Sir, — I was interested to read the paper of McDonald and colleagues on a time-study of the anaesthetist's intraoperative period [1], particularly the method of monitoring the anaesthetist and the resultant division of time. Anaesthetists were monitored by video camera, having been informed that they were the subjects of the study. Results showed that 70% of the time was spent monitoring the patient and record keeping, and that no other activity took up more than 10%.

Whilst these results are commendable, I wonder how much they reflect the true situation. I feel that any anaesthetist informed that he was to be filmed during a case would be acutely aware that his every move was being recorded and analysed; is it any surprise, therefore, that the majority of time spent was in monitoring the patient, with negligible time spent talking or idling? I feel the true situation may be somewhat different, and only would be revealed by surveillance of anaesthetists blissfully unaware of an all-seeing video camera.

D. Sutton
Southampton

REFERENCE

Sir, — Thank you for the opportunity to reply to the letters of Dr Goodman and Dr Sutton.

While it may be true that computerized intraoperative records "will always be more expensive than hand-written charts", the cost: benefit ratio may improve to a point at which everyday use of these machines will be both practical and realistic, even in view of the financial limits of the health service. The cost of this technology, in common with other computer technologies, is likely to come down in the future, so that automatic record keeping will be an attractive alternative to the manual method.

The advantages and disadvantages of automatic patient record keepers that affect the benefit side of the cost: benefit ratio have already been discussed [1, 2]. Dr Goodman has voiced the primary potential disadvantage of automatic record keepers. These devices may take the anaesthetist out of touch with the patient [2]. However, presently there is no convincing evidence to support this contention.

Dr Goodman's point concerning erroneous information is one which must be considered from both sides of the record keeping discussion. It is true that the automatic record keeper will record artefactual data that are not processed out by the monitors, but the manual record keeper — that is, the anaesthetist — also may record artefactual data. For example, during a clinically demanding period when the anaesthetist is attending to the patient, he/she often does not have the opportunity to record patient information for an extended period of time. The anaesthetist must then rely on memory when filling in the chart. There are examples in the literature of actual and manually recorded data under these circumstances which were substantially different [1].

An important advantage of automatic record keepers is that they produce an objective, legible, complete and accurate data sheet. Such a record is more supportive of a clinician than handwritten records in medico-legal issues [1].

Although we agree with Dr Sutton that a preferable methodology in our study would have been to video tape the anaesthetists while they were "blissfully unaware of an all-seeing video camera", our institution requires us to obtain verbal consent from the anaesthetists to be filmed.

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REFERENCES