

thesiologists who specialize in anesthesia for cardiac surgery. They often attend preoperative conferences at which cardiac catheterization, electrocardiographic and radiologic data are presented and evaluated. This practice prepares the anesthesiologist in such a way that there should be no intraoperative surprises. Why limit this to cardiac surgery patients?

Finally, most patients are very knowledgeable about their surgeon but know very little, if anything, about their anesthesiologist. It is many times very difficult, if not impossible, for the patient to get to know the anesthesiologist during the standard preoperative visit. Indeed, the patient may appear to be listening to the anesthesiologist but may hear very little of what the anesthesiologist has to say during this visit. In that situation the anesthesiologist seems to be just one more interloper thrust upon him at a most inappropriate moment. How much more satis-

factory it would be if the anesthesiologist had seen and come to know the patient in advance of the operation.

How to organize an anesthesia liaison service would vary from hospital to hospital, depending on just what is expected of this service. It might start as an outpatient service, or an inpatient service, depending upon where the greater need is. In some hospitals it might involve both inpatients and outpatients from the start. One thing is certain: the value to all concerned, including the resident in training, is immediately evident.

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Audio vs. Visual Oxygen Alarm

To the Editor:—The use of an in-line oxygen monitor for anesthetic gas mixtures is rapidly becoming an established routine, considered by many to be essential for patient safety during inhalational anesthesia. Unfortunately, some models of these oxygen monitors are not as foolproof as they might be.

We recently became aware of a case in which a serious hypoxic incident was narrowly averted despite the use of an in-line oxygen monitor. In this instance, an Ohio 200 oxygen monitor was in use and had been correctly calibrated. Following this, however, it had been switched to the "visual alarm on" position, rather than the "audio-visual alarm on" position (fig. 1). When, subsequently, the hypoxic mixture of gases was accidentally selected, the anesthesiologist did not observe the small flashing warning light on the oxygen monitor that indicated a hypoxic mixture until the patient became cyanotic.

It is our opinion that any warning system should have a single on/off switch, and in the on position all possible warning systems should be activated (including visual and audible). Accordingly, we have modified all our oxygen monitors so that with the switch on either "on" position both visual and audible alarms are activated. We can see no reason for equipping a piece of safety equipment as vital as an oxygen alarm with a silent mode.

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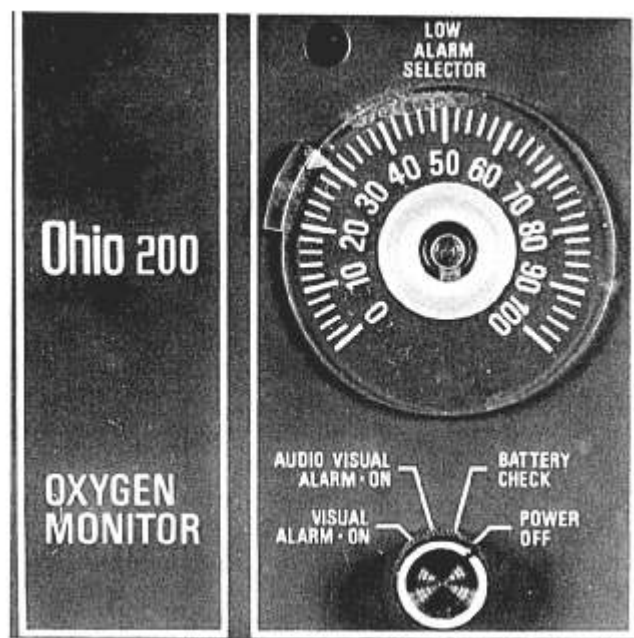


FIG. 1. The monitor, showing switch positions.

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