The impact of professional liability insurance on nurse anesthesia practice

Courts have been reluctant to admit that liability insurance has had an impact on the law. Liability insurance is very seldom discussed, primarily because insurance is irrelevant to the major issues that are before the court:

- Was there a duty of care?
- Was there a breach of that duty of care?
- What are the damages?

One of the philosophical justifications of malpractice liability is to make professionals more careful. Greater care will be taken if the person knows he or she can be liable for the damages caused. For awhile, there was a question whether liability insurance, which provided protection against the consequences of negligence, was against public policy. By the early 1920's, the courts appeared to have finally accepted the idea of malpractice insurance.

Doctrine of Charitable Immunity

In the field of nurse anesthesia, it is difficult to determine which has had the greater influence: law on insurance or insurance on law. The first example is the Doctrine of Charitable Immunity which can be traced back to 1876 and the Massachusetts case of McDonald v. Massachusetts General Hospital, 120 Mass. 432 (1876).

In McDonald, a patient claimed that he had been damaged by the actions of a doctor on the staff of Massachusetts General Hospital. The patient was receiving free care at the hospital and the physicians and surgeons were also providing free services. Moreover, the funds for Massachusetts General Hospital were derived primarily from grants and donations. Patients paid only according to their ability and not according to the services which they received. The Massachusetts court reasoned that the hospital was acting in a similar way to a government agency. Just as a government has sovereign immunity (meaning it cannot be sued), the court held that a charity had charitable immunity. If the grants and donations which the charity solicited from the public were used to pay malpractice claims, the court worried that the public would not support the hospital and a very worthwhile activity would be denied the public.

“Captain of the Ship” and “Borrowed Servant” doctrines

The courts were not willing to agree that patients who were injured at charitable hospitals had no recourse. In a number of cases, one of which is Schloendorf v. Society of New York Hospital, 211 N.Y. 125, 105 N.E. 92 (1914), the court held that physicians who were on the hospital's staff were not employees of the hospital for purposes of liability. Similarly, nurses engaged in treating patients, even though paid by the hospital, were not acting for the hospital but as servants of the doctor. From this developed the doctrines known as “Captain of the Ship” (once the surgeon assumes control of the operating room, the surgeon is responsible for any negligence which occurs); and the “Borrowed Servant” rule (a doctor may be held liable for the negligence of a hospital employee who is subject to the doctor's control).

Liability from “administrative” acts of hospital employees

Consideration had to be given to the fact that hospitals had administrative employees who were not engaged in patient care. Nurses did not spend all of their time on patient care; time was also spent on adminis-
trative matters. Despite the doctrines of "Captain of the Ship" and "Borrowed Servant," there were some activities of hospital employees for which only hospitals were liable.

In some states, the courts held firm and persons damaged by "administrative" acts of hospital employees were unable to recover. In other states, the courts attempted to deal with this problem by developing exceptions to Charitable Immunity and "Captain of the Ship." In those states, when a nurse negligently injured someone while engaged in "administrative" activities the hospital was liable, but when a nurse injured someone while engaged in "medical" duties a physician was liable.

**Bing v. Thunig and malpractice Insurance**

This led to any number of seemingly inconsistent holdings on liability of nurses and hospital employees. And, because there were some activities of their employees for which some hospitals were liable, hospitals began to purchase insurance. In 1957, New York began to rollback Charitable Immunity and "Captain of the Ship" in the case of **Bing v. Thunig**, 2 N.Y. 2d 656, 143 N.E. 2d 3 (1957). The court in **Bing v. Thunig** emphasized the inconsistent results of Charitable Immunity. Although the court did not base its decision on the presence of insurance, you can see that the presence of insurance did have a major impact on the court's outcome.

In a key paragraph, the Bing court pointed out that when the doctrine was originally adopted courts were concerned that without this protection, hospitals would be subject to malpractice suits and would be destroyed. The court pointed out that in those states that had not adopted Charitable Immunity, hospitals had not failed. But, obviously, one of the main reasons hospitals did not fail was that they were covered by malpractice insurance.

**Nurse anesthetists and malpractice Insurance**

When Charitable Immunity died, one would have expected its companions "Captain of the Ship" and "Borrowed Servant" to die with it. However, the courts are unwilling to place innocent victims in a position where they cannot fully recover for their injuries. When the persons who cause damage are unable to compensate victims, victims actively pursue relief against persons whose wrongdoing is more remote. Therefore, nurse anesthetists must continue to have access to adequate amounts of malpractice insurance.

