very difficult to achieve, because what constitutes “no reasonable prospect of survival” today, may not apply tomorrow, because knowledge and experience will have changed. There is certainly no place for pride or prejudice in making these decisions. What is required is a careful weighing of the available evidence. Certainly this may be difficult, but that does not absolve doctors who work in intensive therapy units from the responsibility of doing so.

J. F. Searle
Exeter

REFERENCES


AWARENESS DURING ANAESTHESIA

Sir,—In view of the comment on a legal action brought for awareness during anaesthesia (Hutter and Tomlin, 1978) it may be useful to describe the points of interest to anaesthetists in a case in which I was asked to advise. The case was heard some 6 years after the event and all the hospital staff concerned were unable to recall any of the “facts” recounted in the Plaintiff’s description of a very unpleasant occurrence. The first independent medical witness to corroborate the Plaintiff’s story did not see her until 18 months after the event. The Judge noted this failure to corroborate the story, the considerable delay before the action was commenced, and he decided that awareness had not occurred. The Court heard that techniques associated with a risk of awareness were used by anaesthetists where deeper anaesthesia was considered dangerous, as for instance during Caesarean section. Anaesthetists who use techniques associated with a substantial risk of awareness, without a specific clinical indication should realize that both parties accepted the patient’s right to be unconscious and not to suffer pain during surgery (Editorial, 1956).

In the 1977 Annual Report the Medical Defence Union referred to difficulties caused by the lack of detailed notes. I imagine that in the above case the prior offer of a small sum in settlement, without prejudice, reflected the genuine doubts concerning an adequate hearing of the case by the defence society concerned, as a result of such lack of annotation.

Anaesthetists should be aware of “traumatic neuroses” similar to that suffered by this patient. Awareness during anaesthesia may form an intense psychological stress, particularly if pain is experienced in addition. Many patients feel degraded and humiliated by this and react by passive de-personalization. They believe themselves to be mad and may make no effort to relate to staff what had occurred. This patient said that she had hidden in her bedroom on her return home, since she felt unable to meet her family. A similar state may follow anaesthetic dreams and can last for several months. Mayer and Blacker (1961) state that where this condition is found, the most effective treatment is a reasonable, accurate explanation of what has happened. Having regard to the difficulties experienced in the case described above, this explanation should not go further than stating that the patient was resistant to the anaesthetic agents used!

Routine visiting of patients after operation will help to detect similar unfortunate cases, but the patients may first describe their unpleasant recurrent dreams resulting from neuroleptanalgesia, or actual awareness, to their general practitioner. Such patients should be referred back to the anaesthetist concerned, for investigation and treatment.

J. M. Cundy
London

REFERENCES


DIFFICULTY IN INTUBATION

Sir,—After reading Dr Dennison’s letter (1978) I feel bound to ask if it was all really necessary. At our hospital, which is a centre for, amongst other things, rheumatoid arthritis, the problem of difficult intubation has largely been avoided. If we can, we choose extradural analgesia, but when general anaesthesia is unavoidable, we obtain x-rays of the cervical spine to assess the possibility of cord compression at the odontoid, and we check the degree of jaw mobility, during the visit before operation. Where we suspect that tracheal intubation by conventional techniques would be difficult, impossible or unsafe, we prefer to anaesthetize the patient with halothane via a mask and airway or a naso-pharyngeal tube.

Halothane, with spontaneous breathing, is perhaps not the ideal anaesthetic for a patient with rheumatoid arthritis undergoing a major orthopaedic operation, but we feel that it is kinder to the patient (and the anaesthetist) than a long and traumatic intubation. We have generally reserved the use of a flexible bronchoscope, under sedation, for neuro-surgical patients in whom intubation is obligatory.

Roger Fletcher
Lund, Sweden

REFERENCE


Sir,—You seem to have had a spate of letters recently about difficult intubations. I presume that these reported difficulties are only a small fraction of the total, most of which is unreported. I sometimes see people struggling valiantly to intubate patients with the cervical spine extended, and that the majority of my colleagues adopt this position is suggested by the difficulty I have in preventing nurses trying to be helpful by whipping all the pillows out as soon as the patient is asleep.