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MEDICAL PRACTICE

NEWS AND NOTES

SUPPLEMENT

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CORRESPONDENCE

We may return unduly long letters to the author for shortening so that we can offer readers as wide a selection as possible. We receive so many letters each week that we have to omit some of them. Letters should be typed with double spacing between lines and must be signed personally by all their authors, who should include their degrees. We cannot acknowledge their receipt unless a stamped addressed envelope or an international reply coupon is enclosed.

Correspondents should present their references in the Vancouver style (see examples in these columns). In particular, the names and initials of all authors must be given unless there are more than six, when only the first three should be given, followed by et al: and the first and last page numbers of articles and chapters should be included. Titles of papers are not, however, included in the correspondence section.

Deaths and anaesthesia

SIR,—The sadly anonymous author of your leading article on deaths and anaesthesia (21 August, p 530) displays considerably more common sense than some leader writers who have commented in the professional journals and lay newspapers on the recently published report *Mortality Associated with Anaesthesia*.[1] There is, however, one matter on which the record should be put straight.

Your leader writer refers to the fact that "half the deaths occurred in the ward on the day of operation" and later to the astounding fact that 20% of hospitals still do not have recovery rooms; he then states that this lack of provision is "yet further evidence of current underfunding in the NHS." I have been an active campaigner for recovery rooms and intensive care units, to which the more serious postoperative cases should be sent for several days, in the various hospitals in which I have worked since the mid '50s. My enthusiasm being first kindled by experience as a senior registrar in pioneer recovery units at the University of Michigan and at Southend General Hospital under Dr J Alfred Lee. I am sorry to have to say that it is unfair to lay the blame for difficulty or failure in establishing such units wholly on financial stringency in the NHS. The primary reason has in fact often been lack of support or outright opposition from medical disciplines other than anaesthesia and from senior administrative nursing staff. "*My* patients are better looked after postoperatively in *my* ward by *my* nurses than is possible in any intensive care unit," has been a typical ex cathedra declaration. How can such a statement be true if apart from any other advantage one considers the difference in nurse-to-patient ratio between a general ward and a well run recovery or intensive care unit? Administrative nurses have often been opposed to the formation of such units because of the very fact of the higher ratio of nurse to patient staffing required and have claimed at times that it was "not