While everyone acknowledges that we are currently in a malpractice crisis, no one can agree on why it exists or who caused it. Whether the courts can be blamed for the crisis can also be challenged. As of August 1982, the median medical malpractice settlement was $9,050 before trial and $13,350 during trial. (Baldwin, "The Phony Medical Malpractice Crisis", TRIAL, April 1985, p. 4).

**Impact of physician-controlled insurance companies on nurse anesthetists**

Out of the medical malpractice crisis has come the development of physician-controlled insurance companies replacing commercial carriers in providing medical malpractice insurance. The development of physician-controlled insurance companies has provided physicians with mechanisms to stop the "encroachment" of non-physician personnel in health care matters.

In the case of nurse anesthetists, the reverse has been the case. Nurse anesthetists have seen the encroachment of physicians into what has been traditionally a nursing field for over 100 years. There have been several attempts to use malpractice insurance as a way to restrict the practice of nurse anesthetists or discourage the use of nurse anesthetists. In Oklahoma, a physician-controlled insurance company required the presence of an anesthesiologist during the administration of anesthesia and threatened to impose higher premiums on surgeons working with nurse anesthetists. When the Oklahoma Association of Nurse Anesthetists objected, the insurance company eventually withdrew the requirement.

In Connecticut, the Connecticut Medical Insurance Company (a physician-controlled insurance company) refused to insure nurse anesthetists administering regional anesthetics. In California, one insurance company has required that general anesthetics in outpatient facilities be administered only by anesthesiologists. In one state, the executive committee of the state Society of Anesthesiologists decided to ask insurance companies to raise the premium rates of surgeons working with nurse anesthetists. In Texas, various restrictions have been imposed on nurse anesthetists including the imposition of higher premium rates of insurance on surgeons working with nurse anesthetists than on those working with anesthesiologists.

There is, of course, no reason for these insurance companies to be imposing any of these restrictions except the economic and financial advantages that they bring to anesthesiologists.

Because malpractice insurance does have an important effect on the law, exceptions to restrictions' coverage on the practice of nurse anesthetists may become "self-fulfilling prophecies." Consequently, nurse anesthetists must be adequately insured and must be vigilant that medical malpractice insurance is not used to restrict their practice.
All of the above. And more.

Being a nurse anesthetist in the Air Force also makes you part of the Air Force professional health care team.

You'll have the opportunity to grow professionally while you serve your country.

And as an Air Force nurse you'll be able to use your education and skills to the fullest. You may also receive financial assistance to pursue higher academic degrees. Qualified nurses have excellent opportunities for advancement.

Find out all about Air Force nursing today. It's as easy as ABC. Talk to your Air Force recruiter or call toll-free 1-800-423-USAF (in Calif. 1-800-232-USAF). You can Aim High in the Air Force.
VERSED
midazolam HCl/Roche IV
INSTEAD
...of hydroxyzine
Key advantages in premedication

- **Sedates faster**

  ![Percent of Patients with Desirable Levels of Sedation](chart)

<table>
<thead>
<tr>
<th>Desirable Level of Sedation at 15 minutes</th>
<th>VERSED</th>
<th>hydroxyzine</th>
</tr>
</thead>
<tbody>
<tr>
<td>(64/149)</td>
<td>43%</td>
<td>19%</td>
</tr>
<tr>
<td></td>
<td>(19/101)</td>
<td></td>
</tr>
</tbody>
</table>

- **Virtually painless**

  Incidence of pain at I.M. injection site

<table>
<thead>
<tr>
<th>VERSED</th>
<th>hydroxyzine</th>
</tr>
</thead>
<tbody>
<tr>
<td>alone</td>
<td>alone</td>
</tr>
<tr>
<td>4.5%</td>
<td>47.1%</td>
</tr>
<tr>
<td>(12/269)</td>
<td>(64/136)</td>
</tr>
<tr>
<td>with other agents</td>
<td>with other agents</td>
</tr>
<tr>
<td>1.8%</td>
<td>62.7%</td>
</tr>
<tr>
<td>(2/111)</td>
<td>(32/51)</td>
</tr>
</tbody>
</table>

- **Pronounced amnestic effect**

  The maximum amnestic effect occurred between 30 and 60 minutes after VERSED (0.08 mg/kg) administration. Caution patients about driving or operating hazardous machinery after receiving VERSED.

