two day meeting on "The quality of care in anaesthetic practice," held at the Royal Society of Medicine in June, was the fourth medical meeting conducted in the "Dobbing" style—a format which by all accounts has proved a success.¹ A straw poll of those attending this one rated it only a partial success, a conclusion for which many explanations are possible.

The original Dobbing style restricted the discussion to those who had also written the major contributions; their chapters were circulated to all participants before the meeting, ready for publication, together with written critiques from each of the other authors.² Thus all those attending had studied the papers and the critiques; the chairman then allowed the author to reply briefly to the criticisms and the critics to reply. At this point (as one can imagine) there was no lack of critical discussion and the task of the chairman was merely to ensure that all important ideas were teased out and dealt with.

It did not quite turn out that way at the Royal Society of Medicine meeting. Perhaps the subject matter was not suitable for the treatment; discussions showed that a wide range of apparently disparate activities were already in progress and perhaps there was too much agreement that by and large what could be done was being done, or at least being planned. Then, again, the sessions on experience and practice in the United States served mainly to remind us of the structural differences, not only in the practice and organisation of medicine but also in the constitutional and legal milieu in which it is practised, thus emphasising the unsuitability of trying to transplant something which has been nurtured in alien soil.

Maybe, however, it was the detailed structure within the general framework that was at fault. Thirteen subjects were dealt with, each having 45 minutes for discussion. The warm up time therefore occupied a good deal of each session, and often the discussion was really becoming fruitful only when it was time to stop. As a chapter writer, critique writer, and session chairman (twice), I thought that an important structural weakness was the insistence that the chapter author should not repeat, or even summarise, his views but merely open the session by dealing with his critics. Unfortunately, however, many of them went into matters tangential to the main thrust of the author's argument, so anyone whose recollection of the actual written chapter was hazy found his mind focused on the critiques, since these were the main matters aired and argued over for the first 10-15 minutes of the session.

Professor Dobbing would probably be right, however, in blaming any failure on another important departure from his blueprint. Only a minority of the authors also wrote criticisms, the remainder being written by 23 other participants. Several other participants had taken no part in preparing the material. Therefore most of those present probably had not done—indeed, could not have done—the detailed preparation required for success. I defy anyone to be prepared to debate each of 13 subjects discussed in a book when he is personally familiar with one, at most.

What was really important, however, was that the meeting took place at all, with the leading figures in the specialty and its various professional bodies all participating. Equally important was the evidence of such widespread activity in Britain across a range of matters bearing on quality assurance in anaesthesia. Most of these are well enumerated in a recent document by the Faculty of Anaesthetists of the Royal College of Surgeons of England,³ which draws attention to the relevant aspects of current faculty policy and requirements in this discipline. Many other initiatives, however, have an important bearing on the subject. For example, a sick or erratic doctor is a particularly acute hazard in anaesthesia, and the Association of Anaesthetists was the first professional body to set up a non-coercive scheme of confidential reporting which could arrange for such individuals to be counselled by a nominee of the Royal College of Psychiatrists.⁴ This has been such a success that the British Medical Association and the royal colleges are now trying to develop a national scheme on similar lines.

The association has also recently published a study of mortality associated with anaesthesia and surgery in several regions of the UK and is working to improve the protocol for further studies.⁵ With the same general viewpoint, the implications for anaesthetists of the triennial reports on maternal mortality also merited a session, disclosing among other things that the epidemiological advisers to the Department of Health and Social Security believe that the great improvements of the past 20 years have rendered its continuation no longer cost effective but that bureaucratic momentum would keep it going. This is just as well from the anaesthetic point of view: the general improvement in maternal mortality has not been matched by improvements in the death rate from avoidable complications of anaesthesia.

Another session debated the work on the personality of

anaesthetists⁶ and heard how one major department is experimenting with the use of personality questionnaires and a trained psychologist in the selection process for new entrants to the specialty.

Some easily avoidable tragedies occur at the hands of trainees, and over the years there has developed a nagging unease that the examination hurdles of the Faculty of Anaesthetists are inappropriate to the natural order of training in the specialty. The changes which will come into effect in 1985 are designed to focus the attention of the first year trainee on safety and craft competence before encouraging him to learn the more detailed aspects of pathophysiology, pharmacology, and the physical sciences necessary for the fully trained specialist.⁷ The consequent need to reappraise the influence of National Health Service gradings on the timing of examination hurdles was also touched on.

