

Letters to the CSA

August 25, 2006

To the Editor:

Re: RBRVS and P4P

The piece written by Kenneth Pauker, M.D., in the Summer 2006 *CSA Bulletin*, “A History of RBRVS As a Perspective on P4P: Part II of III: Anesthesia Time, Cross-Links, and the Derivation of the Initial Anesthesia Conversion Factor,” was an excellent and informative article in the *Bulletin*. Thanks for taking the time to research and further clarify a very important issue.

Steven D. Goldfien, M.D., CSA President 2000-2001



August 25, 2006

To the Editor:

I want to commend Dr. Kent Garman for his informative article, “Stay Off the Sidelines,” which appeared in the Summer 2006 issue of the *CSA Bulletin*. I also want to urge all CSA members to do as the title suggests and register with your local Medical Reserve Corps (<www.medicalreservecorps.gov>). The October 2006 issue of the *California Medical Board Newsletter* leads with an article that suggests contacting the California Emergency Medical Services Authority at www.medicalvolunteer.ca.gov. This brand new Web site allows registration online for the State’s volunteer database.

Dr. Garman’s article caught my attention particularly because I read it just the day after I had been “sworn in” by the organizers of my local Santa Clara County disaster preparedness volunteer group. As it happened, I had responded to a postcard that those organizers had sent out earlier in the year, and after being added to their database as an anesthesiologist in the community, the final step was an official swearing-in ceremony, at which time a photo ID armband is given to identify me as officially preregistered. This is an important step, which enables authorities (police or military) to know that the person identified by the badge is really a medical caregiver. It was emphasized that it is a big problem in the confusion following a disaster for authorities to know that people are really who they say they are. They also emphasized that by registering, one is in no way obligated to do anything, even in the event of a disaster. They made it clear that we all have obligations to our individual hospitals and, of course, foremost to our families, and that this voluntary

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activity is permissive only and subject to our individual availability. I echo Dr. Garman's advice and urge every CSA member to check out the Web site or call your local medical society office and ask how to get involved. It's painless and easy but, in the event of a disaster, could be vital.

Mark Singleton, M.D., CSA President 2006-2007

To the Editor:

Re: *CSA Bulletin* Article: "We Should Always Listen to the Patient"

It is the standard of care for the capnographic and oximetric alarms to be audible to the anesthesiologist. Using stethoscopy is surely extremely helpful for anesthesiologists in training to learn physiology and to reinforce good monitoring practice. I would argue that mature expert anesthesiologists ought to be able to choose whatever supplemental monitors they wish to monitor respiration and oxygenation, but that stethoscopy with a monaural stethoscope need not be resurrected as a standard practice. **What is standard and must be standard is that the alarms must be activated and audible.** Wireless stethoscopy with projection from a speaker not attached to the anesthesiologist may be a useful modern addition, but where are the data to demonstrate that modern monitoring techniques with the alarms activated and audible produce inferior outcomes from more rudimentary techniques?

Kenneth Y. Pauker, M.D., Chair, Legislative and Practice Affairs Division,
Associate Editor, *CSA Bulletin*

To the Editor:

Re: Tips from the Top by Danielle Reicher, M.D.

Has the precordial stethoscope been replaced by the end-tidal CO₂ wave form? A poll of the *Bulletin* editors reveals no consensus. But I agree with Dr. Reicher that use of the stethoscope provides early warning before the patient moves, coughs or obstructs. It is part of our vigilance.

As a director at NORCAL Mutual Insurance Company, I review anesthetic mishaps and disasters. In an all-too-typical scenario, a patient arrests while receiving intravenous analgesia/anesthesia. The patient, although resuscitated promptly, is left with hypoxic encephalopathy. The cause is inadequate

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monitoring of the patient. Often the alarms are silenced or disabled, contrary to ASA Standards.* The case against the anesthesiologist is not defensible.

I would argue that we should be using the precordial/esophageal stethoscope, in addition to pulse oximetry and capnography. One of the best indicators of ventilation is to hear the movement of air. Especially during MAC cases, why not use a precordial stethoscope?

Patricia A. Dailey, M.D., CSA President 2002-2003,
Associate Editor, *CSA Bulletin*

To the Editor:

I'm back again, that crusty Devonian gasser, now 85, from so many years ago.

This issue of the *Bulletin* had two articles that tweaked my musty memory: One, the Leffingwell lecture by Clyde Jones, in which he mentioned my invention of the monaural stethoscope and the Constant Monitor System, and the other by Danielle Reicher ("Tips From the Top") concerning the continuing importance of constant monitoring with the monaural chest or esophageal stethoscope.

When the oximeter was developed (first used in Japan in 1974), I hailed it as the most important instrument for patient safety and predicted the demise of my favorite monaural monitor. I now believe that events since that time have proven me partially wrong. I subscribe to Dr. Reicher's admonitions with enthusiasm and would hope that residency programs across America would again require earpiece monitoring as an element of training. The development of multiple sophisticated electronic monitoring devices has relegated the earpiece far to the background in residency training, but it **seems** that despite familiarity with these newer aids to vigilance, it's still possible to miss vital clues to patient distress until one or more of the other monitors alerts us. Dr. Reicher's admonitions are thus as important now as they were in my day. It's amazing what you can learn from routine use of the earpiece.

*ASA Standards for Basic Anesthetic Monitoring require the end tidal CO₂ alarm to be audible to the anesthesiologist when capnography or capnometry is utilized. They also state that the adequacy of ventilation shall be evaluated by continual observation of qualitative clinical signs and/or monitoring for the presence of exhaled carbon dioxide during regional anesthesia and monitored anesthesia care.

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I've been retired now for 21 years and have not missed one of those "moments of sheer terror" we all know so well. My compliments to Dr. Reicher and my thanks to Dr. Jones for his re-telling the story of early constant monitoring.

Dr. Leffingwell was a wonderful gentleman and a good friend. He told me one day that the monaural stethoscope had taught him what he "had been doing to children during tonsillectomies for the very first time." He was an enthusiastic devotee and he required the monaural stethoscope for each of his residents.

Best wishes and thanks for your work as Editor of the *Bulletin*.

Robert E. Ploss, M.D., Editor of the *Bulletin*, Summer 1962-January 1966

Editor's Note: It should be noted that the letters published in this section represent the opinions of the individual authors, and no inference should be made as to the opinion of the California Society of Anesthesiologists or the editor. The views expressed here are not official policy of the CSA, and a letter's publication does not imply agreement or disagreement with the author.

We are attempting to provide the membership with a forum to express their thoughts to other California anesthesiologists. We also make every attempt to publish the letters in their entirety and just as we receive them. Insofar as possible, related or opposing views will be published. If a letter deserves a reply, its publication may be delayed until the companion letter is available. Please remember, we do have deadlines and space limitations—thus, the publication of your letter may be delayed to the next issue for these reasons.

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