Anesthesia Preoperative Evaluation Clinic: I

To the Editor.—Stanford’s Anesthesia Preoperative Evaluation Clinic (APEC) was only possible with significant financial commitment by the parent institution, funds not forthcoming in all practice settings. The ‘study hypothesis’ asked whether ‘APEC could reduce preoperative testing, surgical cancellations and hospital costs’ isolated events! Reducing laboratory testing and surgery cancellations specifically via effects of APEC appears questionable, because the study lacked a blinded design comparative to any concurrent ‘gold standard.’ Although cost effectiveness was repeatedly stressed, there was little evidence that overall reduced costs (sum of all spent dollars, materials, and worker and patient hours) or improved patient care resulted, making ‘cost effectiveness’ relatively meaningless. The supportive editorial recognized that ‘Little in this report is new or unique.’ Both articles read as advertisements for the ‘new’ time-consuming, and expensive method, founded on incomplete and very circumspect calculations by protagonists.

Is APEC really a financial albatross? What did the renovation of the unit, material overhead, and personnel costs (98% of operating costs!) of the APEC amount to in absolute and relative dollars spent? To what degree are the reported financial benefits a result of a self-fulfilling study design? Is the reduction in ordered tests due to APEC’s use of the Nelcor HealthQuiz, modernization, education, or mindset? Inappropriate ‘Shotgun’ testing (costs) to satisfy outdated ‘anesthesia department standards’ may have been replaced with ‘Shotgun’ examinations (costs). Was the reduced cancellation rate by design? . . . we structured an ‘informal assurance’ that if a patient was evaluated by the APEC, the case would proceed to surgery without cancellation or delay.

Adverse outcomes apparently resulted from implementation of the APEC, yet received little regard: ‘long patient waits for evaluation occurred.’ Anesthesia personnel were ‘assigned to the OR and were unavailable for the APEC’ and vice versa? At critical moments! Negative occurrences were inadequately evaluated using only one, wall-mounted ‘patient suggestion box’!

The single most cost-effective preoperative evaluation likely occurs when competent surgeons thoroughly evaluate and prepare their patients regarding perioperative needs, including appropriate consultation. APEC assumes this role completely, necessitating large numbers of clearly healthy (ASA physical status 1 and 2) patients to undergo expensive (unnecessary?) APEC procedures. Will Stanford’s surgeons never develop necessary skills, necessitating the APEC in numerous ‘satellite’ private practices at great cost? Are patients or third party payors really served?

It appears that Registered Nurse Practitioners (RNP) play the primary beneficial role in the APEC system, not anesthesiologists. Why should patients ‘cleared’ by the RNP in the APEC be automatically assumed suitable for surgery, whereas Stanford’s patients cleared by primary care physicians were not? Why is an RNP better (cheaper) than a surgeon or family practice physician at this duty? Are increased nursing interactions and basic patient education the key? Is algorithmic nursing evaluation superior or adequate, relative APPROPRIATE medical preparation? Which preoperative measures are clearly worth the cost, in what volume and setting? Are Fischer’s findings useful and fiscally feasible in the described practice of residents needing guidance, yet detrimental to surgical education and responsibility? Finally, what are ALL costs/benefits of anesthesia, assuming this surgical duty?

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References


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Anesthesia Preoperative Evaluation Clinic: II

To the Editor.—Fischer1 recently described the Anesthesia Preoperative Evaluation Clinic at Stanford, in which the unavailability of anesthesia attendings or residents for preoperative visits led to the delegation of many responsibilities to a nurse practitioner. At Stanford, the nurse ‘determines the suitability of the patient’s condition for anesthesia and surgery,’ ‘performs a complete preoperative physical examination,’ and ‘informs the patient about options for anesthesia and postoperative pain control.’

Last year, and in many prior years, the American Society of Anesthesiologists prevailed upon the U.S. Congress to leave intact the Medicare rules of participation that address the essential elements of an anesthesiologist’s care. The leaders of our specialty successfully ar...