Please see references and summary of product information on the following page.
VERSED (brand of midazolam HCl/Roche) INJECTION

Before prescribing, please consult product information completely, a summary
with which follows:

INDICATIONS: IM: preoperative sedation, to impair memory of perioperative events; IV: conscious sedation prior to short diagnostic or endoscopic procedures, alone or with a narcotic, induction of general anesthesia before administration of other anesthetic agents, as a component of intravenous supplementation of nitrous oxide and oxygen (balanced anesthesia) for short surgical procedures (longer procedures have not been studied). When used IV, VERSED depresses respiration, and apnea and other sedatives can add to this depression, should be administered as induction agent only by a person trained in general anesthesia For serious respiratory effects, do not administer IV by rapid or massive bolus. Serious cardiorespiratory adverse events have occurred, predominantly in older chronically ill patients and with concomitant use of other cardiorespiratory depressant agents. These have included respiratory depression, apnea, respiratory arrest and/or cardiac arrest, sometimes resulting in death. Do not administer in shock, coma, acute alcohol intoxication with depression of vital signs. Protect against unauthorized intra-arterial injection, hazards in humans unknown. Avoid extravasation.

Higher risk surgical or debilitated patients require lower doses for induction of anesthesia, premedicated or not. Patients with chronic obstructive pulmonary disease are unusually sensitive to the respiratory depressant effects of VERSED. Patients with chronic renal failure have a 1 5- to 2-fold increase in elimination half-life, total body clearance and volume of distribution of midazolam. Patients with congestive heart failure have a 2- to 3-fold increase in elimination half-life, total body clearance and volume of distribution of midazolam. Patients over 55 require lower doses for induction of anesthesia; premedicated or not. Because elderly patients frequently have inefficient function of one or more organ systems, and because dosage requirements have been shown to decrease with age, reduce initial dosage and consider possibility of a prolonged and/or prolonged effect. Concomitant use of barbiturates, alcohol or other CNS depressants may increase the risk of underventilation or apnea and may contribute to profound and/or prolonged drug effect. Narcotic premedication also depresses the respiratory response to carbon dioxide stimulation. Hypotension occurred more frequently in the conscious sedation studies in patients premedicated with a narcotic. Gross tests of recovery from the effects of VERSED cannot alone predict recovery time under stress. This drug is never used alone during anesthesia, and the contribution of other perioperative drugs and events can vary. The decision as to whether sedatives and/or other anesthetic agents are required must be individualized, it is recommended that no patient should operate hazardous machinery or a motor vehicle until the effects of the drug, such as drowsiness, have cleared or subsided or 2 to 3 half-lives after the last dose.

Usage in Pregnancy: An increased risk of congenital malformations associated with the use of benzodiazepines (diazepam and chlordiazepoxide) has been suggested in several studies. If VERSED is used during pregnancy, it is recommended that alternative techniques be used to prevent induction of labor should spontaneous labor occur. If VERSED is used during labor, it is recommended that alternative techniques be used to prevent induction of labor should spontaneous labor occur. If VERSED is used during pregnancy, the patient should be advised to avoid breast feeding.
MiniOx 100 Pulse Oximeter

....The Next Chapter

Catalyst Research has expanded its continuous oxygen monitoring line by introducing the MiniOx 100 Pulse Oximeter. The MiniOx 100 continues the tradition of dependable, sophisticated, easy-to-operate instrumentation. Dependability! You've come to expect it from Catalyst Research. The MiniOx 100 provides immediate, accurate, non-invasive measurements of arterial oxygen saturation and pulse rate.

The Quality Indicator is your built-in measure of confidence. This feature indicates the consistency of the raw data and the confidence level of the SaO2 readings. The MiniOx 100 features a complete alarm package. SaO2 and Pulse readings have both visual and audible alarms with a variable volume control.

To assure integrity, the MiniOx 100 uses an advanced microprocessor which periodically performs self-checks of its system. The heart of the MiniOx 100 is its modularly designed electronics. Excellence of design and affordability have become the underlying themes in the continuing story of MiniOx.

