Anesthesia and Perioperative Medicine

A Department of Anesthesiology Changes Its Name

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ON August 11, 1995, the board of trustees of the Medical University of South Carolina approved changing the name of the Department of Anesthesiology to the Department of Anesthesia and Perioperative Medicine. The impetus to include perioperative medicine in our name came from five fronts. First, there were the proposals of Greene and Saidman in their respective 31st and 33rd Rovenstine lectures at the 1992 and 1994 annual meetings of the American Society of Anesthesiologists (ASA) that a name change for the specialty was in order. Greene believed that anesthesia had moved from a defining term for the profession to a confining one. To make the point that many of us were involved in much more than anesthetic administration, he took the intellectual if not esoteric tack of creating a new word, metesthesia, which he defined as everything we do. Saidman, although recognizing the merit in Greene’s observation, suggested dropping all derivatives of the term “anaesthesia.” He proposed perioperative medicine and pain management as a term that unambiguously described the full extent of our activities.

Second, there was the fear that external economic pressure would soon be exerted on us to “right-size” our department. By assuming greater responsibility for more aspects of the system that cares for the surgical patient, we become the right people to keep around to manage the delivery of perioperative care. In the current fee-for-service system, there is a financial disincentive to spend nonrevenue-generating time performing tasks outside the operating room that are essential to the delivery of quality anesthesia care and for which we are legally and ethically held accountable. When global or capitated fee systems become the norm, we no longer want our share to be based solely on anesthesia time and the performance of specific psychomotor tasks. We want to be reimbursed for our decisions on what should be done and for our management of the consequences of these decisions. Surgeons andinternists will be more than willing to accept our activities in this area when they realize (1) we are reducing their “at risk” costs, (2) they must see more patients in the operating room and clinic, and (3) they are no longer being reimbursed fee-for-service for reading electrocardiograms, providing consults, and managing patient-controlled analgesia. As Rosenthal stated, “With the many changes in health care delivery, the future survival of anesthesiology as a specialty may well depend on the acceptance that perioperative involvement, rather than sole intraoperative anesthesia practice, is the purview of the anesthesiologists.”

Third, there was the appreciation of the more subtle contributions of anesthesia to perioperative mortality and morbidity. When Yeager et al. compared epidural-general with epidural analgesia and general with parenteral analgesia, no statistically significant difference was observed in mortality rate or in the incidence of traditional anesthesia-related complications. However, when all complications, such as major infection, organ system failure, and reoperation, were included, the total incidence was significantly less in the epidural group. Thus, perioperative complications formerly considered purely medical or surgical were shown to have an anesthesia component. Subsequent studies have demonstrated that techniques we apply intraoperatively and the analgesia and care we are responsible for postoperatively significantly affect...
morbidity\textsuperscript{5,8-10} and that morbidity increases cost and length of stay.\textsuperscript{8,9,11} For example, events occurring on postprocedure days 1 and 2 are recognized as clinical indicators of an anesthesia care system in need of review and improvement.\textsuperscript{12}

Fourth, there was the success of recent interdepartmental collaborative efforts. We seriously considered the recommendations of the Joint Commission on Accreditation of Healthcare Organizations that our department be actively involved in the review and implementation of policy and procedures referring to conscious and deep sedation administered anywhere in the hospital or clinic. We developed subspecialty calls for pediatric, cardiac, obstetric, and transplant anesthesia and for intensive care and have designated specific anesthesiologists as liaisons between our department and the various surgical specialties. We worked closely with pulmonary medicine in the medicine intensive care unit; with trauma surgery in the emergency room and surgical intensive care unit; with cardiology in the treatment of patients with intractable angina and the provision of intraoperative transesophageal echocardiography; with pediatrics in the development of pain treatment protocols, introduction of laryngeal mask airways to the pediatric intensive care unit, provision of general anesthesia for pacemaker insertions, transesophageal echocardiography, and cardioversion procedures, and administration of deep sedation for bone marrow biopsies and cerebral spinal fluid aspirations and injections; with neurology for intraoperative neurophysiologic monitoring; with psychiatry for electroconvulsive therapy; with obstetrics in labor and delivery; with gastrointestinal medicine for the provision of general anesthesia for endoscopic retrograde cholangiopancreatography; and with radiology for magnetic resonance imaging and invasive radiologic procedures. We established productive joint research efforts with cardiology,\textsuperscript{13} cardiothoracic surgery,\textsuperscript{14-16} vascular surgery,\textsuperscript{17} pediatric dentistry,\textsuperscript{18} and psychiatry\textsuperscript{19} and are working closely with hospital administration to improve patient flow, change from a small anesthesia preoperative evaluation area to a hospital preadmission clinic, improve our inventory control, and reduce total patient operating room, recovery room, intensive care, and hospitalization time and costs. These efforts have not progressed as far as those described by Macario \textit{et al.}\textsuperscript{20} and critiqued by Orkin.\textsuperscript{21,22}

Fifth, there was an evaluation of our faculty effort distribution. Based on an average 52-h week of clinical time, including in-house call and excluding vacation time, the percentage of time spent in the operating room was 68% for faculty assigned full time to the operating room. These attendings were involved in clinical care activities outside the operating room for one-third of their time. An unresolved problem is how much more we can afford to do with the current salary structure and number of faculty. Each department member takes more call hours because of the subspecialty call system, and most of the nonoperating room activity is accomplished through longer daily time commitments. We have not hired additional staff specifically for these activities but may effectively be doing so when we recruit anesthesiologists to administer anesthesia in place of residents because of a reduction in the size of our residency. The hospital administration is helping to defray some of our salary burden on the promise that productivity in the area of perioperative medicine will reduce their costs and patient care charges. However, their pockets are not as deep as they once were.

