

Anesthesiology  
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*In reply:*—We are grateful to Dr. Ament for describing the missing events that led to our present Physical Status Classification, now recorded for public record. The “indignity” to which I referred related not to the profession, the ASA or the revisionists. The only persons properly indignant are the innovators, whose original contribution published under their names was ignored by those who used the system and worse, attributed it to someone else.

Dr. Fink errs in stating I suspected physical status assessment is often weighted by considerations of anesthetic and operative risk. To explain the correlation, albeit low, between Physical Status and anesthetic mortality, I offered two postulates. One, which I do not believe, is stated above. The other, which I favor, is the inability of surveyors of anesthetic mortality

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### Broken Code—The ASA Classification Exposed

*To the Editor:*—The article by Owens, Felts and Spitznagel<sup>1</sup> demonstrates the inconsistency and inadequacy of the ASA physical status classification. Dr. Keats' editorial in the same issue points out that the classification was never devised as a predictor of operative outcome. However, 91 per cent of the respondents used the classification routinely, and according to the authors, many use it as a risk classification. About 43 per cent use the classification as a risk index for billing purposes. I have abandoned entirely the use of the ASA classification system, because I believe that a written summary of patient risk factors communicates more accurately than the ASA classification my assessment of those factors. The targets of my written summary include my anesthetic colleagues, nurses, surgeons, house officers, and hospital administrators. In short, my aim is to communicate clearly my assessment of risk to anyone who may read my preoperative note, even if this includes attorneys and lay jurors. To accomplish this goal I simply conclude my preoperative note with a sentence or two detailing my concerns and subsequent plans. This format can be used for all of the sample patients in the study by Owens, *et al.* My conclusion regarding Patient 7 would be: “This patient is at routine risk for anesthesia and surgery except for mild anemia consistent with blood loss and oral hydration. To ensure satisfactory volume status, I plan vigorous intravenous hydration prior to and during anesthesia for this procedure.” For Patient

to distinguish between an anesthetic death and a death attributable to a patient's disease and his operation. Nevertheless, Dr. Fink proposes another explanation for a correlation between Physical Status and anesthetic mortality. His postulate is reasonable if it is based on a correct assumption, that anesthetic errors are more likely to be fatal in PS IV than PS I patients. Is intubation of the esophagus, administration of pure N<sub>2</sub>O, or complete airway obstruction more fatal in patients classified PS IV than in those classified PS I?

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10, my conclusion would be: “This patient is at increased risk for anesthesia and surgery due to chronic hypertension and coronary-artery disease manifested by exertional angina following an anterior myocardial infarction five years ago. I plan general endotracheal anesthesia following cardiologic consultation to substantiate my impression that this patient's disease state is not progressive at present. I plan to maintain the patient's cardiovascular variables at or near control values throughout the procedure.” Any reader of the record can understand my concerns and plans. I feel this is better than obscuring the assessment with a numerical code which, though devised to communicate within our specialty (often to the exclusion of other health professionals), confuses even anesthesiologists who use it regularly.

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#### REFERENCE

- Owens WD, Felts JA, Spitznagel EL Jr: ASA physical status classifications: A study of consistency of ratings. *ANESTHESIOLOGY* 49:239–243, 1978

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