Anesthesiology
1997; 87:1588

Why Must the Practice of Anesthesiology Change? Economics is Not the Only Thing!

To the Editor:—Articles and editorials addressing the economics of anesthesia practice are rarely published in ANESTHESIOLOGY. That makes the recent publication of four articles and two editorials in the May issue all the more unusual, and I applaud the Editorial Board for recognizing the realities forced on all physicians, whether by market forces or by managed care-inspired cost restraints.[1-6] As Shapiro points out in his editorial, Fisher and Macario place the articles in a perspective that challenges all anesthesiologists to examine the economics of their practice.

However, Shapiro's editorial also expresses opinions not acceptable to many anesthesiologists, and his interpretations of history is at variance with the facts as I know them. Although I agree with the basic tenet of his message that perioperative medicine is the future of our specialty, that does not mean that the direct administration of anesthesia by physicians is history! Further, I do not concur with his statement that we are perceived, "as far too expensive for the limited services (*i.e.*, direct physician-administered anesthesia) we render."

Shapiro's suggestion that the Anesthesia Care Team (ACT) developed in response to this perception and the replacement of "explosive and poorly controllable anesthetic agents in conjunction with limited monitoring capabilities" by better, safer agents and more sophisticated monitoring in the mid-1960s is not true. The ACT functioned much earlier in response to a shortage of trained anesthesiologists and permitted their knowledge and skills to be available to more patients by means of physician extenders.

Has the introduction of better agents and monitoring decreased the need for direct administration of anesthesia by physicians? Absolutely not! Rather, it has only permitted us to anesthetize sicker patients for more complex procedures safely. Radical cancer surgery, aggressive trauma surgery, and multiple organ transplants are examples of procedures that developed after the administration of anesthesia became safer. Direct administration of anesthesia to patients may have been the anesthesiologist's sole focus at one time. Today we have exported and greatly expanded our talents to acute and chronic pain management and to critical care. Preoperative preparation (as opposed to evaluation), efficient operating room (OR) management, and satisfaction of patient, surgeon, and hospital administrator are all areas that demand and deserve our attention as perioperative physicians.[7] The "added value" in these new areas is just that—added—and does not mean the demise of direct administration of anesthesia by physicians is history. To suggest otherwise does a disservice to the many anesthesiologists who practice in this manner and, frankly, denigrates their services.

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References

1. Fisher DM, Macario AM: Economics of anesthesia care. ANESTHESIOLOGY 1997; 86:1018-9
2. Shapiro BA: Why must the practice of anesthesiology change? It's Economics, Doctor! ANESTHESIOLOGY 1997; 86:1020-2
3. Lubarsky DA, Glass PSA, Ginsberg B, et al: The successful implementation of pharmaceutical practice guidelines: Analysis of associated outcomes and cost savings. ANESTHESIOLOGY 1997; 86:1145-60
4. Lubarsky DA, Sanderson IC, Gibert WC, et al: Using an information management system as a cost containment tool: Description and validation. ANESTHESIOLOGY 1997; 86:1160-9
5. Watcha MF, White PF: Economics of anesthetic practice. ANESTHESIOLOGY 1997; 86:1170-96
6. Sperry RJ: Principles of economic analysis. ANESTHESIOLOGY 1997; 86:1197-205
7. Longnecker DE: Planning the future Of Anesthesiology. ANESTHESIOLOGY 1996; 84:495-7

(Accepted for publication July 29, 1997.)

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In Reply:—I have great respect for the leadership Dr. Ellison has contributed to our specialty. We have all benefited from his knowledge and experience. I have no doubt that his reluctance to accept the message in my editorial[1] reflects the opinion of many anesthesiologists. I welcome the criticism and hope the result will be a continued constructive debate.

Although Dr. Ellison disagrees with my historical interpretation of the development of the Anesthesia Care Team (ACT) concept, we do agree that the ACT concept permitted the knowledge and skills of the anesthesiologist to be available to more patients by means of physician extenders. Evidently my suggestion that the ACT concept added value to our services is inferred by Dr. Ellison to mean that I advocate "that the direct administration of anesthesia by physicians is history!" I neither stated, nor suggested, such a position in my