To get to the next chapter of MiniOx and further details on the MiniOx 100 Pulse Oximeter, call 1-800-851-4500

Catalyst Research
A Division of Mine Safety Appliances Company
3706 Cronkell Lane
Owings Mills, Maryland 21117

**********

Chapter I

MINIOX Oxygen Monitors can be found in virtually every hospital in North America. That's because today, more and more hospitals are turning to MINIOX; quality instruments that respiratory therapists, neonatologists and anesthesiologists now rely on in critical situations.

END OF CHAPTER I.

Chapter II

Introducing the MiniOx 100 Pulse Oximeter from the makers of MiniOx. It's pulse oximetry with all the qualities users have come to expect from MiniOx. Expect more in the chapters to come.

Get the MiniOx advantage
Because You Demand Excellence!

As a medical professional, you demand nothing less than excellence in all areas of operating room procedure. And your CO₂ absorbent is just as important as your anesthetic agent. For over 60 years, Sodasorb Absorbent has consistently provided superior performance and on-the-job reliability without compromise.

**Depend on Sodasorb CO₂ Absorbent for:**
- **Consistent High Quality**—For over 60 years Sodasorb Absorbent has been the industry standard.
- **Safety**—Sodasorb CO₂ Absorbent is 100% non-toxic.
- **Availability**—Sodasorb maintains a nationwide distributor network.
- **Savings**—Pound for pound, Sodasorb Absorbent lasts longer.
- **Less Dusting**—Sodasorb Absorbent has the strictest hardness standard in the industry.

Sodasorb CO₂ Absorbent is especially packaged for ease of handling and is available in four convenient packages—Pre-Pak®, Pre-Pak II, Canister-Pak®, and Plastic Pail. For further information, contact your local distributor.

Sodasorb CO₂ Absorbent... The standard of professionals for over 60 years.

---

**Contact Information**

GRACE
W.R. Grace & Co.
Dewey and Almy Chemical Division
5225 Philip Lee Drive, S.W. Atlanta, GA 30336
(404) 691-8646
We Have A Better Electrode Story.
And We Can Make It Stick.

During stress testing, in the operating room, I.C.U. and C.C.U., even after defibrillation, our high-demand electrodes stay put and provide crisp, clear and accurate tracings.

For paramedic or emergency room trauma cases where prep time is limited, our electrodes remain in place and provide a solid base line, a good clean trace and minimal motion artifact.

The unique Accutac™ gel on our high-demand ECG electrodes sticks and performs well during open heart and other major surgery, the kind of demanding conditions that might cause other electrodes to fail or fall off.

For expediency in the emergency room and surgery, high demand electrodes can be prestaged without concern of dryout.

Experience the effectiveness of our high-demand electrodes firsthand, receive a free sample kit when you contact Peggy Razzano at 1-800-543-4890 or in Ohio 1-800-762-4810.
In Today's Rough and Tumble DRG

The Mon-a-therm Family.

An adaptable species.

If you love your present monitors, fine. We'll adapt.
Our Mon-a-therm systems approach to continuous temperature monitoring works with the conditions that prevail. If you've already invested heavily in your own monitors, or if you don't want to make life more complicated for your biomedical engineers, we'll adapt. Our two new Temperature Sensor Adapters will let our family of sensors work perfectly with most major temperature monitors you can own or choose.

If you don't love your present monitors, we have a present for you.
Sign a contract for our Mon-a-therm sensors and our monitors will be yours to use at no charge. Choose our light, small and compact Model 6500, or our 3-Temp Model 7000, with its innovative multiple displays, temperature trend indicator and elapsed timer.

---

30-TON BODY
TOO MASSIVE, REQUIRED TOO MUCH FOOD.
SMART, SLEEK MON-A-THERM ADAPTS TO DRG'S.

OUTMODED TAIL
UNNECESSARY SINCE THE SWAMPS WERE DRAINED. MON-A-THERM LETS YOU ADAPT TO COST PRESSURES.
World, You Adapt. Or Disappear.

Our sensors adapt to your every need.
The heart of our system is a constantly growing family of disposable sensors with a quality and reliability you've come to expect from MON-A-TERM. Despite their astonishing sensitivity and sophistication, Mon-a-therm sensors are easy to use. When you get them where you want them, Mon-a-therm sensors give you sure performance and low trauma.

