EDITORIAL

THE FUNCTION OF ANESTHESIA STUDY COMMISSIONS

THE scientific justification for the reporting of anesthetic errors or complications to local or state anesthesia study commissions is clear. If every community of reasonable size set up such a commission the number of reports available for study would be materially increased. Only by the correction of errors in judgment or technic can a specialty progress. Unfortunately, death certificates take no cognizance of anesthesia as a cause of death and therefore it is impossible to obtain any mortality figures from this source. That anesthesia was at fault in a large number of maternal deaths is clear from reports on maternal mortality, a number of which have been published in the past 15 years. These studies range from ten year periods by committees on maternal welfare to individual reports from hospitals. The number of deaths ascribed to the anesthetic has ranged from 1 to 7 per cent of the total deaths.

The Philadelphia Anesthesia Study Commission in 1947 published an analysis of operating room fatalities over a ten year period and concluded that half of these on analysis had to be classified as preventable deaths caused by faulty management of the anesthesia.

The assumption of responsibility is a measure of maturity. As the relatively young specialty of anesthesiology moves toward maturity, anesthesiologists are assuming the responsibility for their own errors in judgment and faulty technic. It is human to err and equally human to prefer not to expose one's shortcomings, especially where human life is at stake. Nevertheless, such admissions also are an index of maturity. Only by studying errors in judgment and technic can safeguards be established.

The local and state anesthesia study commissions serve a dual function. They are a clearing house for case reports of anesthetic deaths or complications, under terms of anonymity, and function as bodies to study the many aspects of anesthesia and of the problems which impinge upon the practice of anesthesiology. Accurate and painstaking compilation of data pertaining to deaths during anesthesia will yield information of value in several ways. It should become possible to assess more accurately the problem in the operating room as it relates to anesthesia, permitting one to determine intelligently what steps should be taken to improve anesthetic practice. Extending experience will be a source of more thorough knowledge of therapeutics and prevention of anesthetic complications. The evaluation of new drugs and methods would be quickened and more

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critical judgment brought to their use. It is possible that such studies will reveal the need for the employment in the operating room of diagnostic instruments that will accurately determine the oxygen content of the blood, the state of the circulation, and the cardiac activity at all times. The commissions may also consider it necessary to clarify the terms in common use ambiguously applied, such as mortality, immediate mortality, gross mortality, remote mortality, death on the table, anesthetic death, and so on, and urge universal adoption of definitions agreed upon in an effort to reduce confusion, clarify statistics and promote better understanding. Furthermore, it would seem rewarding to extend investigations and discussions to nonfatal anesthetic complications because, if not properly diagnosed, they may cease to become anesthetic complications in the postoperative period and become cerebral, circulatory or metabolic complications. Thus, fatalities occurring 24 or 48 hours after surgery, and generally attributed to these causes, are often in reality the results of anesthetic complications permitted to become chronic. The same applies to aspiration during anesthesia in obstetrical cases in which death ultimately follows pneumonia which in inception is due to aspiration.

The anesthesia study commissions are beginning to close a serious gap in medical science. They can make it possible to investigate analytically the problems of operative mortality and morbidity as well as postoperative fatalities resulting from anesthetic complications. The fact that anesthesia accounts for a large number of preventable deaths, often in good risk patients undergoing minor surgery, must make the setting up and the functioning of these study commissions as vital a matter to surgeons as it is to the anesthesiologists.

ERRATUM NOTICES

All refer to the July issue:

Page 371. The twelfth line under, "Report of a Case," ventricular rate 350, auricular rate 80, should read ventricular rate 80, auricular rate 350.

Page 496. The twentieth line from the bottom of the page; the word case should be plural.

Page 497. The sixth line from the top of the page; grains of hyoscine, 1/500 should read 1/150.

Page 497. The fifteenth line from the top of the page; grains of ephedrine, ½ should read 1½.

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