

# President's Page

## Compelling Storytelling

By *Kenneth Y. Pauker, M.D., President*



If you don't tell your own story, there are only two possible consequences: someone will tell it for you in a way that you might not like, or it will remain untold. Storytelling is a powerful means of communicating, as ancient as cave art and as modern as “blogging.” I believe it's time for anesthesiologists to go public and tell our own, individual stories about what we stand for and what we do as physicians. Here's why.

Leaders in the CSA and the ASA have argued for years that it is critical for anesthesiologists to find more effective methods to communicate what it is that we do. So many diverse people and different interest groups consider themselves to be stakeholders in anesthesia care—even “owners” in a strange sociopolitical kind of way—and yet most have only the most superficial understanding of who we are, what standards of care we uphold, and how indispensable anesthesiology is to the perioperative engine that powers so much of medical care. Last year, the American Medical Association's Scope of Practice Partnership “Truth in Advertising” survey found that 19 percent of respondents did not even know (an additional 3 percent were not sure) that an anesthesiologist is a medical doctor.<sup>1</sup>

## Understanding What We Do

As physicians, for each specific patient and sometimes in the face of conflicting priorities, we must tailor a coherent anesthetic plan. First, we determine a balance among complex co-morbidities shaping the probabilities of various outcomes, sometimes influenced by the choice of anesthetic technique. For example, we might care for a geriatric patient, scheduled to have a revision of a total knee replacement, who has emphysema, severe aortic stenosis, and trifascicular heart block without a pacemaker in place. Should this patient have a general, neuraxial or regional anesthetic?

On another level, superimposed on the first, we consider an individual patient's personal attitudes, cultural background and preferences for anesthetic technique. A patient presenting for an elective cesarean delivery may be morbidly obese and speak only Spanish, may have chronic low back pain, and may have grown up in a country where spinal anesthesia is known and feared as “arachia,” a Mexican slang term for a painful “spinal tap” that is believed to cause paralysis.

Should she have a spinal, versus a general that could require awake intubation? What kind of explanation or informed consent can be achieved with the available resources for translation?

Finally, individual patients have diverse priorities with regard to their own health, and have differing levels of risk aversion. One patient with indwelling spinal instrumentation might be willing to accept a small risk of infection or of a failed spinal anesthetic in order to avoid a general anesthetic and its potential for postoperative confusion and nausea, while a similar patient would never want to risk infecting spinal hardware and would insist upon a general anesthetic. These patients rank the potential outcomes differently.

### When Others Tell Our Story

We are conversant with best practices and guidelines written by experts in our field, as well as with practice parameters that are based upon expert *opinion* because definitive scientific evidence simply does not exist. Our care is nuanced, and represents high-level judgment—risks and benefits that are weighed according to our training, education and experience. *Administrative* data—abstracted from billing codes and completely unadjusted for risk because it is not *clinical* data—do not tell our story. Rather, others use this kind of data inappropriately—and occasionally disingenuously—to measure how we practice and the so-called “quality” of our care.<sup>2</sup>

Beyond the unreliable pseudoscience of abstracted administrative data being used to measure performance, some in government have so misunderstood or misrepresented what we do that they even have inserted federal civil rights antidiscrimination clauses into the Patient Protection and Affordability Care Act. Indeed, they are working to foist antitrust considerations into ongoing scope-of-practice battles. For example, the Federal Trade Commission (FTC) cautioned the Alabama Board of Medicine not to promulgate regulations declaring that chronic pain management is the practice of medicine. The FTC said that doing so might be an antitrust violation because it could deny non-physician anesthesia care extenders, who claim the expertise to care for such patients, the ability to practice independently. The ASA, in turn, cautioned the FTC.<sup>3</sup> This is all about politics.

If this novel aspect of government activity is news to you, you may find it hard to believe that there could be such intrusion into the very fabric of our profession. Sadly, this irresponsible and disingenuous campaign by the executive and legislative branches of government to “cut our profession down to size” is by no means a joke.

**Dobbs (Bogart):** “If you’re the police where are your badges?”

**Gold Hat (Bedoya):** “Badges? We ain’t got no badges. We don’t need no badges! I don’t have to show you any stinkin’ badges! We federales!”

— The film *The Treasure of the Sierra Madre*, 1948

### Whom to Educate

The long list of those who would benefit from a better understanding and appreciation of what we do and why we do it includes state and federal regulators, the Centers for Medicare and Medicaid Services (CMS), other governmental agencies, legislators, payers, health advocacy groups, journalists, commentators, both plaintiff and defense lawyers, other physicians—as expected, mainly primary care physicians—and, most important, our patients and their families.

The CMS, insurers, payers, and business purchasers want value—to pay less for more and better care—as they struggle to define quality, but their motivations are colored by the nature of their business model and overriding financial considerations. Although they call for quality, and even broadly assert that it’s not primarily about the money, their jargon translates into: it is *mostly* about the money and the bottom line.

Health advocacy groups, many physicians, and patients stand more at the quality end of the value equation. There are health-related organizations and entrepreneurs that extract administrative data from billing information and then proceed to interpret outcomes without the ability to adjust for risk. It’s very difficult to obtain large-scale *clinical data that can be scientifically adjusted for risk* and would yield true information about outcomes and quality of care.

