transfusion, but outcome data supporting their use in cardiothoracic surgery has been difficult to come by and is not available for surgery in pregnancy. Finally, it should be remembered that a single unit of plasma is preserved with more EDTA than one unit of packed erythrocytes. As such, hypocalcemia may occur more rapidly with newer transfusion protocols than traditional protocols. Large clinical trials of transfusion practices in pregnancy are important but will be difficult to conduct because bleeding is often unexpected and occurs after hours. Careful retrospective analysis of outcomes after change to a new protocol may be helpful while we wait for more definitive guidance.

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In Reply:
We thank Watkinson and Tarassenko for the interest they have taken in our review on patient surveillance.¹

We are in agreement that in their cited work, they tested mandated five-channel physiologic monitoring versus standard care,² and that extra monitoring with Biosign™ (OBS Medical Ltd., Abingdon, Oxon, United Kingdom) had no effect on adverse event rates or mortality, which we had summarized as patient outcome. As we pointed out in our review, the study of measuring the impact of patient surveillance or continuous monitoring is challenging.

In addition, we also agree, as described in our review, that deterioration detection must move beyond the use of just static alarm threshold to optimize the balance between “true” and nuisance alarms. In their mentioned recent study of their Biosign™ monitor in a step-down unit,³ use of the device decreased the authors’ cardiorespiratory instability criteria without changing the rate of medical emergency team (MET) activations. In our own work,⁴ we consider a reduction of MET calls a success, a sign of an intervention that happened at an earlier stage of deterioration and therefore prevented a physiologic derangement that necessitated a MET activation. But, if on the other hand, monitoring is used to trigger MET alerts, an increase in activations may be a desirable outcome.

At Dartmouth, all medical and surgical patients are now continuously monitored; we have a physiologic database containing more than 3 million hours of patient physiologic data and more than 20 trillion individual data points of inpatient oxygen saturations and heart rates. Like the Oxford research group, we have seen little variation across patient groups. What we have seen is a hospital-wide reduction of MET alerts and transfers to the intensive care unit: between 10–67% depending on the unit.

The research done at Oxford, Pittsburgh, and other locations is outstanding: more pieces are being added to solve the puzzle of patient surveillance, and our patients benefit.

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Are Faculties Another Brick in the Wall?

To the Editor:
The investigation in education by Baker¹ is an excellent source of information for practicing academic anesthesiologists involved in resident education. Despite efforts to normalize evaluations and potentially control for bias, concerns remain about the structure of this or any evaluation system because of unavoidable introduction of faculty bias. Baker’s results show that none of the residents received a score less than 3 and evaluations consistently increased with progression through CA-1 to CA-3 yr. Although acknowledging the finding, does Baker have any explanation for this, or whether this may be related to the faculty cohort here or for all faculty? In addition to unintentional penalty for being less experienced as a CA-1, the more senior the resident, the longer the time that a particular faculty has spent with a resident. A longer professional relationship will likely lead to greater confidence in assigning a higher evaluation grade, especially if residents with lower scores have been removed from the peer group by attrition.

Of greater significance, is the faculty really free not to be biased? When faculty are aware that their resident evaluations are accessible to the resident, acknowledging that their own teaching evaluations may subsequently be affected in a retaliatory fashion, a positive bias is expected.

As doubts remain whether faculty are assigning unbiased scores of resident evaluations, more information is required from academic educators, including how well residents and faculty are matched in terms of time and cases done together to allow accurate assessment of performance.

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