took up to one and half hours to complete. The questionnaires assessed, before, during, and after the operation, the degree of supervision and the presence of the right facilities and personnel. Many facets of performance were scored by both the independent assessors and the doctors. Feedback was offered to participating doctors, but only 5% took up this offer.

There were 485 850 operations included in this study, and 5081 deaths fitted the CEPD criteria. Comprehensive paired anaesthetic and surgical data were obtained for only 2391 cases; some consultants dropped out during the study.

The distribution of deaths contained no surprises: 79% of the patients dying were over 65; 75% of the deaths occurred within 15 days of surgery; and most operations were performed during daylight hours. Trainees did more operations that resulted in a death at night than consultants and this was also true of weekends and Fridays.

The data showed inconsistencies in the numbers and types of operation and even in the dates of death. Self scoring was generally lower among anaesthetists than surgeons, perhaps reflecting surgical egotism. Low scores from assessors were given for avoidable elements in the death and for departures from ideal practice. Whether the operation was an emergency and the preoperative state of the patient were all taken into account. The necropsy rate was surprisingly low at 43%, with less than a third of the surgeons attending the necropsies.

Most deaths occurred in severely ill elderly patients who were admitted urgently or as emergencies, and most deaths occurred in general, vascular, and orthopaedic surgery. Consultants saw the patients before their operations in 66-79% of cases, but a disturbingly large number of major cases were operated on by juniors without the consultant having seen the patient. Surgery was the sole cause of death in 7% of patients because of inappropriate operations and poor pre-operative management or the wrong grade of surgeon operating. Important problems were the lack of manned emergency theatres and equipment deficiencies; some of these problems related to "economy" measures.

Some operations were performed in hospitals ill equipped to deal with critically ill postoperative patients who required intensive care. There was a catalogue of surgical misadventures relating to specific procedures, including repair of aortic aneurysms (25.6% of avoidable deaths) and prostatectomy (25% of avoidable deaths). In the main, these operations should have been performed by trained vascular surgeons and urologists. Lack of consultant supervision in orthopaedic surgery was cited as a major deficiency in emergency hip surgery, with only 19% of cases being performed by consultants. Thirty per cent of deaths in colorectal surgery were avoidable, and 17% of these patients underwent inappropriate operations—nearly 30% of patients underwent abdominoperineal excision of the rectum.

Anaesthesia caused fewer avoidable deaths than surgery. Patients were seen by consultant anaesthetists before the operation in 82% of cases. The general state of debility of the patient was assessed using the American Society of Anesthesiology grades 1-5 (with 5 being the lowest), and most of the deaths occurred in patients who were graded 4 and 5. Consultant anaesthetists were more willing to assist trainees than were consultant surgeons and unavailability was cited as a primary deficiency in only 17.6% of trainee cases. Preoperative preparation was deemed inadequate in 33% of anaesthesia associated deaths, but this problem is interdisciplinary. There were 410 deaths in which anaesthesia played some part (14%), but in only three was anaesthesia the sole factor recorded by anaesthetic assessors.

Thus overall mortality was 0.7% with only a small fraction being attributable to surgical or anaesthetic failure or both. The main deficiencies were failure to supervise junior staff, failure of consultants to see patients before operations, and general surgeons performing operations that should have been done by specialists.

The report also showed that few districts have regular reviews of surgical and anaesthetic practice, and the main lesson for the future is that such reviews should be done regularly. The reviews should look at other postoperative sequelae apart from death and should be interdisciplinary. Codes of practice should be established, which as well as aiding audit will also help training and development of services.

Another lesson is that consultants must take more of the decisions over operations and must be more accountable. This may, however, prove difficult if we are to have only a moderate increase in the numbers of consultants but a draconian cut in the numbers of juniors. Orthopaedic surgeons, for instance, are dealt with harshly in the report, but they have fewer junior staff than those in other specialties and are under ever increasing demands, particularly from operations for joint replacement. A final lesson is that districts and regions need to have the right balance of surgical specialties.

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Which treatments work for drinking problems?

If no effective treatment exists for a common and distressing condition that runs a fluctuating course, claims will abound for sovereign remedies. This has often been the case with inebriety. While the more bizarre approaches, such as brain surgery,¹ treatment with lysergide,² or apnoea induced by scopolamine as a form of aversion,³ all came and went, "the treatment of alcoholism" in most Western countries gradually and by consensus settled down to a package of group therapy, individual and family counselling, referral to Alcoholics Anonymous, and aftercare, together with an insistence on abstinence as the therapeutic goal.⁴⁻⁷ When research suggested that the expensive paraphernalia of the orthodox and intensive regimen conferred little advantage over much simpler interventions,⁸ it began to be argued that conventional treatment constituted a package of nostrums lacking scientific proof of efficacy.^{9,10} Abstinence as the treatment goal had also come under attack.¹¹

Happily there is now movement upwards from that trough of pessimism and confusion. The advances do not, however, allow final consensus on what treatments work. The movement is better characterised as a more confident sense of the nature of the issues that have to be addressed.

Firstly, there is a sharper awareness that excessive drinkers constitute an extremely diverse population. They vary in the nature and severity of their drinking problem, in their degree of dependence on alcohol, and in their psychological and

social characteristics. Recent research has focused on defining clinically useful typologies of problem drinking.¹²⁻¹⁵ The question has moved from the inappropriate search for the universal treatment for the stereotyped "alcoholic" to finding out which treatment is likely to work best for which person; a further wave of research has tried to match treatments to patient types.^{16,17} In particular there is a realisation that it is every health professional's responsibility to help at an early stage patients who are beginning to drink marginally too much for their health. This is a welcome change from treatment services being conceived only in terms of the specialist who deals with advanced cases.¹⁸

Another influence on rethinking treatments has been research that confirms that people with drinking problems, including those with severe problems, have a considerable capacity to ameliorate or halt their drinking.¹⁹⁻²² Sometimes these shifts come about after treatment or from contact with Alcoholics Anonymous, but often the change is accomplished without formal interventions. The question of "how people do it" offers a rich subject for research; it may be possible to design treatments that are catalytic or supportive of people's own ways of changing behaviour. Research has also investigated how people may be helped to maintain that change.^{23,24}

What is the current "best buy" for treating drinking problems? Whatever the type or degree of the trouble and whether the doctor is generalist or specialist, the first step

must be to identify the problem. Laboratory tests are useful,¹⁸ but there is no substitute for the doctor routinely and confidently asking patients about their drinking. Doctors still have to overcome an embarrassment in talking about alcohol that can handicap good practice.²⁵

What is needed for treating the commoner and milder manifestations of excessive drinking is demystification, destigmatisation, and common sense. Such drinking is better conceived as dietary indiscretion or a fault in lifestyle than as a disease or neurosis. The best treatment is advice and the catalysing and monitoring of the patient's own strategies for amelioration.^{17,18,26,27} As to what treatment works for a high degree of dependence, here the debate is particularly open.²⁸⁻³⁰ Intensity of dependence is not the only relevant criterion that bears on choice of treatment,³¹ but the view that abstinence is the best choice for the highly dependent drinker has again received wide support.³²⁻³⁴ All the evidence suggests that at this end of the spectrum different types of patients will then require different types of help, and a flexible and consumer oriented approach that seeks to mobilise "natural processes of healing" offers more hope than doctrinal imposition of any old or new panacea.³⁵

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