Steroid use and chemotherapy were also significant risk factors for 12 month mortality (odds ratio (OR) 1.4, 1.2–1.6, P<0.001 and OR 1.5, 1.2–1.9, P<0.001, respectively) (Table 1).

Our ICU, in-hospital, and 12 month mortality are comparable with published studies in non-cancer populations of ICU long stayers, allowing for differences in case mix and definition of long stay.1–6

We report that more than half of long-stay critically ill cancer patients survive 1 yr or more. Our data demonstrate that even within the group of long-staying cancer patients on ICU, there are patients who have good long-term prognosis. Here, we were also able to identify several risk factors for increased mortality (respiratory failure, chemotherapy before ICU admission, and use of steroids) that if validated could aid in individual patient risk stratification for long-stay oncology patients in the ICU and serve as starting points for future investigations to improve the outcomes of this patient subgroup.

Declaration of interest
None declared.

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Knowledge related to anaesthesia among laypeople

Editor—An audit to assess the knowledge related to anaesthesia in laypeople was recently carried out. A questionnaire, based on an AAGBI patient information leaflet ‘Anaesthesia Explained’,1 was completed by 73 patients randomly selected from those attending a rural GP practice. Questions were asked on the qualifications and roles of the anaesthetist, and some of the common side-effects of anaesthesia.

Of the 73 participants, 93.2% (n=68) knew that anaesthetists were medically qualified; however, only 43.8% (n=32) identified the anaesthetist as a doctor, with 41% (n=30) mistaking the anaesthetist for an Operating Department Practitioner. The minimum training period of an anaesthetist from...
leaving university to attaining a Certificate of Completion of Training (CCT) was identified most popularly as 3 yr (20.5%, n=15), 4 yr (20.5%, n=15), and 5 yr (34.2%, n=25); 8.2% of patients thought it took <2 yr to attain a CCT.

With regard to the role of the anaesthetist, 87.7% (n=64) of participants identified that the anaesthetist is responsible for administering the anaesthetic. Other roles were less well understood. Significantly, just 13.7% (n=10) knew that anaesthetists are responsible for administering blood transfusions intraoperatively and 20.5% (n=15) identified that providing analgesia is a key role of the anaesthetist. Figure 1 opposite illustrates the knowledge of potential side-effects after anaesthesia.

If patients are aware that the anaesthetist has a wider role than just administering an anaesthetic, they will be empowered to discuss the different options available and make a fully informed choice. This will help shift the dynamic of the doctor–patient relationship away from paternalistic care, and decrease patient anxiety before operation.

It is likely that the gaps in patient knowledge will be filled by the anaesthetist before operation, either at preoperative assessment clinics or during the consent process. However, it can often be difficult to cover all necessary aspects verbally due to time constraints, and the level of understanding patients have can easily be overestimated. Literature such as the Anaesthesia Explained booklet should be utilized in patient areas to help aid this process, although it has previously been shown that verbal communication is the most effective way of decreasing preoperative anxiety.2 Thus, practitioners must remember the onus remains on them to ensure patients are fully informed of their role before anaesthesia.