A topic that was highlighted for further attention was the effect of the quality of management and administration in anaesthetic departments and the importance of efficient scheduling of both work and training. For example, there is a need to mitigate the tensions created when a slow surgeon or an over running operating list threatens to impinge on some other scheduled commitment, whether professional or social. Interestingly, anaesthetics is the first specialty in which a course on management has been specifically designed solely for its members. Another aspect of the possible influence of departmental organisation on the quality of care is the need to rethink what the emergency anaesthetist could be doing while waiting for the emergency. Given reliable communications, could he not be attending to the quality of postoperative pain relief, generally acknowledged to be a major weakness in modern medical practice?⁸

In fact, relatively few totally new ideas emerged that might have a direct impact on safety or on the quality of care. Perhaps this is because in terms of the usual indicators we are now working on a vanishingly small margin. The number of avoidable deaths is a very small proportion of the total number of anaesthetics given and may not be reducible by general educational efforts. It is probably still as true today as when first written that: "In the great majority [of deaths] there was a serious departure from generally accepted safe practice."⁹ Critical incident reporting, recently introduced by the British Airline Pilots Association, may have a more relevant part to play.¹⁰ At the other end of the range much minor morbidity is knowingly accepted for the sake of other benefits.¹¹

From the patient's point of view, empathy and reassurance before the operation, good (and safe) pain control after it, and freedom from the ill effects of anaesthesia are his only possible measures of quality. These are a good deal less easy to measure than the indices on which we currently focus. The vigour with which the specialty, both corporately and individually, is addressing itself to these problems is perhaps merely the obverse of the difficulty of making rapid progress. At all events, and despite its problems, the book which was written (and rewritten) at this meeting promises to be a milestone in the pursuit of high quality care in anaesthesia.

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¹ Anonymous. Less listening, more discussion. *Br Med J* 1981;283:2.

² Dobbing J, ed. *Maternal nutrition in pregnancy: eating for two?* New York: Academic Press, 1981.

³ Faculty of Anaesthetists. *Quality control in anaesthesia*. London: Royal College of Surgeons of England, 1983.

⁴ Anonymous. Help for the sick doctor. *Anaesthesia* 1979;34:410-1.

⁵ Lunn JN, Mushin WW. *Mortality associated with anaesthesia*. London: Nuffield Provincial Hospitals Trust, 1982.

⁶ Reeve PE. Personality characteristics of a sample of anaesthetists. *Anaesthesia* 1980;35:559-68.

⁷ Faculty of Anaesthetists. *Guidance on examinations leading to DA(UK) and FFARCS (Eng)*. London: Royal College of Surgeons of England, 1983.

⁸ Anonymous. Postoperative pain. *Br Med J* 1978;iii:517-8.

⁹ Edwards G, Morton HJV, Pask EA, Wylie WD. Deaths associated with anaesthesia; a report on 1000 cases. *Anaesthesia* 1956;11:194-220.

¹⁰ Craig J, Wilson ME. A survey of anaesthetic misadventures. *Anaesthesia* 1981;36:933-6.

¹¹ Goold JE. Anaesthesia for day-care surgery; a review. *J R Soc Med* 1983;76:415-20.

Changing patterns of cervical cancer rates

Despite all the efforts put into screening for cancer of the cervix mortality from the disease in England and Wales has changed very little in the past 15 years. This apparent lack of effect on mortality rates has raised questions about the effectiveness of the cervical screening programme: doubts have been expressed both about the official policy of concentrating screening on older women¹ and about the actual practice in which more intensive screening appears to have been carried out on younger women²⁻⁴ and on those of higher social class.^{4,5}

Evidence for the effectiveness of screening is available from a number of other countries. Hakama⁶ has summarised recent data from the Nordic countries, concluding that changes in incidence in these countries have corresponded with the level of screening, the effect being most pronounced in Iceland, which has the most intensive screening, followed by Finland and Sweden. In each of these countries screening covers the entire country, but in Finland and Sweden the age range is shorter than in Iceland, and screening is repeated at longer intervals. A smaller effect was observed in Denmark, where only 40% of women are covered by an organised screening programme; in Norway, where the organised programme covered only 5% of the population, the disease showed an increasing trend during the period considered. Hakama suggests that the use of personal invitations to take part in screening programmes is an important factor in bringing women at high risk into the screening programme and hence in the reduction in incidence.

Miller *et al*⁷ found evidence for a relation between the intensity of screening and the fall in death rates from cancer of the uterus in the 10 provinces of Canada between 1960-2 and 1970-2. In a later analysis, however, Miller *et al*^{7a} found no correlation between intensity of screening and changes in mortality over the period 1964-6 to 1974-6; one possible explanation is that the women most at risk were not being covered by the screening programme even though the number of smears was increasing. Cramer⁸ showed that falls in mortality in different areas of the United States were also related to the level of screening. Such relations are not, of course, necessarily causal. Macgregor and Teper⁹ analysed mortality data for the years 1968-76 in Scotland, comparing the Grampian and Tayside regions—where screening was most intensive—with the rest of Scotland, and concluded that trends in mortality in these regions were attributable to the screening programme, though the results were based on small numbers.

Various explanations have been suggested for the apparent