Safety in Anaesthesia

The practice of Anaesthesia is fundamental to the practice of medicine. According to the Institute of Medicine, Anaesthesia practice is among the most successful specialties in assuring patient safety and reducing mortality. Death due to administration of anaesthesia has come down from 1 per 5000 anaesthesia administered to 1 death per 2,00,000-3,00,000 [1]. In 1987 CEPOD (first Confidential Enquiry into Perioperative Deaths) revealed that very few deaths were actually due to the direct result of general anaesthesia. To compare one hour of being under anaesthesia, with say one hour spent in traffic or one hour of flying; the risk of dying is about 1 in 10,000 in traffic, about 1 in 1000, 000 in an aircraft and 1 in 1,00,000-5,00,000 under anaesthesia [2].

According to Webster medical dictionary, safe is defined as not causing harm or injury, having a low incidence of adverse events and learning from experience. Provision of safe anesthesia is difficult without appropriate resources like water, electricity, water, oxygen, properly functioning monitors, drugs and equipments [15]. Likewise unrecognized malfunctioning equipment can result in disasters. Safe and effective monitors are necessary for conduct of safe anaesthesia for patients. ‘Finger on pulse’ is no longer a substitute or acceptable standard. Failure to adhere to standard guidelines and checklists is also a deterring factor towards safety. Anaesthesia providers resuscitation skills are limited if necessary fluids, blood and blood products are not available [15]. Safety is thus interplay of many factors, individual and organizational with human and cultural values playing an important role [16]. Every hospital and organization must have a institutional safety plan with skill based anaesthesia performance and information process. These form a robust system to achieve desired successful outcomes.

The patient safety plan must provide a systematic, coordinated and continuous approach to the reduction of medical errors. These adverse events can be significantly reduced by implementing safety control such as regular monitoring by workers within a complex healthcare delivery system. Effective communication amongst all the staff members and adequate rest to prevent fatigue and overload of anaesthesiologist plays a pivotal role. Employing non blame culture for incident reporting and healthy analysis for prevention of these mishaps in the future is a must.

Structured patient education wherein information on anaesthesia expectation should be addressed by concerned anaesthesiologist [16]. Comprehensive patient education provision can be quite a consuming affair. Nevertheless this is important for gaining patient's trust and satisfaction. Patients should be educated about five point questionnaire addressing the safety of surgery, anesthesia and patient.

Amongst the medical practitioners, anaesthesiologists tend to be the most risk oriented and interested in addressing patient safety issues [17]. The specialty of anaesthesia has highly organized training, patient risk assessment scales, high patient monitoring standards and patient safety foundation [18,19].

The outstanding anaesthesiologist’s performance comes from the hardwork of pioneer in anaesthesia from all over the world. Contribution of various organizations such as WFSA (World Federation of Anaesthesiologist)
through its educational initiatives is noteworthy [20]. WFSA anesthesia tutorial of the week provides peer reviewed tutorial on various topics [21]. The

References

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Conflict of Interest: Nil
Source of Support: None


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