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(Accepted for publication April 13, 2010.)

The Private Practicing Anesthesiologist and the Four-legged Stool

To the Editor:

As always, I read this month's publication of ANESTHESIOLOGY with my usual enthusiasm and interest. The inclusion of a dedicated section devoted to education is a welcomed addition. As Dr. Schwartz states in his editorial, education is one of anesthesia's "four key activities" with patient care, practice administration, and research the three other legs needed to build a sturdy "four-legged stool" for anesthesiology to use.[1]

Unfortunately, these four legs are missing an important joint, the private practicing anesthesiologist. Private practitioners attend to more patients and have more clinical practice administration experience than most other anesthesiologists. Yet, despite comprising a majority of anesthesiologists, this group has been essentially precluded from research because of several situations. They encounter a lack of support from the hospitals in which they practice; they must understand and comply with onerous, yet important, requirements of Investigational Review Boards; they are not provided resources needed for research such as statistical or secretarial assistance; and they are faced with an unacknowledged, yet possibly occurring, discouragement from anesthesia journals by reviewers and editors. (How many articles in journals of anesthesiology are written by anesthesiologists in private practice?)

One example of the exclusion of private practitioners from the "four-legged stool" is The Foundation for Anesthesia Education and Research and its Pediatric Research Council. In order to receive funding for any of their four grant divisions, academic appointments or academic affiliations are required. In addition, a letter sent by the Pediatric Research Council of The Foundation for Anesthesia Education and Research "seeking research funding applications . . ." is only addressed to the Society for Academic Chairs and Academic Anesthesia Program Directors.* There are no invitations for nonacademic private practicing researchers.

As recognized, it is time for education to be a dedicated section of Anesthesiology, but it is also time for the encouragement and support of private practicing anesthesiologists to be more a part of the four key activities encompassing anesthesia. If anesthesia is to have a stable and sturdy stool to stand on, it must be big enough for all anesthesiologists.

Steve Serlin, M.D., Valley Anesthesiology Consultants, Phoenix, Arizona. spserlin@cox.net

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1. Schwartz AJ: Education: An essential leg for anesthesiology's four-legged stool! ANESTHESIOLOGY 2010; 112:3–5

(Accepted for publication April 20, 2010.)

In Reply:

A gem sparkles because it is multifaceted. Anesthesiology is a gem as it is truly multifaceted, that is, our specialty includes individuals who are facile clinicians, inspiring educators, inquisitive scientists, and practice management experts. Today's reality and complexities of patient care, education, research, and administration make it virtually impossible to be all things that encompass our specialty. The fact that there are many anesthesiologists with great facility in each of these areas tells us to select our strengths and passions and sit on the anesthesiology four-legged stool on equitable and firm footing.[1]

Dr. Serlin expresses disappointment about what he describes as being precluded from sitting at the table on a stable stool. He is, however, a rightful and important participant. He is a member of a group of private clinician practitioners. Their contribution to the strength and stability of the anesthesiology stool is quite reassuring as they provide anesthesia patient care and facilitate operating room and hospital clinical practice. Dr. Serlin laments what he perceives as research activity he would like private practitioners to be able to do were it not for lack of support from hospitals, the burdens of Investigational Review Board requirements, and discouragement from anesthesia journals. He calls on our specialty to support private practicing anesthesiologists to be more a part of the research component of our four-legged stool.

I agree with Dr. Serlin's assertion, ". . . it is [always] time for the encouragement and support of private practicing anesthesiologists to be a part of the four key activities encompassing anesthesia." Anesthesiology is a specialty with options. Anesthesiologists are lucky to have choices for how they devote their professional time. Private practitioners are

* Foundation for Anesthesia Education and Research, Pediatric Research Council letter seeking research funding applications. May 22, 2006. http://www.pedsanesthesia.org/faer_rfp.iphtml. Accessed April 27, 2010.

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facile clinicians and practice management experts. They are also inspiring educators, able to teach patients and their families, physician peers, and the vast array of paraprofessional hospital staff about anesthesiology. As individuals who champion anesthesia patient care, clinician practitioners are astute observers of much that we do not understand. Dr. Serlin, sit on the anesthesiology stool by asking the questions about what we do not understand about anesthesiology and make the choice to investigate the answers by reallocating your time and resources.

Alan Jay Schwartz, M.D., M.S.Ed., Children's Hospital of Philadelphia, Philadelphia, Pennsylvania. schwartza@email.chop.edu

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(Accepted for publication April 20, 2010.)

Procedure-specific Guidelines

To the Editor:

A recent article on how to improve postoperative pain management states that an epidural is "clearly not appropriate for open hysterectomy."[1] This statement seemed unusual to us, especially considering that one of the authors has previously published articles promoting the benefits of neuraxial block for hysterectomy.[2–7] On the basis of some of these prior studies, a low thoracic epidural together with a propofol infusion seems appropriate for the patient who is anxious about vomiting or those who cannot tolerate "pain medicines." Table 1 in this recent article[1] recommends local anesthetic wound infusion for this procedure, but that fails to address opioid use during the procedure.

Hysterectomy is not a single entity. Some hysterectomies can entail lymph node dissections that involve midline incisions above the umbilicus, while others involve very small Pfannenstiel incisions. Likewise, epidural anesthesia is not a single entity. The catheter can be placed in the lumbar or thoracic interspaces, and the drugs and drug combinations are numerous. Indeed, the cited Web site* quotes several unconventional techniques (epidural clonidine, ketamine, neostigmine, lumbar catheters) to support the claim that epidural anesthesia "is not recommended for hysterectomy due to low benefit:risk ratio." The issue of how to administer the anesthetic should not be decided by referring to a table or a Web site that refers to unusual techniques and then lumping a vast spectrum of operations under a single category designated "hysterectomy."

The article also states that epidural anesthesia is "clearly not appropriate for nephrectomy."[1] There is no reference for this statement, and the cited Web site has no information on nephrectomy. One might think that some modalities of anesthetic management, such as epidural anesthesia, might be "transferable" into "nephrectomy" from other procedures, similar to what is suggested for the use of gabapentanoids.

We do not "give an anesthetic for a nephrectomy." Rather we "give an anesthetic to *a patient* who is having a nephrectomy." This patient almost always has unique fears and apprehensions that often relate to pain on emergence and/or nausea and vomiting.[8–11] If, for example, a patient states that they are intolerant of "pain medicines, like Vicodin® or morphine" because of unpleasant side effects, such as nausea and vomiting or mental status changes, then it would seem appropriate to suggest that the anesthetic could be conducted without these drugs by using an epidural and an infusion of a drug that has antiemetic properties. Another patient scheduled for nephrectomy might fear the experience of severe pain upon awakening from anesthesia. An epidural titrated to cover the surgical wound site[12] would essentially guarantee a pain-free emergence that could be accomplished without the (use of and) side effects of opioids. Of course, the patient might also not want to have "a needle in their back"; ideally, all of these issues relating to anesthesia would be thoroughly discussed with the patient during the preoperative interview.

The idea of procedure-based pain therapy (PROSPECT) is reasonable, but the procedure itself may not always be the main factor in deciding how to administer the anesthetic or how to provide for postoperative pain therapy. Other important factors are the skills of the anesthesia provider, the concerns of the patient, and the experience and cooperation of nursing and surgical colleagues.

Noah Stites-Hallett, M.D., Merlin D. Larson, M.D.† †University of California, San Francisco, San Francisco, California. larsonm@anesthesia.ucsf.edu

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