

## ■ CORRESPONDENCE

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### Forget the Costs: Use What Is Best

*To the Editor:*—Anesthesiology is reaching a new low when we worry about and calculate cost per minute of anesthesia time; particularly because the difference is pennies per minute. The cost analysis by Macario *et al.*<sup>1</sup> compares the cost of different methods of airway management—mask, laryngeal mask, and endotracheal tube—and drug costs with each. The assumption is such that, with a mask, gas flows of 6 l/min must be used. The authors seem unaware of the fact that it is possible (and was standard practice) to use even a closed system with a mask. Flow rates of 300–400 ml/min were customary. I am sure that low flows would have a major impact on the calculations and would make the mask method best by far. It should come as no surprise to anyone that reused items are less costly than disposables.

What troubles me is that what is best for the patient is not even considered. Is inconvenience for the anesthesiologist more important?

I have yet to see surgeons calculating the cost per stitch for suture materials, swaged-on needles, disposable *versus* reusable sponges, drapes, and other items. Expensive high-technology surgery is acceptable and sought. It is demeaning for the anesthesiologist and a disservice to patients that we should consider pennies per minute to be important.

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*In Reply:*—Our economic analysis of the laryngeal mask airway for outpatient elective surgery provides a model to identify the variables that have the greatest effect on cost-efficiency when determining airway management choice.<sup>1</sup> Jacoby raises several important points. The first is that intraoperative anesthesia costs (*i.e.*, cost per minute of anesthesia) are a small portion (5.6%) of the overall costs related to perioperative care of a surgical patient.<sup>2</sup> Although the cost per case of anesthesia drugs and supplies is small, given the large number of anesthetics administered, small savings per case can represent substantial savings when aggregated. By taking a leadership role in analyses of operating room economics, we will be better able to work with our surgical and nursing colleagues to improve the fiscal profile of surgical care.

In a capitated reimbursement environment, where a healthcare

When I have my operation, I want what is best for me, not what is cheapest and most convenient for the anesthesiologist.  
Primum non nocere.

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### Reference

1. Macario A, Chang P, Stempel D, Brock-Utne J: A cost analysis of the laryngeal mask airway for adult elective outpatient surgery. *ANESTHESIOLOGY* 1995; 83:250–7

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system is paid a fixed amount of money per month to care for a predefined number of covered lives, anesthesiologists need to continually determine how to achieve the best outcomes at the lowest reasonable cost, even if the marginal cost difference between anesthetics is low. Quantitatively defining what is best for the patient can be difficult. In our cost analysis, we placed value on what is best for the patient by factoring in the cost of various complications (*i.e.*, risk of dental injury). We also state that delivering high-quality anesthesia care requires that specific patient preferences regarding airway choice be incorporated into the airway management decision.

We assumed the fresh gas flow used for a face-mask anesthetic (6 l/min in our baseline case) to be greater than the fresh gas flow used for the laryngeal mask airway or the tracheal tube. Certainly, if the flow rates used for the face masks are decreased to 400 ml/min, the

face mask becomes a  
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