correspondence

ward, nor did they include the period after the patients were discharged to the ward in the observation period. Therefore the burden of proof that Dr. Lubarsky et al.'s patients did not experience clinically significant residual block that might have adversely influenced outcome still rests with the authors.

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References


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Pharmaceutical Practice Guidelines: Do They Actually Cost Money?

To the Editor:—Lubarsky1,2 dismisses the concerns of Riley3 and Bailey and Egan4 who question the magnitude of savings that would be attained using Lubarsky et al.'s pharmaceutical practice guidelines. When Riley noted that a 3-min increase in 'emergence time' would increase costs at his institution, Lubarsky replied that this cost would be incurred only at Riley's institution. However, the same increased costs would be incurred at our hospital (and possibly others), in which nurses chronically work overtime. In addition, Lubarsky dismisses a 3-min savings as not detectable by an accounting system. We doubt this. As an analogy, if General Motors could shave 3 min off the production time for each vehicle, it would certainly do so.

Similarly, Lubarsky claims that Riley is "mistaken in his analysis of the one case of prolonged mechanical ventilation resulting from pancuronium administration" because the difference in incidence of adverse events "was not any different before versus after the implementation of practice guidelines." Although he is correct, he should acknowledge that his study is underpowered for detecting an increased incidence of severe (and potentially extremely costly) adverse events.

A more important issue has been completely ignored by Lubarsky et al. in their economic analysis. If anesthesiologists are under pressure to reduce costs, so are surgeons (and other operating room personnel). In our institution (which is presumably similar to Lubarsky's), surgical attendings are now present during a larger percentage of the procedure than in past years, and skin closure is no longer delegated to undersupervised medical students. In support of this, Macario et al.5 recently reported that operating room costs for pa...
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tients undergoing prostatectomy decreased 7% during sequential peri-
ods during which no special cost-saving techniques were imple-
mented. If similar changes occurred at Duke University, case duration
probably should have decreased during the course of Lubarsky's
study. In contrast, their figure 1 shows that case duration increased
from 2.7 h to 2.9 h during the course of their study. The cost of this
12-min increase in case duration probably overwhelms the savings
on anesthetic drugs.

Unfortunately the study design used by Lubarsky et al. (data ob-
tained during sequential periods) does not permit them to truly claim
cost savings. Until a randomized, prospective trial examining all peri-
operative costs is performed, we remain unconvinced that the answer
is known. Hopefully, recent research and correspondence in this
journal has piqued the interest of investigators.

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In Reply — Drs. Fisher and Kelley note that some increased cost
would be incurred at a hospital in which nurses chronically work
overtime. This is possibly true. However, this is true only under the
condition that the nurses tally their overtime in less than 3-min
increments. This is unlikely. It is also not definite that 3 min were
added onto the time between cases. Nurses may have been doing
parallel tasks during the 3 min increase in the time interval from end
of surgery to arrival in PACU. Second, there’s the mistaken analogy
of comparing the operating room to General Motors. If a General
Motors plant assembly line produced three cars a day, they really
would not care about shaving 3 min off the production time of each
car. If a General Motors assembly plant produces, as it does, many
more cars a day, then shaving 3 min off per car would make a
difference. Finally, partial assembly is possible, so one can put an
extra 3 min to good use. There also are time clocks for the workers,
so even 3-min increments may be tallied in computing overtime.

This may also be the case for surgery in an operating room that
does 20 cases a day, shaving 3 min off each case makes a difference.
The average operating room, like those at Duke University Hospital
which accommodate 3-4 cases/day, does not benefit by shaving 3
min off of each case. That does not mean that it is useless; it simply
means that it does not show up in the bottom line. Partial operations,
unlike partial completion of a car assembly, are not generally consid-
ered a good thing, so the extra 3 min is likely to be lost rather than
put to good use.

As for their complaint about the statistical analysis of the incidence
of adverse events not being powerful enough, the study was powerful
enough to conclude that rare complications, like prolonged mechan-