MON-A-THERM has, for a number of years, become known throughout the industry as the leading edge in sensor development. For an ever-widening variety of procedures, our family of sensors includes Myocardial, Foley Catheter, Skin, Esophageal Stethoscope with Temperature, Esophageal/Rectal, Tympanic, Luer Lock, and Nasopharyngeal. We have also crafted a special Esophageal Stethoscope in three French sizes, and we will continue to introduce the new sensors you need.

Now that you've discovered the high reliability and added DRG values of disposable sensors, it's time to dispose of the brands you've had to settle for and move to the one that has more. Mon-a-therm, the adaptable species.

We're easy to get along with... but not without.
Whether you have your own monitors or whether you'll need the complete range of products we offer, joining the Mon-a-therm family takes only a visit from our rep, an evaluation period, and a contract. We'll not only improve your program of Continuous Temperature Monitoring in the OR, Recovery and Critical Care, we'll help you beat the DRGs... or join them.

MON-A-THERM
The Adaptable Species

MON-A-THERM, INC. 520 S. Jefferson Avenue, St. Louis, Missouri 63103
(800) 325-7474 TOLL FREE • (314) 241-7474 IN MISSOURI • TELEX 532488 MONATHERM
True, it's just one small reason to choose Ohmeda for your oximetry needs.

So we'll give you 10 million more.

That's actually less than the number of patients for whom health care professionals, hospitals, and clinics have chosen Ohmeda oximetry for safe, accurate oxygenation monitoring. That's more than 15 million monitoring hours by Ohmeda pulse oximeters. From neonatal to geriatric patients, critical care to home care.

While that kind of experience is reason enough to go with the world leader in noninvasive pulse oximetry, Ohmeda gives you several reasons more.

Due care for your patients.
At Ohmeda we've always felt the best patient care possible meant our pulse oximeters should give you not just data, but useful information about that data. So our compact Ohmeda Biox 3700 pulse oximeter provides far more than SaO₂ and pulse rate readouts. It also gives you trend memory to assess oxygenation patterns over time. Waveform display to verify the reliability of SaO₂ measurements. A full array of cost-effective probes.

Our SaO₂ trend memory, and waveform display were world firsts. Other companies have attempted to follow our lead. They haven't followed far enough.

Due care for you.
Your choice in oximetry starts with patient care, but it depends on your needs and your hospital's needs, too. That's why we offer a full line of monitors, as well as other state of the art medical equipment. Complete systems—from anesthesia delivery and ventilation to infant warmers. In critical care, respiratory care, anesthesiology, and neonatal intensive care.

And we back you up with a strong reliability record and the on-site service and follow-up support of more than 200 factory-trained service representatives. That's one of the largest dedicated service organizations in critical care and life support.

Due care for your patients, and due care for you. Two of the best reasons to choose Ohmeda oximetry. Not to mention ten million more.

For more information about Ohmeda oximetry call us toll-free, or write.

Ohmeda oximetry. Right from the start.

For neonatal to geriatric patients in critical care, anesthesia delivery, and neonatal intensive care—the Ohmeda Biox 3700.

Ohmeda
4765 Walnut Street  Boulder CO 80301 USA
To Order: hospital 1 800 345 2700  non hospital 1 800 652 2469
303 447 9842  Telex 296 445 BTI UR
A Division of The BOC Group Inc

BOC Health Care © 1987 The BOC Group Inc  Form #E002
Organon presents:
The new, distinctive Pavulon vial for positive identification and handling ease.

- New functionally contoured vial speeds selection and helps assure positive identification.
- Easy-grip, no-slip design for better handling.
- Now there is one more reason to choose PAVULON®, with over 14 years of successful clinical experience.

Pavulon® (pancuronium bromide injection)
Now...tangibly different.

© 1986 ORGANON INC 080-6017

Before prescribing, please consult complete prescribing information, of which the following is a brief summary.


DESCRIPTION: SUFENTA is a sterile, preservative free, aqueous solution containing sufentanil citrate equivalent to 50 µg per ml of sufentanil base for intravenous injection. The solution has a pH range of 3.5-4.0.

INDICATIONS AND USAGE: SUFENTA (sufentanil citrate) is indicated: As an analgesic adjunct in the maintenance of balanced general anesthesia. As a primary anesthetic agent for the induction and maintenance of anesthesia with 100% oxygen in patients undergoing major surgical procedures, such as cardiovascular surgery or neurosurgical procedures in the sitting position, to provide favorable myocardial and cerebral oxygen balance or when extended postoperative ventilation is anticipated. SEE DOSAGE CHART FOR MORE COMPLETE INFORMATION ON THE USE OF SUFENTA.

