

Anesthesiology
73:192, 1990

An Issue of Supervision

To the Editor:—A recent article¹ summarizes records from 11 major intraoperative accidents since 1976. These records were made available by the malpractice insurance carrier covering nine anesthesia departments affiliated with Harvard Medical School. Five involved residents; three involved C.R.N.A.s; and three involved anesthesiologists working alone. In the three cases in which C.R.N.A.s were involved, the author alleges, without justification, that there is an issue of the adequacy of supervision of the C.R.N.A.s. We all share in the goal of making anesthesia safer for our patients. Certainly we all believe that while we may not always be able to prevent a complication, early detection of problems can lead in most instances to more favorable outcomes. However, Dr. Eichorn's analysis of these eleven individual cases appears to be somewhat less than objective.

Although Dr. Eichorn states that an associated issue with the cases in which a resident or C.R.N.A. administered the anesthesia was inadequate supervision, he makes no comment as to whether "supervision" might have been beneficial in the cases attributed to anesthesiologists. In fact, he concludes that "although an attractive speculation, whether closer supervision of those administering anesthesia at the time of the initial mishap (independent of patient monitoring) would have prevented the accidents cannot be known." What is known is that anesthesiologists as well as C.R.N.A.s and residents were not immune to anesthesia accidents.

No one will deny that anesthesiology residents and nurse anesthesia students need both instruction and supervision during their clinical learning experiences. But until studies can be accomplished that demonstrate that "supervision" of C.R.N.A.s does indeed make a difference,

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In Reply:—Mr. Gunn's interest in and agreement with the value of "safety monitoring" in the prevention of intraoperative anesthesia catastrophes is appreciated. It is important that he and all readers understand that the case analyses were done as objectively as humanly possible with the extensive information available in the insurance company records. There was neither space nor, in fact, need for great factual detail in the case summaries, particularly when differing interpretations of events were involved.

The term "supervision" of a C.R.N.A. or resident by an attending anesthesiologist involves legal responsibilities, and is a convenient term, with which readers of this journal are familiar. There is no element at all of any "turf game." Exact roles vary in different settings, and it is certainly more cumbersome but potentially valid to say "attending anesthesiologists working in consultation and collaboration with co-professional anesthesia care providers."

The point to be made is simple. Safety monitoring and the resultant early warning of untoward developments are critical elements in preventing anesthesia catastrophes. However, human performance factors also are important. Analysis revealed that in 8 of the 11 subject cases, either relative inexperience of the person administering anesthesia at the moment or lack of immediate involvement of the responsible attending was coincident in time with an untoward event. This was cited as an associated factor to emphasize that however beneficial safety

Dr. Eichorn's analysis must be considered as part of a long standing turf game.

To be certain, on occasion, all anesthesia providers may need some assistance. This may range from merely a second pair of hands to a more extensive independent assessment and second opinion. Supervision, in the sense most often applied by anesthesiologists, is not the answer to the majority of anesthesia mishaps. Consultation and collaboration may be the far superior *modus operandi*. In fact, what is truly needed are vigilant, competent anesthesia providers, both C.R.N.A.s and anesthesiologists, who, while confident in their knowledge and capabilities, do not consider themselves infallible and consequently seek help from whoever is available to provide it, when help is indicated.

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REFERENCE

1. Eichhorn JH: Prevention of intraoperative anesthesia accidents and related severe injury through safety monitoring. *ANESTHESIOLOGY* 70:572-577, 1989

(Accepted for publication April 17, 1990.)

monitoring can be, it should not be the only consideration. In addition to responding appropriately to monitoring information, knowing when assistance is needed and then securing it are key human factor issues, ones best learned from one-on-one clinical teaching in the operating room.

It is certainly true that all anesthesia providers may occasionally need some assistance. No one can ever argue against "vigilant, competent anesthesia providers" because the goal is universal—the best possible clinical anesthesia care for all patients. More medical malpractice insurance companies are reducing premiums specifically for anesthesiologists. Because insurance actuaries are not noted for their charity, these premium cuts must reflect the occurrence of fewer anesthesia catastrophes, indicating that we are making progress toward the universal goal of good care.

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(Accepted for publication April 17, 1990.)