

# LETTERS



## EXPERT TESTIMONY

### To the editor:

I feel compelled to comment on Gene Blumenreich's informative and well-written "Legal Briefs" column that appeared in the June 2004 issue of *AANA Journal*.<sup>1</sup> Mr Blumenreich regards as problematic the outcome of *Sullivan v Edward Hospital*, a case in which the court decided that only another professional nurse—not a physician expert in the area of patient fall protection—could serve as an expert witness in the malpractice case of a floor nurse who administered a calming drug to a confused patient that was subsequently injured in a fall. Mr Blumenreich discusses his concerns that this ruling might have an impact on nurse anesthetists, in that based on this ruling, courts might decide that a physician anesthesiologist cannot testify as to the standard of practice for nurse anesthetists and vice versa, implying there are 2 standards of anesthesia care. Mr Blumenreich, the AANA, and all nurse anesthetists have been trying to correctly convince the world that there is only 1 high standard of anesthesia care that all anesthesia providers must adhere to, be they nurse or physician.

Mr Blumenreich goes on to discuss the amicus brief that the American Association of Nurse Attorneys filed in the *Sullivan* case, in which a variety of nurse "specialists" were named who would not be permitted to testify as expert witnesses for physicians working in the same specialty area. Mr Blumenreich speculates that such

nurse experts (operating room nurses, endoscopy nurses, labor and delivery nurses) could not be expert witnesses for physicians in their areas because their scope of practice did not overlap with the physicians, whereas nurse anesthetists do exactly the same things anesthesiologists do. This is not as rare as you think it is, Mr Blumenreich—nurse practitioners now do the same thing primary care physicians do in multiple specialties, and nurse midwives practice the same as obstetricians. I am not certain any of those nurse specialists would care to have a physician in the same specialty testify as an expert witness either for or against them.

It seems you are trying to have anesthesia practice both ways: it is just 1 standard of care, yes, but how many times have you written "when nurses do it, it is nursing; when physicians do it, it is medicine." Both physician and nurse anesthesia providers perform anesthesia, but we achieve our identical standard of care from 2 professional perspectives. I was trained as a nurse to assess, diagnose, plan, and implement physiological, mental, and emotional care for my patients, approaching them humanistically and scientifically, striving to maintain their homeostatic mechanisms and return them to health in the face of their disease challenges. Physicians are trained to view patients more as collections of diseases and pathophysiology in need of lifesaving and life changing medical treatment. I am not certain a physician anesthesiologist could serve fairly as a judge of my nurse anesthesia practice, though many

fine anesthesiologists practice in a manner consistent with nurse anesthesia. On a realistic and worldly level, with the degree of opprobrium between our 2 professions in recent years, I am not certain all physician anesthesiologists could be impartial expert witnesses for nurse anesthesia care. Though you have been a tireless champion for nurse anesthesia for these 20 years, I think this matter bears more thought and is more complicated than you realized, Mr Blumenreich.

### REFERENCE

1. Blumenreich GA. Expert testimony [Legal Briefs]. *AANA J*. 2004;72:173-177.

### **Charles A. Griffis, CRNA, MS**

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## RAVE DRUGS: PHARMACOLOGICAL CONSIDERATIONS

### To the editor:

The article by Klein and Kramer, which recently appeared in this journal,<sup>1</sup> provides a comprehensive review of several popular drugs of abuse; however, their discussion on gamma hydroxybutyrate (GHB) warrants several clarifying comments.

Despite being popularized as a club drug, GHB also has been intensely studied as a therapeutic agent. Since the 1970s, it has been evaluated for the treatment of a particularly troubling symptom of narcolepsy known as cataplexy.<sup>2</sup> Based on the promising results of numerous investigators over a span of 20 years, Orphan Medical began the development of GHB (given the

generic name sodium oxybate) for the treatment of cataplexy in 1996. Since that time, short- and long-term clinical trials have established the safety and efficacy of sodium oxybate for the treatment of cataplexy,<sup>3,4</sup> leading to the approval of Xyrem (sodium oxybate) oral solution by the US Food and Drug Administration in July 2002 for the treatment of cataplexy in patients with narcolepsy.