CONTRAINDICATIONS: SUFENTA is contraindicated in patients with known hypersensitivity to the drug. An opioid antagonist, resuscitative and intubation equipment and oxygen should be readily available.

SUFINA may cause skeletal muscle rigidity, particularly of the truncal muscles. The incidence and severity of muscle rigidity is dose related. Administration of SUFENTA may produce muscular rigidity with a more rapid onset than that seen with fentanyl. SUFENTA may produce muscular rigidity that involves the skeletal muscles of the neck and extremities. The incidence can be reduced by: 1) administration of up to 1/4 of the full paralyzing dose of a non-depolarizing neuromuscular blocking agent (at prior to administration of SUFENTA at dosages of up to 8 µg/kg), 2) administration of a full paralyzing dose of a neuromuscular blocking agent following loss of consciousness when SUFENTA is used in anesthetic dosages (above 8 µg/kg) titrated by slow intravenous infusion, or, 3) simultaneous administration of SUFENTA and a full paralyzing dose of a neuromuscular blocking agent when SUFENTA is used in rapidly administered anesthetic dosages (above 8 µg/kg). The neuromuscular blocking agent should be compatible with the patient’s cardiovascular status. Adequate facilities should be available for postoperative monitoring and ventilation of patients administered SUFENTA.

PRECAUTIONS: General: The initial dose of SUFENTA should be appropriately reduced in elderly and debilitated patients. The effect of the initial dose should be considered in determining supplemental doses. Vital signs should be monitored routinely. Nitrous oxide may produce cardiovascular depression when given with high doses of SUFENTA (see CLINICAL PHARMACOLOGY). The hemodynamic effects of a particular muscle relaxant and the degree of skeletal muscle relaxation required should be considered in the selection of a neuromuscular blocking agent. High doses of pancuronium may produce increases in heart rate during SUFENTA-oxygen anesthesia. Bradycardia has been reported infrequently with SUFENTA-oxygen anesthesia and has been responsive to atropine. Respiratory depression caused by opioid analgesics can be reversed by opioid antagonists such as naloxone. Because the duration of respiratory depression produced by SUFENTA may last longer than the duration of the opioid antagonist action, appropriate surveillance should be maintained. As with all opioid analgesics, profound analgesia is accompanied by depression of respiration and diminished sensitivity to CO2 stimulation which may persist into or recur in the postoperative period. Appropriate respiratory monitoring should be employed to ensure that adequate spontaneous breathing is established and maintained prior to discharging the patient from the recovery area. Interaction with Other Central Nervous System Depressants: Both the magnitude and duration of central nervous system and cardiovascular effects may be enhanced when SUFENTA is administered to patients receiving barbiturates, tranquilizers, other opioids, general anesthetics or other CNS depressants. In such cases of combined treatment, the dose of one or both agents should be reduced. Head Injuries: SUFENTA may obscure the clinical course of patients with head injuries. Impaired Respiration: SUFENTA should be used with caution in patients with pulmonary disease, decreased respiratory reserve or potentially compromised respiration. In such patients, opioids may additionally decrease respiratory drive and increase airway resistance. During anesthesia, this can be managed by assisted or controlled respiration. Impaired Hepatic or Renal Function: In patients with liver or kidney dysfunction, SUFENTA should be administered with caution due to the importance of these organs in the metabolism and excretion...
THE PRIMARY ANESTHETIC
THAT KEEPS PATIENTS
ON TRACK

SUFENTA
(sufentanil citrate) Injection

Predictable control for longer, more stressful procedures

Provides smooth induction
BLUNTS hemodynamic response to intubation
and surgical stimulation

REDUCES need for vasoactive drugs in the
intraoperative and postoperative periods

RESULTS in lower postoperative morbidity after
aortic surgery compared with isoflurane

CONVENIENT: Fewer ampoules to open

Cardiovascular: tachycardia, arrhythmia
Gastrointestinal: nausea, vomiting
Respiratory: apnea, postoperative respiratory
depression, bronchoospasm

Drug Abuse and Dependence: SUFENTA (sufentanil citrate) is a Schedule II controlled drug substance that can produce drug dependence of the morphine type and therefore has the potential for being abused.

