sprayed at the end of tonsillectomy while the patient is breathing spontaneously, one should be aware that apnoea, one of the major signs of bupivacaine toxicity, always precedes cardiovascular collapse.⁴

I agree with Dr. Brown that bupivacaine may become the agent of choice for longer and more satisfactory post-tonsillectomy analgesia. However, I believe that further investigation of the safety and recommended dosage is required before we can support its general use.

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Anaesthesia high-risk nurse

To the Editor:

In these demanding times it is difficult to understand why, as a group, we have chosen to disregard an opportunity for a cost-effective, efficient means of improving patient care and support for our role as anaesthetists. By unequivocally accepting the concept of an anaesthesia technician, the CAS Council (February 1990) endorsed a choice but not an optimal solution.

In providing care to high-risk surgical patients, the composition of the anaesthesia care team (ACT) is crucial. We have identified the need for a nurse who provides a combination of patient management and technical support and a bridge between our patients' needs and our role as practitioners. In our institution, we have found that an anaesthesia high-risk nurse (AHRN) fulfils this vital role extremely well. This position is held by a registered nurse with an approved diploma from an intensive care nursing program with one to two years of clinical intensive care unit experience. In addition, the nurse receives one to two months of training on our Department's routines, protocols, etc.

Without providing a full job description, let us outline some of the benefits of this position. First, it is cost-effective and efficient. Training costs are manageable

because the majority of the education has already been completed. In addition, both practitioner and patient benefit from the broad experience and technical skills already gained in the intensive care unit. The nurse's equipment and monitoring experience has improved the efficiency of our patient transfer. Her/his role as a liaison with recovery and intensive care staff has reduced system duplication. The AHRN is also a major participant in meeting the overall objectives of our Department. Product and cost evaluation; efficient use of various drug administration routines; participation with other allied units in an ongoing equipment and technical review; all play a contributing role in our Department's effective operation.

More important, though, is the impact of this position on the management of our patients, especially those of the high-risk category. As a member of the team, the nurse's assessment capabilities, problem-solving skills and ability to intervene where necessary, further supports the anaesthetist's ability to provide quality care. The AHRN has drug administration experience and monitoring expertise that provide vital information on a given patient's progress. Her/his skills and experience enable proper dealing with the patient's emotional and physiological needs in the perioperative period. How often do anaesthetists have the luxury of time, or the capacity to deal with many of these issues satisfactorily?

In building a support team, the question becomes, Does the restrictive nature of a technical position, by definition, provide the answer? Does it increase our ability to provide better care? Perhaps. Does it help our patients? Not to the extent of the experience or capability of a well-trained AHRN. By adding a technician we may be adding more skill, but are we solving the problem? Instead of debating whether the answer lies with a technician or a nurse, perhaps the optimum answer lies in addressing which "position" will enable us to do our job better.

We strongly recommend that instead of accepting a unilateral approach of utilizing an anaesthesia assistant/technologist that other approaches, such as the role outlined above, be considered.

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