As illicit GHB was popularized as a substance of abuse and implicated in cases of sexual assault during the 1990s, the enactment of Public Law 106-172 amended the Federal Controlled Substances Act, making GHB a Schedule I agent; however, recognizing the medical value of GHB (sodium oxybate), a provision to PL 106-172 created for the first time, a “bifurcated” or split Schedule for GHB/sodium oxybate.<sup>5</sup> The FDA-approved form of sodium oxybate is controlled under Schedule III, while unapproved forms of GHB are subject to Schedule I penalties for illegal use. The 5,542 emergency department mentions of GHB reported by the Drug Abuse Warning Network in the year 2000 decreased by 33% to 3,330, within 2 years of the passage of PL 106-172.<sup>6</sup>

Klein and Kramer also suggest that GHB is highly addictive. The severe withdrawal syndrome, which has been reported following illicit GHB abuse, has consistently been associated with escalating doses and increased dosing frequency, eventually leading to the use of GHB many times daily.<sup>7</sup> In contrast, Xyrem is administered at bedtime and, due to its exceptionally short half-life, the dose is repeated once during the night. By morning, the patient is essentially drug-free and remains so throughout the day until his or her next nightly dose. In an Orphan Medical-sponsored clinical trial designed to assess the long-term

efficacy of Xyrem for cataplexy, 27 of 55 patients who used Xyrem nightly for an average of 21 months (range: 7-44 months) were abruptly switched to placebo in double-blind fashion for 2 weeks. No signs of overt drug withdrawal were reported in any patients.<sup>8</sup>

Additional information about Xyrem, including full prescribing information, may be obtained on the Internet by visiting <http://xyrem.info>.

#### REFERENCES

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2. Broughton R, Mamelak M. The treatment of narcolepsy-cataplexy with nocturnal gamma-hydroxybutyrate. *Can J Neurol Sci*. 1979;6:1-6.
3. US Xyrem Multicenter Study Group. A randomized, double blind, placebo-controlled multicenter trial comparing the effects of three doses of orally administered sodium oxybate with placebo for the treatment of narcolepsy. *Sleep*. 2002;25:42-49.
4. US Xyrem Multicenter Study Group. Sodium oxybate demonstrates long-term efficacy for the treatment of cataplexy in patients with narcolepsy. *Sleep Med*. 2004; 5:119-123.
5. US Department of Justice. Drug Enforcement Administration. Schedules of Controlled Substances: Addition of gamma-hydroxybutyric acid to Schedule I. *Fed Regist*. 2000;65:13235-13238.
6. U.S. Department of Health and Human Services. Drug Abuse Warning Network. Available at: <http://dawninfo.samhsa.gov>. Accessed June 29, 2004.
7. Dyer JE, Roth B, Hyma BA. Gamma-hydroxybutyrate withdrawal syndrome. *Ann Emerg Med*. 2001;37:147-153.
8. US Xyrem Multicenter Study Group. The abrupt cessation of therapeutically administered sodium oxybate (GHB) does not cause withdrawal symptoms. *J Toxicol Clin Toxicol*. 2003;41:131-135.

#### **Carl S. Hornfeldt, PhD, RPH**

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#### **Response:**

While the focus of our article was popular drugs of abuse and their anesthetic implications, the authors wish to thank Dr Hornfeldt

for his informative comments on the development of gamma hydroxybutyrate (GHB) as a therapeutic agent. Hopefully, the FDA-approved form of sodium oxybate, Xyrem, will not become a drug of abuse of the future.

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## **RURAL ANESTHESIA: A PILOT STUDY**

### **To the Editor**

The recent article published in the June 2004 *AANA Journal* titled “Rural anesthesia practice: A pilot study,”<sup>1</sup> defies the quality and integrity of a peer reviewed scientific journal.

The extremely poor response rate to the questionnaire should have alerted the authors to stop and evaluate their methodology (despite the efforts of obtaining “content validity”) before writing the article and describing the rural anesthesia practice setting. However, the poor results did not stop the authors from using the 28 returned surveys and submitting the article for publication.

