

Anesthesiology
67:152, 1987

No Evidence that Anesthesiologists Enhance Care of the Parturient

To the Editor:—I would like to challenge the editorial on obstetrical coverage by Levinson and Shnider.¹ They state that “parturients in this country do not receive ideal obstetrical anesthesia care” and view as “alarming” the low participation by physician anesthesiologists. However, no evidence is presented (as none exists) that obstetric anesthesia care provided by nurse anesthetists and/or obstetricians is unsatisfactory or of lesser quality than that provided by physician anesthetists. Yet, the basis for the editorial opinion is the unwarranted assumption that anesthesia for obstetrics provided by anesthesiologists is superior to that provided by nurse anesthetists.

Statements that “nurses cannot make medical decisions” can be countered with the view that most deliveries do not require such decisions and, in the small number that do, the decisions are made almost entirely by obstetricians, and not by anesthetists, whatever their training.

One might go a step further from discussion of nurse *versus* physician anesthesia provider, and ask whether anesthetic intervention in the birth process can be justified. Anesthesia is necessary for most surgical procedures, thus justifying some level of anesthesia-related morbidity/mortality. But what level of morbidity/mortality can be justified when the normal birth process will surely proceed without anesthesia? The presumed ben-

efit is relief of pain, but what is the overall cost in terms of maternal and fetal complications? Is there a difference in anesthesia-related morbidity rates in small *versus* large centers when other factors are controlled? It would seem that these questions need to be answered before advocating the need for physician-provided anesthesia at delivery.

I would like to commend Gibbs *et al.*² for their timely report, and Levinson and Shnider for their provocative editorial. The current dramatic structural and economic changes in American medicine accelerate the need for objective data to help define what is optimal anesthetic participation in obstetrics.

MORLEY M. SINGER, M.D.
Staff Anesthesiologist
Pacific Presbyterian Medical Center
Clay at Buchanan
San Francisco, California 94109

REFERENCES

1. Levinson G, Shnider S: Obstetric anesthesia coverage—A continuing problem. *ANESTHESIOLOGY* 65:245–246, 1986
2. Gibbs CP, Krischer J, Peckham BM, Sharp H, Kirschbaum TH: Obstetric anesthesia: A national survey. *ANESTHESIOLOGY* 65:298–306, 1986

(Accepted for publication April 2, 1987.)

Anesthesiology
67:152–154, 1987

In Reply:—We agree with the American Society of Anesthesiologists,* the American College of Obstetricians and Gynecologists,† and the Joint Commission on Hospital Accreditation‡ that the quality of anesthesia care for the obstetric patient should be the *same* as for the surgical patient. We regret that Dr. Singer wishes to develop a double standard. He would encourage obstetricians and CRNAs directed by obstetricians to administer anesthesia in the obstetric suite, but not, of course, in the operating room. If, indeed, a study had been done of surgical patients which demonstrated findings similar to Gibbs' survey of obstetric patients, we would have made the statement that “surgical patients in this country do not receive ideal anesthesia care” and “view as alarming the low participation by physician anesthesiologists.” Fortunately, this is not the situation in most of the United States. In Dr. Singer's hospital, do obstetri-

cians administer anesthesia for vaginal surgery, or do nurse anesthetists function without direct supervision by an anesthesiologist?

Dr. Singer is correct in stating that studies comparing nurse anesthetists with anesthesiologists are, indeed, few. These are clearly difficult to properly perform because of the lack of accurate reporting and data collection methods regarding anesthetic morbidity and mortality, particularly as related to personnel administering anesthesia. We have nothing in this country comparable to Great Britain's “Confidential Enquiries on Maternal Deaths.”¹ Most available data come from review of insurance company closed-claim files, and may simply reflect the tendency to impose blame and liability on the person who carries the most insurance. Nurse anesthetists seldom carry enough malpractice insurance to pay for their alleged errors. Furthermore, nurse anesthe-