Why change from anesthesiology to anesthesia? Anesthesiology is classically defined as that branch of medicine that studies anesthesia. An anesthesiologist originally was anyone who studied the anesthetic state and anesthetic agents. An anesthetist originally denoted the individual inducing the anesthetic state. Now anesthetists and anesthesiologists refer respectively to nurses who administer anesthesia and physicians who administer or supervise the administration of anesthesia. By changing from anesthesiology to anesthesia, we became inclusive of everyone involved in research and administration of anesthesia and intravenous sedation at our institution.

Although we agree with Saidman that perioperative medicine and pain management is the most ideal name, we were not prepared to eliminate anesthesia for several reasons. First, the word anesthesia carries an amount of tradition. Second, anesthesia is the hub from which the spokes of our interest in perioperative medicine, pain management, and critical care are derived. It is our area of acknowledged special expertise. Our training programs are monitored by an anesthesia residency review committee; we are certified by the American Board of Anesthesiology; we are members of the ASA and other societies with anesthesia in their names; and we publish primarily in journals with anesthesia in their titles. Third, the majority of our time is spent in the operating room, and most of our revenue is derived from a fee-for-service anesthesia practice. Fourth, we have yet to define what it means to be a
perioperative physician (see below). Fifth, once a consensus definition of perioperative medicine is reached, we will need to market the concept outside the profession that anesthesia is only part of what we do as perioperative physicians. Sixth, dropping anesthesia completely is more likely to arouse the suspicions of our medical colleagues that we are invading their turf when we are only filling a current vacuum in informatics, management, outcome studies, cost-effectiveness and efficiency efforts, and patient relations.

We also elected not to add pain management or critical care to our department’s name. Neither is always perioperative, but we participate in these activities. Adding either or both would make our name unwieldy. We have achieved recognition of our roles in acute, chronic, and cancer pain management and in critical care units. The Accreditation Council for Graduate Medical Education accredits anesthesia critical care medicine programs and anesthesia pain management programs, and the American Board of Anesthesiology grants certificates for special qualifications in critical care medicine and for added qualifications in pain management. However, recognition does not mean market share. Although chronic pain management services are enjoying free-standing clinic status with reasonable recognition, referrals, and reimbursement, they may evolve into regional multidisciplinary centers in the future when we might not be the manager unless we make concerted effort to maintain our current leadership role. It is difficult to regain a presence once it is relinquished. This fate has befallen many critical care units, but we still have a strong core of programs.23

The process we followed to secure the name change involved four major steps. First, we did not change our name and immediately demand additional responsibility. Rather we assumed additional responsibility and after several years asked to have our name changed to reflect these efforts. Second, we discussed the ramifications of a name change at the departmental level, reached a consensus, voted unanimously in favor of the name change, and documented this in the minutes of our meeting. This was important because part of the motivation was to influence our own behavior. Third, the name change was discussed with the respective chairs of the departments of surgery and medicine and with the dean. The chair of medicine also consulted with the division heads of cardiology and pulmonary medicine, with whom we have had very constructive and productive collaborative relationships over the last 3 yr. With their support, a letter was sent to the dean formally requesting the name change. The dean relayed the request to the provost and vice president for academic affairs with an accompanying letter supporting us. The provost presented it to the board of trustees, who discussed the issue extensively in subcommittee. "During the preliminary meeting of the Subcommittee on Education, Faculty, and Student Affairs, there was a thorough discussion of this topic. Questions were raised and addressed about whether the name change implied any expansion of responsibilities in patient care or confusion of roles with other disciplines. Ultimately, the Subcommittee concluded that the proposed new name better reflected the services currently provided by the department and unanimously endorsed the change."§

During this discussion, we assumed that the definition of the term perioperative medicine is so intuitively obvious that it requires no definition. An analysis of what it means in practice today in medical centers across the country would reveal a range in definitions on a patient-care level (from operating room anesthesia alone to total care of the surgical patient24), on a managerial level (from no input into the operating room schedule to complete control of scheduling), and on a research and informatics level (from no activity to sophisticated program projects). We have described the range of the activities of one department, which we know is not unique. At many institutions such as ours, perioperative activity within the department 3 yr ago was less than it is now. Thus, not only is local interpretation of the definition not uniform from medical center to medical center, it is evolving within each institution. Whether special training will be required will depend on the responsibilities assumed. Beattie envisions a revision of the residency program, including the clinical base year, to reflect an ambitious, didactic research and clinical program in perioperative medicine. || Physical diagnosis skills may need to be honed, personnel and business management skills developed, and outcome-based health services research performed. An organized effort to define perioperative medicine from the perspective of an anesthesiologist needs to emerge from the academic medical centers and from the ASA.

In summary, we propose a series of time-dependent departmental name changes from anesthesia to

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§ Greenburg R: Personal communication. 1995.

|| Beattie C: Personal communication. 1995.

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anesthesia and perioperative medicine to perioperative medicine and pain management. The rate of change will depend on when we can achieve a consensus definition for perioperative medicine and how successful we are in our efforts to convince those outside the profession of the validity of this project. Our name change locally is an institutional acknowledgement that the members of our department have taken a major step toward recognition as perioperative physicians.

References

22. Orkin FK: Practice standards: The Midas touch or the emperor's new clothes (editorial)? Anesthesiology 1989; 70:567–71

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