Overdosage: Overdosage would be manifested by an extension of the pharmacological actions of SUFENTA (see Clinical Pharmacology) as with other potent opioid analgesics. However, no experiences of overdosage with SUFENTA have been established during clinical trials. The intravenous LD₅₀ of SUFENTA in male mice is 9.34 to 12.5 mg/kg (see Animal Toxicology for LD₅₀ in other species). Intravenous administration of an opioid antagonist such as naloxone should be employed as a specific antidote to manage respiratory depression. The duration of respiratory depression following overdosage with SUFENTA may be longer than the duration of action of the opioid antagonist. Administration of an opioid antagonist should not preclude immediate countermeasures. In the event of overdosage, oxygen should be administered and ventilation assisted or controlled as indicated for hypoxemia or apnea. A patent airway must be maintained, and a nasopharyngeal airway or endotracheal tube may be indicated. If depressed respiration is associated with muscular rigidity, a neuromuscular blocking agent may be required to facilitate assisted or controlled respiration. Intravenous fluids and vasopressors for the treatment of hypotension and other supportive measures may be employed.

DOSAGE AND ADMINISTRATION: The dosage of SUFENTA should be individualized in each case according to body weight, physical status, underlying pathological condition, use of other drugs, and type of surgical procedure and anesthesia. In obese patients (more than 20% above ideal body weight), the dosage of SUFENTA should be determined on the basis of lean body weight. Dosage should be reduced in elderly and debilitated patients (see Precautions).

U.S. Patent No. 3,969,834
7991834-M
January 1988, March 1988
J-70
**Anesthesia Services of Fairfax** is accepting resumes from CRNA's (or board/eligible graduates) who want the challenge of working on complex cases using our state-of-the-art equipment in an ultra-modern Level I Trauma facility.

We'll give you the opportunity to rotate between a variety of clinical areas. Flexible scheduling available. Our comprehensive benefits package includes liability insurance and excellent salary.

Wake up to a rewarding career with us. Send your resume, in complete confidence, to: Gail Glasser, RN, Nursing Resource Coordinator, Fairfax Hospital, 3300 Gallows Road, Falls Church, VA 22046. We are an equal opportunity employer.
502 PULSE OXIMETER

THE MOST VERSATILE PULSE OXIMETER YOU CAN BUY

No other pulse oximeter on the market offers all the features of the CSI 502.

- Select continuous pulse waveform or pulse ladder display.
- Display up to 8 hours of stored data in 1- or 8-hour trend format.
- Monitor high and low saturation and pulse rate—full alarm capability.
- Graphic and alphanumeric documentation available with built-in printer option.
- Rechargeable battery powers unit for 12 hours.
- Documented accuracy, even at low saturation levels.

Find out more about the 502 Pulse Oximeter from Criticare Systems, Inc. Clip and mail the coupon today.

CRITICARE SYSTEMS, INC.
P.O. BOX 26556
MILWAUKEE, WI 53226
(414) 797-8282

Please send me complete information on the new 502 Pulse Oximeter from CSI.
Most O.R. nurses join the Army Reserve for the challenge. The chance to learn more. Be more.

"It may sound corny but it's true."
They join, despite busy schedules and previous accomplishment, to grow in new and exciting ways.

"You're a counsellor, a teacher, a program developer, a leader."

Many join for the educational opportunities, often unavailable in the private sector.

"I've studied staff development, curriculum design, O.R. nurse management, and taken courses at The American College of Surgeons and The Academy of Ophthalmology—all as part of my Army Reserve training."

They join to refine their nursing skills and to learn new ones.

Other O.R. nurses join the Army Reserve for the chance to work part-time outside the O.R. To gain skills and proficiency in unfamiliar fields like mass casualty medicine, triage and the organization and management of a field hospital.

"Every time I go into the field, the thing I learn the most about is me."

Still others join for the rewards of being an officer.

For the respect, pay and privileges that go with the rank. For the chance to lead and grow in confidence and effectiveness. For the pride that comes with accomplishment.

"And the retirement benefits aren't bad, either."

If you're willing to give up one weekend a month plus two weeks during the year to join these exceptional people as a nurse in the Army Reserve, call us at 1-800-USA-ARMY.

ARMY RESERVE.
BE ALL YOU CAN BE.