Essay By: TH –
16 November 2007

TOPIC: "The patient who is expected to live but died"

Anaesthesia is not just a profession where you see your colleagues and follow simply because they are in that field. It is a profession that needs minds that are technically inclined, dutiful, and meticulously observant. Every inch of action is accounted for the safety of the patient, yet sometimes the unexpected thing happens as a result of an unskilful or skilful hands. Though, no one is a perfect anaesthetist, even the most experienced anaesthetist may have a crisis which may lead to a morbidity or mortality, in a rare situation with the experienced and skilful anaesthetist.

I may use the analogy of comparison with aviation and anaesthesia. The most critical time of aviation is when taken off and landing; the same as anaesthesia critical time being induction and extubation or recovery periods. If an inexperienced and careless anesthetist does not prepare properly his anesthesia regimen, like for example, no Oxygen, faulty Laryngoscope and leaking anesthesia machine, drugs not label, the routine of reading and making sure at least three times before giving the drug may avoid the unexpected disastrous crisis, which is one of the common causes of death. In time of crisis you will become panic, confused and defused. Make sure your table can tilt various directions, so as to avoid vomiting. Check your endotracheal tubes with effective and functional cuff, possibly to prevent regurgitation. Have various sizes of tubes three at most. If no proper preparation and crisis arises you will go helter-skelter and not knowing what to do, if there airway problem the next three or five minutes. Time wasted to get things do will be disastrous, depriving the major organs of oxygen eg brain, heart and the kidneys, leading to irreversible conditions and finally death. This is the result of a careless and inattentive nurse anesthetist.

Let us assume you have intubated the patient, is the airway patient, is the tube in the trachea instead of the esophagus? Is chest symmetrical in its movement? Is the breath sound heard in lower and upper parts of the lungs? Is the ETT not placed deep in the right bronchus? If all of these are done you are on the right path. Is this only the path of safety? NO

Now the bigger path of safety is the proper monitoring intra-operatively and post-operatively making sure the airway in patients checking vital signs and recording and at the same observing the operation performed, especially the site: never you leave your patient with the inexperienced assistant if interrupted, ventilation may result into hypoxia especially children leading to developing acute acidosis.

Monitoring needs again careful, attentive and keen observation. If you are not attentive, you will receive a message of unexpected events from your patient or a fatal news. A lot can happen in a few seconds or minutes.

Many times there is no assistant in our setting and so the responsibilities are double in monitoring the patient, if you have any doubt relating to the tube placement in the trachea – reinsert it to avoid being in the esophagus, this is the common error with the

most complacent and confident anesthetist. If all these are put in place and the patient dies, then he may have a concealed internal problem that was not noticed before surgery. Monitoring also include fluid replacement.