

The Dumb-pipe Anesthesiologists

By *Mona Kotecha, M.D.*



Comcast and AT&T executives stay up late at night worrying about becoming “dumb pipe” purveyors, meaning that all they do is transfer bytes of data back and forth. They don’t add any value to the flow. They’re forgettable, interchangeable, and easily replaced. Now, in my opinion, anesthesiologists are in danger of becoming the “dumb pipe” specialty of the medical profession. It’s no exaggeration: When I entered residency in 2005, I never would have thought that my specialty would be viewed as merely enabling the flow of patients from the preoperative area to the recovery room with as little noise and as few adverse incidents as possible. Unfortunately, staunchly clutching the outdated notion that the most effective anesthesiologist—or anesthetic—is the entirely forgettable one has contributed to the challenges our profession faces. Our life’s work has gone unnoticed for too long. We should strive to become as noticeable and unforgettable as possible: noticed by hospitals, colleagues, patients and the public, not only for our professionalism and leadership in the operating room, but even more so for the ownership we take of the patient’s entire perioperative experience and for our expertise in perioperative clinical medicine.

The profession of anesthesiology is at a crossroads. Most of us have felt anxious at the threat of “invaders” on our scope of practice and wondered why no one seems to “get” what we do. Most troubling are the views that anesthesiologists simply sign others’ records, are replaceable by non-physicians, or do little but read the newspaper in the operating room suite. But these incorrect and misinformed perceptions result directly from our failure to engage in meaningful and effective advocacy on our own behalf. Reactively defending our profession is not enough: we must proactively promote and reinvent it. We should continue to champion patient safety, but this is inadequate to sustain our profession in the current socioeconomic and political milieu. We must participate in the entire patient experience of wellness around surgery and view induction and emergence as but two pieces of this experience. And it is time to demonstrate to the public and our colleagues that physician-led anesthesia care is essential to both patient well-being and safety.

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First, we should take ownership of the entire perioperative experience. Preoperative planning for any surgical patient should begin with the immediate engagement of an anesthesiologist. Not every patient needs to visit her primary care doctor, see a cardiologist, or have any preoperative testing done at all. It's high time that we fully coordinate the decision of who needs what before surgery. This means insisting on reimbursement for a preoperative clinic visit as we accept full responsibility for the preoperative medical workup, personally deciding upon sub-specialty referrals, and vigorously interfacing with the patient's other health care providers. Successfully leading this endeavor will require us to fine-tune and implement evidence-based protocols for perioperative care. After surgery, we should claim increased responsibility for the patient's postoperative experience by providing safe and effective pain management, and remaining involved in the patient's care beyond immediate discharge from the recovery room. We could continue to consult on inpatients—as do other consultants—for continuity of care. Most surgical patients are not ICU patients, but I argue that they would benefit as deeply as the critically ill from our expertise.

Second, we should strive to become more visible and accessible to the patient and the family. At every opportunity we should connect with our patients and their families before and beyond the day of surgery. For instance, I imagine a world where a newly pregnant patient selects her anesthesia care group with the same care and knowledge with which she chooses her obstetric group. She deserves the right to learn how anesthesia can influence her birthing experience, and she deserves a choice in who provides this important facet of her care. Prenatal classes, given by anesthesiologists for expectant couples, are a good example of this proactivity and a benefit to all concerned when confronted with the throes of labor or an obstetric emergency.

Both the preanesthetic informed consent discussion and the postoperative visit serve as distinct opportunities for more visibility and continuity: They are venues to educate families and caregivers about our role in their loved ones' care as well as for us to learn from our patients' experiences. Indeed, each patient deserves improved access to an anesthesiologist throughout the entire experience of surgery. With respect to continuity of care, we also must strive to minimize unnecessary patient care hand-offs, for nothing discredits our profession more than a revolving door of anesthesia providers.

Third, we personally should market our brand of services directly to hospitals and patients. Orthopedic surgeons attract patients with their cutting-edge and evidence-based interventions and novel surgical techniques. We can attract patients and surgeons with our sub-specialty expertise in the fields of regional, pediatric, obstetric, pain and cardiothoracic anesthesiology. We

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can also expand into other arenas including hospice and palliative care. Patients have become more sophisticated and knowledgeable, scoping out their interventions and providers on the Internet. If we expand access to information about our expertise, then eventually they will demand it. Shouldn't an orthopedic patient have the opportunity to pick an anesthesia care team that has adopted evidence-based pain management protocols or one that uses home nerve catheter infusions? Shouldn't parents have full information about the expertise of their newborn's anesthesiologist? Needless to say, this advancement of subspecialty expertise requires a true commitment to research, education and innovation, as they constitute the building blocks for re-branding our profession.

Fourth, nurse anesthetists' unyielding pursuit of independent practice poses a serious challenge to our specialty's ethical goal to provide safe anesthesia care for every patient. In addition to opposing state opt-outs of nurse anesthetist supervision, which I do not believe represents an actual turf battle, our objective should be to redefine and expand the culture and breadth of our specialty. This is, in fact, what will be most critical to the future of anesthesiology. Then we also must educate the public about the key and valued role that anesthesiologists provide for the health care of the citizens of this country. As a workforce, anesthesiologists will not be able to provide solo care to every patient in this country, yet we should continue to stand firmly behind our goal of having an anesthesiologist involved in each patient's care. Indeed, we confidently can support the validity of the statement that anesthesiologists have been—and will continue to be—the sole source and wellspring of the scientific advances in anesthesia, and as such, anesthesiologists are indisputably integral to the “lifeline of modern medicine.”

Finally—and I believe most crucially—we must fully leverage the value of our human capital by nurturing the genesis of a broad set of voices within our ranks. Fostering diversity in our profession is more than paying lip service to a politically correct cliché; it is essential to our success in modern medicine and a long-term, valuable investment for the future. Without a healthy debate among those who are drawn to anesthesiology from different backgrounds and experiences, including those who present dissenting viewpoints, we will not develop innovative solutions to the challenges facing our profession. Indeed, homogeneity of leadership is a pervasive barrier to innovation. I believe that we should welcome those with alternative career tracks, and not attempt to dissuade them from entering anesthesiology. We need to promote our field as an equal opportunity one and create inclusive and flexible work environments. Then we shall succeed in recruiting and retaining the most gifted and creative medical students and young physicians. The talent is out there; let's recruit it, nurture it, and retain it.

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Fighting scope-of-practice laws and lobbying government legislators and regulators for higher reimbursements and recognition are only a few of the useful steps that must be integral to a fundamental reinvention of our field. The advancement of anesthesiology requires each one of us—in each interface with administrators, colleagues and patients—to promote our specialty, expand our services, and build a brand and culture of medical care that is irreplaceable, and above all, benefits our patients. The opportunity for the promotion of physician-led anesthesia services exists at every patient and family interaction, departmental personnel and staffing decision, and hospital administration—medical staff interaction. Unless we engage in these goals every single day, we will continue to walk down an ominous path toward becoming a commodity.

Customers of broadband Internet providers take notice of Google, Facebook and Netflix—but they ignore the pipe that delivers the experience to them. Without rethinking the fundamentals of our profession, we will be perceived as the latest “dumb pipes,” no more than affable automatons who enable the flow of cases through the operating room with little fuss or muss. In reality, we have the capacity and opportunity to be hospital managers, advocates for equal opportunity, perioperative team leaders, and sub-specialists who ultimately enhance the safety and improve the well-being of our patients. Do we have the will and courage to make it happen?

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