participating in the management of PCA. Additionally, based on table 2, the number of institutions indicating their participation in PCA is greater than the number of institutions responding to the survey. From this, we infer that there is an overlap of the groups participating in the management of PCA. However, it is unclear which groups overlap and which have primary responsibility for PCA management. Those with the responsibility will determine the quality of care and ultimately, perhaps, patient outcome.

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In Reply.—Weitz suggests the data in my survey are misleading. I would say, rather, that they may require additional interpretation. It was noted that 236 institutions reported having an anesthesiology-based acute pain service, whereas 221 institutions reported that anesthesiologists manage patient-controlled analgesia (PCA). This indicates that among the institutions identified as managing PCA but provide other forms of analgesia, I am aware of numerous institutions that function in such a manner.

Table 2 lists the therapist group or groups reported to manage PCA by the survey respondents. In some institutions, there was only one group; in others, there were several. When there were a number of therapist groups involved in one institution, each that was identified contributed to the number of responses seen in table 2. The total of the responses therefore is greater than the number of institutions that indicate they offer PCA. The design of the survey was short and simple. An advantage of that approach was a respectable response rate; a disadvantage, as Weitz points out, is a lack of more detailed information about PCA management behaviors.

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Reference

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More on the Language of Anesthesia

To the Editor.—I disagree with the comments made on terminology in the correspondence by Ben-David et al. 1 These authors state that the terms "general anesthesia," "conscious sedation," and "combined technique" confuse and frustrate communication (and create a linguistic trap with wide ramifications). The patients I interview have no difficulty with these terms or the concepts that they represent. Simply put, a general anesthetic is a drug-induced loss of consciousness, administered usually for the purposes of performing an otherwise unpleasant surgical procedure. Our own definition within the specialty may refer to muscular relaxation and reduction of reflex activity, but those descriptions are unnecessary during discussions with patients. Whether the entire autonomic and hormonal response to a surgical procedure is blocked by the general anesthetic is irrelevant to the patient as long as there is no awareness of pain (Ben-David et al. misuse the word pain, which is a conscious sensation). It may be true that the nervous system is not entirely insensitive, but with adequate anesthesia, the patient does not move in response to a supramaximal stimulus, e.g., the patient appears to be

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In Reply.—We find it difficult to argue that local anesthetic patients have a common understanding of these terms when, as evidenced by the letter of Ben-David et al., they are unable to communicate that they are used for local, regional, or general anesthesia. The authors make the point that these terms are difficult for patients to understand. However, it seems likely that the language used by anesthesiologists in describing the potential benefits of anesthesia to patients is more important than the language used in describing the effects of anesthesia. As long as patients understand that they will have minimal awareness of the procedure, they are likely to be satisfied with the procedure. The authors are correct that the language used in describing the effects of anesthesia is not important for patients. We agree that the language used by anesthesiologists in describing the potential benefits of anesthesia is important for patients. We do not agree that the language used in describing the effects of anesthesia is not important for patients. The language used by anesthesiologists in describing the potential benefits of anesthesia is important for patients. We agree that the language used in describing the effects of anesthesia is not important for patients. The language used by anesthesiologists in describing the potential benefits of anesthesia is important for patients. We do not agree that the language used in describing the effects of anesthesia is not important for patients.

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CORRESPONDENCE

insensitive, and therefore, the word anesthesia fits with its original
derivation (an = neg., aesthesis = Greek for sensation).

Conscious sedation is sedation that occurs without the loss of con-
sciousness. Although some philosophers may have difficulty with the
term consciousness, it is a common lay word that simply means the
presence of self-awareness. If one is sedated but still conscious, then
this is “conscious sedation.” Finally, the patient who wants to have
a regional anesthetic but also wants to be unconscious during the
procedure can readily understand that a “combined anesthetic” can
meet their needs, even though they would not have pain with a re-
gional method alone. Patients having upper abdominal surgery with
epidural anesthesia may be upset if they feel like they cannot breathe
adequately. In these cases, I find it useful to have the patients asleep,
with tracheal intubation and controlled ventilation. It would be lu-
dicrous if I would refer to this anesthetic, as the authors suggest, as
“epidural anesthesia with deep sedation.”

If we say to our patients that we are now about to begin “the
anesthetic,” ask them to turn on their side, and begin to insert a 10-
cm needle into their back, I think most people of average intelligence
would ask for a more specific definition of what is meant by the term
“anesthetic” in this case. I submit that, if we introduce the subject
with the term “combined anesthetic” and proceed to define what
advantages this technique offers (such as fewer systemic drugs used,
painless emergence, and reduction of the “stress” response), we
have distinguished this method from the ordinary “anesthetic.” Dur-
ing the ensuing discussion, they will understand the reasoning behind
the procedures that are performed and why they are recommended.
Until a better phrase is advanced I see no reason to abandon the one
that is in common use.

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Reference

1. Ben-David B, Levin H, Solomon E: A trap of our own making

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In Reply.—We find it difficult to accept Larson’s contention that
he and his patients have a common understanding as to the meaning
of these terms when, as evidenced by this correspondence, even we
who are educated in the field cannot agree. Our experience is quite
the opposite of his. We commonly receive patients who, based on
hearsay, insist on one anesthetic or another with little concept of
what they are talking about. They may grasp, for example, the term
“general anesthesia” as to a life raft in the storm of their fears. In
the ensuing discussion, it may become clear that the real issue is that
the patient does not want to be aware during the surgery. Careful
and empathetic explanation that this can be achieved without “gen-
eral anesthesia” is not always successful in proving loose that grip.
This is just one of many examples we could offer as to how these
terms frustrate communication.

As to the definition of “general anesthesia,” we do not agree that
it is simply a drug-induced loss of consciousness where there is no
awareness of pain and the patient does not move during cardiopul-
monary bypass. Several percent of patients receiving “general anes-
thesia” may have awareness and recall of the intraoperative events—
a figure not much different than that for patients undergoing rhino-
plasty under “local anesthesia with sedation.”! The latter, inciden-
tially, are often adamant about not wanting a “general anesthesia,”
as if the avoidance of this term makes the procedure less intimidating.

We agree that nociception under inhalational anesthesia is not pain
per se. This is why we introduced the issue speaking of “no-
icceptive afferent stimuli.” “Pain is when it hurts” is the traditionally
accepted definition. However, with recent advances regarding no-
icceptive hyperexcitability (“windup”) perhaps we need to be more
inclusive. The patient’s consciousness may not remember the pain,