
Guest Editorial

Death on the table: preparing for the inevitable

"The death on the operating table of the patient is a harrowing experience for a surgeon"¹ – and it is no less so for an anaesthetist. We are in this business to save lives, and losing one is therefore a potentially very traumatic event. Nonetheless, it is only relatively recently that significant research has been performed in the area of perioperative catastrophes and their effect on the operating team. The topic was breached most forcefully when, in 1998, one UK surgeon suffered two intraoperative deaths on the same day. This led to guidelines by the Royal College of Surgeons, published in 2001, and a number of survey studies of surgeons and anaesthetists. Most of those studies, however, were performed in Europe, a few in the USA, but none in the southern hemisphere. It is exciting, therefore, to see published in this issue of *SAJAA* a study investigating the experiences of South African anaesthetic registrars after a perioperative death.

Interestingly, and likely not surprisingly, the findings mimic in many ways the results from previous investigations: there was a clearly felt need for debriefing and formal support – which, however, was rarely available. The need for time off after such an event was variably perceived. Most importantly, the responses made clear that in addition to the primary victim of the event – the patient – there is a "second victim" (the anaesthetist) and even a "third victim" (subsequent patients cared for by the anaesthetist), as has been suggested previously.²

Anaesthetists may be at particular risk of being impacted deeply by such events, for several reasons. Our practice (happily) does not typically include a substantial number of deaths or major adverse patient outcomes, unlike some other specialities. We are focused on prevention of injury, not its management. Possibly as a result of this, our speciality does not devote much time to teaching trainees how to deal with poor outcomes and their aftermath, again unlike some other specialities. Similarly, our departmental structures are typically not set up to provide support in the case of a major perioperative mishap. Finally, anaesthetists often work in a much more solitary environment than do physicians in other specialities, which may make it more difficult to deal with the aftermath of a poor outcome. It is important to point out, though, that several studies have shown that, overall, anaesthesiology is not to be considered a speciality with higher stress levels than other professional groups.³ Anaesthetists do, however, suffer increased rates of substance abuse and suicide.

Possibly in part as a result of these factors, anaesthetists' responses to an intraoperative catastrophe can be remarkably deep and long-lived. For example, in a recent survey study in the USA⁴ respondents were asked about the aftermath of their "most memorable event". The majority (64%) of respondents who had been involved in an intraoperative catastrophe *that they believed not to have been preventable* still reported that they felt personally responsible. This compared with 76% in situations where the respondent felt the event to be preventable. The emotional impact was oftentimes profound, with reliving the event, anxiety and guilt each

reported by more than 70% of respondents. Remarkably, more than 20% of respondents had considered a career change, and 5% used drugs or alcohol in response to the event. The time to emotional recovery was often long, and highly variable: responses ranged from one day to more than one year; about 10% stated they were "not affected", but close to 20% reported that they "never fully recovered".

The overall picture is one of a major disruptive impact of a perioperative catastrophe, with variable, but often profound and enduring effects on the anaesthetist. Whether care of the "third victim" (subsequent patients) is adversely affected is at this time unknown, although about half of respondents in the study mentioned above felt that the event had an impact on subsequent patient care for 24h or longer. Whether impact on the provider can be limited by early intervention is similarly not quite clear, although some preliminary data suggest there may be benefit to a structured support system. The Association of Anaesthetists of Great Britain and Ireland has published useful recommendations in this regard.⁵ They encompass some practical recommendations, suggestions for the anaesthesiologist involved, and, importantly, guidelines for the department. The latter include assigning a senior colleague as a mentor, having colleagues cover the involved anaesthesiologist's duties for some time, and have a formal evaluation platform such as a morbidity and mortality meeting. The USA Anesthesia Patient Safety Foundation similarly has published recommendations.⁶

Perioperative catastrophes are rare, but they will always be an inevitable part of our practice. Understanding our responses to these events is critically important: it allows us to prepare for them and, by timely and proper intervention, limit their impact on the anaesthetist involved. The article in this issue of the *Journal* will help southern African anaesthetists do exactly these things.

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References

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