Editorial. I remain a staunch defender of direct physician administration and supervision of anesthesia as the primary contribution of our specialty to patient safety in the operating room. What I advocate in the editorial is that anesthesiologists must now add value to their core service (direct administration and supervision of anesthesia) to maintain their fair share of healthcare dollars.

I would like to call particular attention to Dr. Ellison's position that he does 'not concur' with my assertion that we are presently perceived as far too expensive for the limited services we render. Although I fully appreciate that Dr. Ellison does not agree with that perception, I find it perplexing that he denies such a perception exists. All one has to do is read the recent literature or discuss the matter with a hospital administrator or managed care executive to be convinced that the perception not only exists, but is pervasive. As I stated in my editorial, 'the validity of the perception is irrelevant!' In my opinion, denial that the perception exists is unjustifiable. I support thoughtful and informed positions that encourage us to gain a realistic understanding of what is happening around us and to become informed advocates for our profession and patient safety.

Finally, my suggestion that we must add value to our basic service is neither a disservice to those who practice anesthesia nor a denigration of the value of direct administration of anesthesia by physicians. Rather, it is a wake-up call that there is an abrupt presence of new economic pressures that are harsh and unforgiving. We must recognize and understand these phenomena to properly evaluate our response. No matter how much we disagree with what is happening, we must consider how others perceive us and realistically evaluate our position. To do less dooms us to failure.

Barry A. Shapiro, M.D.
James E. Eckenhoff Professor and Chair Department of Anesthesiology Northwestern University Medical School Chicago, Illinois 60611

References
5. Vaughan RW: It's ours to choose or ours to lose. ASA Newsletter 1997; 61(7):26–8

(Accepted for publication July 29, 1997.)

Anesthesia: Coach, Business, or First Class?

To the Editor — A group of articles in the May 1997 issue provide solid background to explore the difficult micro- and macroeconomic issues that lie ahead for physicians and anesthesiologists. The view of medicine as a profession and industry is rapidly evolving. In Dr. Shapiro's words, the practice of medicine is no longer 'a risk-free economic enterprise completely independent of marketplace forces.' Corporate America and our society in general have required that standard principles of economics be applied, sometimes abruptly, to health care. Managed care has thrived in this environment. Are physicians and society prepared and willing to deal with the ethical and financial dilemmas that will arise from the full application of marketplace forces to the nation's health care industry?

Today, the public expects to receive the best possible anesthetic care at little or no personal financial cost. For them, optimal care translates into well-trained board-certified anesthesiologists applying high-tech monitoring, performing skill-intensive techniques, and administering the newest drug in the market. A basic rule of the marketplace is that quality and cost are intimately related. Are the public and the governmental agencies, state and federal, entrusted with overseeing and financing health care delivery, prepared to accept that the quality of the anesthetic service (degree of postoperative pain relief, incidence of side effects, and likelihood of significant complications) would depend on the payment amount? Are anesthesiologists ready to embark in such an enterprise? Should an anesthesiologist consider the expected reimbursement for the hospital and him or her while finetuning the anesthetic plan? Would we uphold the Hippocratic Oath then? Certainly, society cannot expect to ignore these difficult issues while some sectors amass the financial benefits of the initial application of the principles of economics.

Another basic rule of free market economics is that the consumer is the recipient of the goods or services and the payer of the product. This tenet is of paramount importance in achieving maximum efficiency in the capitalist system. The consumer selects the product depending on his or her perception of quality and value. This perception is based on factual information, past experience, recommendations, and marketing. In a true free market, the intersection of the supply and demand curves dictates the market price of the service, i.e., the anesthesiologist's professional fee.

Our current system leads to inefficiency because the patient is...
the recipient of services, but not the buyer. The government is the buyer for the Medicare and Medicaid programs. The government sets the reimbursement rates based on budgetary considerations and HCFA recommendations. For most employed people, the insurance carrier is selected by the employer. This decision is based on the cost of the plan, not necessarily its quality. This arrangement excludes the recipient of services from the decision-making process of selecting an insurer, and by association, a provider. The only way to seek an efficient free market is to transfer the buying decision to the direct consumer, the patient.

I fully understand the dogma of "It's Economics, Doctor," as presented by Dr. Shapiro. But are we as a profession and as society prepared to apply the full weight of economics to the health care market? How far are we from asking our clients: "Which anesthesia service would you like to book—coach, business, or first class?"

Jose J. Dávila, M.D.
Medical Director
Department of Anesthesiology
HealthSouth Doctors' Hospital
Coral Gables, Florida

Reference


(Accepted for publication July 29, 1997)

Barry A. Shapiro, M.D.
James E. Eckenhoff Professor and Chair Department of Anesthesiology Northwestern University Medical School Chicago, Illinois 60611

(Accepted for publication July 29, 1997)

Optimal Rehydration of Desiccated CO₂ Absorbents

To the Editor — The work by Baxter and Kharasch1 confirms the concept that the CO₂ absorbent water content is critically important to the production of CO from anesthetic breakdown. Adding water to desiccated absorbent provides a safe, easy, cost-effective maneuver that can reduce the risk of CO poisoning from anesthetic breakdown. If this technique is brought into clinical practice, two additional factors may need to be considered. First, because the water content of absorbent in clinical use is rarely known, it may be a fairly common occurrence to add water to absorbent that is already hydrated. Although a small decrease in CO₂ absorption rate results from increasing the absorbent water content above 22%, this will probably be of minimal clinical significance because the actual capacity to absorb CO₂ is not greatly altered by water content. However, it may be more important to ensure that the water is well distributed throughout the previously desiccated absorbent to ensure that all areas of absorbent are rehydrated and are therefore incapable of producing CO. Baxter and Kharasch1 showed that some CO production still resulted, even though the absorbent had been rehydrated with the full complement (13%) of water. This may be a result of incomplete mixing of the water with the absorbent granules, leaving some absorbent sufficiently dried to allow chemical reaction. When rehydrating potentially dried absorbent in a clinical situation, particularly when the absorbent is packaged in plastic canisters that may impair water distribution (as compared with loose fill absorbent), it may be desirable to use even greater quantities of water than the minimum to ensure that all absorbent has been rehydrated. If sufficient care can be taken to avoid skin injury from dissolved alkali, in some situations, it may even be reasonable to briefly plunge the entire CO₂ absorbent canister into a bucket of water to ensure that the absorbent is completely rehydrated.

Harvey Wochlick, M.D.
Associate Professor of Anesthesiology
Medical College of Wisconsin
Milwaukee, Wisconsin 53226

References


(Accepted for publication July 29, 1997)