The work of the anaesthetist is not of its nature particularly aseptic. He gets his fingers soiled with tracheobronchial secretions and muco-pus, as he handles sucker tubes, laryngoscopes and endotracheal tubes. With a perfunctory wipe on a swab or towel, he can spread contamination to reservoir bag, flowmeter taps and other pieces of equipment. Soiled instruments may be put down on the anaesthetic table top, on which, later, clean instruments are laid out for the next patient. Face masks, breathing tubes, laryngoscopes and the anaesthetic apparatus itself sometimes receive little, if any, real cleansing between patients. This is the common picture even if painted a little darkly. Its main features are still nearly universally discernible; the whole effect must depress any but the least sensitive.

The extent to which the anaesthetist is responsible for serious cross-infection is still only guessed at, though even if it were known it might do little more in the present climate to remedy matters than ordinary fastidiousness should do now.

What we really need are the same standards of cleanliness applied to the work of the anaesthetist as to that of the surgeon. Frequently scrubbed hands, an awareness of the meaning of cross-infection, active sterilization of anaesthetic instruments by such means as Stratford, Clark and Dixson describe in this issue, and a complete change of anaesthetic apparatus for each case, so that the contaminated parts can be cleaned and, where possible, sterilized ready for the next patient.

Essential needs are for comprehension and physical assistance. We can assume that anaesthetists comprehend fully the meaning of cleanliness, sterility and cross-infection. That their comprehension is not carried into practice may be partly due to sloth, but also partly, if not largely, to lack of assistance. Anaesthetists have over the years allowed themselves to be fobbed off with second best where assistance is concerned. That they need a helper is as self-evident as that the surgeon needs one. Whether this is in the form of a theatre technician, or a nurse—high or low in grade—it is important that the duties be well defined. Included in them, the maintenance of cleanliness and sterility of anaesthetic equipment should stand high. Of the nurse it can certainly be said that the ideas of cross-infection and asepsis are imbued into her from the commencement of her training. The technician is another matter, for with no clinical hospital background or paramedical training before he enters the operating theatre, he needs very considerable and arduous indoctrination before he can be relied upon in practice. If, between handling the anaesthetist's tubes and instruments, he is also called upon to adjust lights, swab the theatre floor and to manhandle buckets of theatre refuse, the problem assumes frightening proportions.

Anaesthetists must be adamant on the question of cleanliness and must insist on facilities for maintaining a good standard in this respect from theatre superintendents and hospital authorities. Only then will they be able to satisfy their colleagues, who will surely one day enquire closely into the part anaesthetists play in hospital cross-infection. This part may well be bigger than is suspected.

REFERENCE