To use community size of less than 10,000 as a “small town,” and 10,000 to 49,999 as a “large town” does not allow for further discrimination between communities having populations of 3,000 or 6,000. In states such as Maine, Wyoming, and Montana, there are few towns that would be considered large while having many falling under the 10,000 population level. The same concept should be considered when looking at hospital size within these same geographic areas.

Not only is there a probable difference between urban and rural anesthesia practice, but there is also a difference between rural areas when compared with other rural areas that needs to be identified. Is there a difference in rural Maine, rural Wyoming, and say rural Maryland or Virginia? Are these differences a factor of population or could they be different because of a different population density? This issue is not addressed.

Having lived and practiced the majority of my 35 years of anesthesia practice in truly rural areas I am not sure the investigators asked the correct questions. The criteria for inclusion and exclusion should be more specific to truly identify a small rural practice.

To use the data generated by this pilot study to draw any but the most general of descriptions of "small vs large" is fraught with errors.

The work the authors started needs to be done but done in such a way that it truly reflects what is happening in rural areas. It just might reveal the quality and types of services provided by us "country cousins" exceed what is accepted as "standard" in the more crowded parts of the country.

#### REFERENCE

1. Seibert EM, Alexander J, Lupien AE. Rural anesthesia practice: A pilot study. *AANA J.* 2004;72:181-190.

#### **Jack Norris, CRNA, MS**

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#### **Response:**

Jack Norris, CRNA, MS, raises good points about our article, "Rural anesthesia practice: A pilot study," which was published in the June 2004 *AANA Journal*. The issues he raises are those that that we struggled with ourselves. We thank the editor of *AANA Journal* for asking us to respond to Mr Norris' letter and thus

keep the need for research on rural CRNA practice in the forefront.

We designed the study as a pilot to assess the usefulness of the instrument for gathering data in larger studies. In this respect, the study was successful in demonstrating the need for further revision of the instrument, as well as providing limited data on rural CRNA practice.

As Mr Norris notes, generalizing based upon a limited response rate is not possible. Our methodology planned for a larger sample, but unfortunately survey research is dependent upon the willingness of participants to respond. Thus, based on the low response rate, we elected to collapse categories for analyses, which further limited the generalization of our findings. However, given the paucity of published information about the practice patterns of rural CRNAs, we felt that the information was worth sharing. We were pleased that the *AANA Journal* agreed with us and published the article.

Mr Norris correctly states that classifying communities and hospitals into broad categories based on size does not adequately discriminate between different rural areas or hospitals. Rurality remains a difficult concept to define and is often a definition of exclusion. Areas that are not defined as metropolitan or urban are considered rural by most federal agencies.<sup>1</sup> For example, the most recent definition proposed by the US Office of Management and Budget identifies areas as Core-Based Statistical Areas or not.<sup>2</sup> If regions do not fit into that core-based definition, they are classified to be rural by exclusion. We selected Rural-Urban Continuum (RUC) codes because they allow a greater degree of discrimination between communities based on population size and degree of urbanization. In future studies,

we plan analyses of hospitals based on the American Hospital Association (AHA) hospital classifications. Using standard measures such as the RUC codes and AHA classifications rather than an investigator-constructed category facilitates comparison with other studies that use these standards.

As Mr Norris suggested, the area of rural CRNA practice is ripe for further study; for example, comparing differences in the availability of consultation or technology in rural areas across the United States. This comparison research is inappropriate in instrument development; thus, we did not attempt to make comparisons based on specific residence of the respondents.

Our study represents a very small piece of the puzzle regarding rural nurse anesthesia practice. Based on our results, we feel that the instrument has the potential for use in future investigations. We hope that our article gives readers food for thought and ideas for future research.

#### REFERENCES

1. Ricketts TC, Johnson-Webb KD, Taylor P. Definitions of rural: A handbook for health policy makers and researchers. *Federal Office of Rural Health Policy* [Web site]. Available at: [http://www.schsr.unc.edu/research\\_programs/Rural\\_Program/ruralit.pdf](http://www.schsr.unc.edu/research_programs/Rural_Program/ruralit.pdf). Accessed May 2, 2000.
2. Slifkin RT, Randolph R, Ricketts TC. The changing metropolitan designation process and rural America. *J Rural Health.* 2004; 20:1-6.

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