

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.

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(Accepted for publication April 2, 1987.)

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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-

tists working without the supervision of anesthesiologists usually are hired by smaller hospitals,²§ and are, therefore, not providing care for comparable patient populations. Finally, a recent survey relating maternal mortality to anesthesia manpower³ indicated that, in Japan, a country which does not have adequate obstetric anesthesia coverage by trained anesthesiologists, maternal mortality rates are five times higher than in England and Wales, which do have a sufficient number of trained anesthetists. For instance, in Japan, in only 46% of district hospitals are anesthetics for cesarean section administered by members of the anesthetic department, the remainder being undertaken by obstetricians. Although firm conclusions cannot be made without further data, Rosen and Fujimori, the authors of the survey and two of the leading obstetric anesthesiologists in the United Kingdom and Japan, respectively, state that "It is a reasonable assumption . . . that a lack of trained anaesthetists is a contributing factor, perhaps a major one. . . ."

We note that Dr. Singer acknowledges that "nurse anesthetists cannot make medical decisions," but we are astounded that he believes that few such decisions are necessary, and that "these decisions are made almost entirely by obstetricians." Frankly, we believe it deplorable that an anesthesiologist as well trained as Dr. Singer would choose to practice anesthesiology as a technician; that is, to allow the obstetrician to make the numerous medical decisions necessary to properly administer obstetric anesthesia. If "ordered" by an obstetrician to "place epidural or caudal when patient's cervix is at 4 cm dilatation," does he do this despite finding an abnormal platelet count, a history of multiple sclerosis or severe sciatica, or the presence of furunculosis of the back, to name just a few conditions that an anesthesiologist's routine pre-anesthetic evaluation might elicit? Does Dr. Singer permit the obstetrician to decide whether regional or general anesthesia should be administered for cesarean section? When Dr. Singer is treating a hypotensive patient, does he ask the obstetrician to decide whether to administer vasopressors, balanced salt solution, or blood? Clearly, space does not permit cataloguing all the medical decisions that must be made in even the most routine obstetric anesthetic—decisions that we believe are best made by anesthesiologists rather than obstetricians.

Dr. Singer points out that "the normal birth process will surely proceed without anesthesia." However, in many cases, the lack of anesthesia will necessitate the use of excessive amounts of narcotics, potentially hazardous anesthetic techniques, such as paracervical blocks, or prevent a timely and indicated instrument delivery. The parturient that Dr. Singer would prefer to neglect may suffer psychological trauma and enough

emotional distress to impede the progress of labor.⁴ The need for anesthesia for vaginal delivery is demonstrated by the demand by obstetricians and patients for it. The severity of normal labor pain has been documented,⁵ the potentially adverse effect of the pain on the fetus^{6,7} has been established, and the potential benefits of epidural anesthesia recognized.^{8,9}

Despite all these benefits, we agree with Dr. Singer that the risk to the patient must be very low. It is precisely for this reason that we would encourage more anesthesiologists to become actively involved in the administration or supervision of obstetric anesthesia.

* Guidelines for Patient Care in Anesthesiology (Amended by House of Delegates on October 16, 1985). American Society of Anesthesiologists, Park Ridge, Illinois.

† Obstetric Anesthesia and Analgesia, ACOG Technical Bulletin, Number 57, The American College of Obstetricians and Gynecologists, Washington, D. C., 1980.

‡ Accreditation Manual for Hospitals, Joint Commission on Accreditation of Hospitals, 1986.

§ Orkin F: The geographical distribution of anesthesia care providers in the United States. Report of the Committee on Manpower, American Society of Anesthesiologists, Park Ridge, Illinois, August, 1983.

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(Accepted for publication April 2, 1987.)

Anesthesiology
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More on Management of the Difficult Airway

To the Editor:—I read, with interest, the article by Bedger *et al.*¹ outlining the use of a jet-stylet endotracheal catheter for the management of patients with a difficult airway. We have used a similar technique in our institution. In place of the "jet-stylet," however, we use an 18-French Salem Sump tube with the proximal end of the tube cut off. This allows us to connect our jet ventilator directly to the suction port of the Salem Sump tube. This tube has multiple side holes at the distal end, allowing for ventilation at low gas flows per orifice.

Additionally, during changing endotracheal tubes in the Intensive Care Unit, the nasogastric tube can be passed through the endotracheal tube, the endotracheal tube can be removed, and the patient ventilated prior to or during the endotracheal change process. This technique has been described as a means of changing endotracheal tubes damaged during orthognathic procedures.²

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The nasogastric tube is inexpensive, readily available, and easy to use if a jet-stylet is unavailable.

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(Accepted for publication April 13, 1987.)

Foreign Body from a Tube of Anesthetic Ointment

To the Editor:—The common practice of lubricating endotracheal tubes with water-soluble ointment may pose an additional risk to our patients. Prior to insertion of an endotracheal tube, pre-lubricated with Xylocaine 5% ointment (Astra Pharmaceutical Products Inc., manufactured by MK Laboratories, Inc., lot #511004, expiration date 11/88), light was noted to be reflected off a foreign body. Closer examination revealed that the small plastic cap liner had become delaminated from its backing and was stuck to the ointment. The plastic seal is clear, and not radioopaque, so its detection to and after insertion of the endotracheal tube would be very difficult. Figure 1 shows the defect as discovered. Examination of our supplies revealed the same defect to exist in many other tubes of the same ointment.



FIG. 1. Cap liner embedded in ointment on the cuff of the endotracheal tube.