### The Power of Our Stories

What then is in play to increase reliable and credible information? We have the substantial resources of the ASA brought to bear to create the Lifeline to Modern Medicine campaign,<sup>4</sup> a fabulous resource for informing patients and others about what happens and what to expect with anesthesia. We also have substantial ASA informational campaigns in Michigan<sup>5</sup> and Iowa,<sup>6</sup> intending to address potential misinformation as Michigan considers an opt-out and Iowa considers opting back in. Within the CSA, we have a new public relations effort under development jointly by the Committee on Professional and Public Communication and the Division of Legislative and Practice Affairs, and we have the *Bulletin* and the website, including “Online First” blogs.<sup>7</sup>

So, this brings me—in a somewhat roundabout, but really poetic license, or even President's license, kind of way—to the power of storytelling, the anecdotal answer to garbage science.

It occurs to me that there is something more we can all do, and should do. Let's come together to tell stories that illuminate our unique accomplishments as physicians. We should construct a repository of stories. Now some might declare that anecdotes really should count for nothing. Well, they seem to me to be far more useful than administrative data, unadjusted for risk. Stories are the currency of human communication; they remind us of what happened to us or to those we know. And the human tendency is to *listen* to those stories. Stories move legislators and the public to consider new information, and potentially to change their opinions in matters that are important to them. Positive stories should not diminish others and what they do, but they can clearly demonstrate the outstanding medical care that is in jeopardy if society marginalizes us and fails to understand anesthesiologists' invaluable contributions to patient safety.

### My Own Story

Everyone loves a good story, and learns from it. I'll be the first to tell one, but *all of you need to write your own stories*, and submit them to the CSA (email to [sjackson@csahq.org](mailto:sjackson@csahq.org)). Selected informative stories will be published in the *Bulletin*, and authors will be rewarded with a year's free membership to the CSA. Now that's something to "write home" about!

So here is a story that shows what can happen in a busy practice when care is fragmented, and how the vigilance of one anesthesiologist can change the outcome for the better.

A patient presents for an elective exploratory laparotomy for recurrent small bowel obstruction (SBO). Over time, she has become less able to eat, eventually needing total parenteral nutrition. She originally had been scheduled for this surgery months earlier, but the surgeon was away on maternity leave. In the interim, the patient developed another SBO, and during that hospitalization was found to have a deep venous thrombosis (DVT) in her legs. She was treated with warfarin and discharged to continue her therapy. However, because of the upcoming surgery, her primary care physician incorrectly advised her to stop taking her anticoagulant.

Upon returning from maternity leave, the surgeon first re-encountered the patient (who was well known to her) on the morning of surgery. The surgeon was unaware of the interim DVT. The anesthesiologist had evaluated the patient, and all seemed in order (phone call the night before, review of the electronic record remotely, appropriate physical examination just before the

surgery). However, the anesthesiologist also uncovered in the patient's medication list a notation about previous warfarin therapy, and realized that a well-documented DVT had been inadequately treated. Discussion with the surgeon led to appropriate cancellation of the surgery. The anesthesiologist had recognized the medical issue and was able to halt the momentum to proceed. Elective abdominal surgery in the setting of a known and undertreated DVT would have exposed the patient to a substantial risk of clot propagation and pulmonary embolus in the perioperative period.

This story is illustrative of an anesthesiologist preventing probable perioperative morbidity and/or mortality, a value added that would not appear in any administrative data, nor would be captured in any kind of quality metric in current use. The patient was "protected" by a physician advocating for that individual patient and causing all involved to pause while the patient's best interests were being addressed.

This watchdog activity and patient advocacy by anesthesiologists happens all the time. You tell your own story. Let's have at it. We'll all be listening.

## References

<sup>1</sup><http://www.ama-assn.org/resources/doc/arc/tiasurvey.pdf>

<sup>2</sup>Glance LG, Neuman M, Martinez EA, Pauker KY, Dutton RP. "Performance measurement at a 'tipping point.'" *Anesth Analg.* 112: April (4). 958-956. 2011 <http://www.aqihq.org/TippingPoint.pdf>

<sup>3</sup>ASA Members Only link: <http://www.asahq.org/For-Members/Advocacy/Washington-Alerts/ASA-Seeks-to-Educate-FTC-on-the-Invaluable-Role-of-Anesthesiologists-in-Treating-Chronic-Pain.aspx>

<sup>4</sup><http://www.lifelinetomodernmedicine.com/>

<sup>5</sup><http://www.asahq.org/Home/For%20the%20Public%20and%20Media/Press%20Room/ASA%20News/MI%20Public%20Education%20Campaign.aspx>

<sup>6</sup><https://docs.google.com/viewer?a=v&pid=gmail&attid=0.1&thid=130c3b64a36cad91&mt=application/vnd.openxmlformats-officedocument.wordprocessingml.document&url=https://mail.google.com/mail/?ui%3D2%26ik%3De4cb3902fb%26view%3Datt%26th%3D130c3b64a36cad91%26attid%3D0.1%26disp%3Dsafe%26zw&sig=AHIEtbSfQ4O04H0Cj0NbLknmSEBzdm7FLg> (*Editor's note: to access this document, you need to have an account with Google.*)

<sup>7</sup><http://members.csahq.org/blog>