

MIND TO MIND

*Creative writing that explores the abstract side
of our profession and our lives*

Carol Wiley Cassella, M.D., Editor

Value-based Healthcare

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Dedicated to my parents, Simon and Dina, for their lifetime of self-sacrifice

An elderly man with advanced esophageal cancer arrives in the operating room: his feeding tube has migrated out of his jejunum, spilling debris and bacteria into a previously sterile abdominal cavity. The OR clock fluoresces “2 AM.” With the patient’s immune system ringing alarm bells, his body has mobilized for biological warfare. His pulse races ... breathing hurries ... temperature climbs. A hint to the severity of his illness, his blood pressure sags, necessitating a vasopressive infusion. While I compress the patient’s cricoid cartilage against his alimentary canal, the senior anesthesiology resident injects conventional weight-based, rapid-sequence-induction doses of an opioid, a hypnotic, and a muscle relaxant. Seconds later, the booming waves of his arterial line tracing flatten out to tiny ripples. A surgeon palpating the patient’s foot calls out, “He has no pulse.” Meanwhile, the laryngoscopist—a new trainee in our department—announces that she cannot visualize the patient’s larynx.

What “value” does an anesthesiologist bring to this patient’s care in the emerging era of “value-based” healthcare and bundled reimbursement? Surgeons expect an anesthesiologist to continue appropriate medical management, safely render the patient unconscious, and maintain a quiet surgical field. But an anesthesiologist’s formal involvement ends once we deliver this man to the post-operative intensive care unit. Yet my curiosity tugs me back to his bedside each day. How will the ICU team continue to resuscitate this man and how will they later manage the many systemic sequelae of volume overload? As his body continues on the curve of convalescence, what will remain of his injured mind? And who will address superordinate questions about goals of care to maximize the quality of the man’s remaining life?

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Back in the operating room, we initiate chest compressions and saturate his cardiovascular system with exogenous adrenergic agonists. Our attending, unruffled, swiftly steps in and secures the patient's airway with an endotracheal tube. His favorable end-tidal carbon dioxide levels confirm the adequacy of our ongoing CPR.

I entered medical school not to deliver anesthesia, but to learn to heal the sick. In the operating room, my emotions ride the roller coaster of blood pressure and heart rate fluctuations. With my blue cap and mask removed, my restless nosiness tethers me to the bedside of the people I once anesthetized. The discreteness of *anesthesia* and *critical care* blurs into a continuum in the eyes of a human being stricken by disease. As anesthesiologist-intensivists, we can treat a septic man with end-stage cancer throughout a lengthy hospitalization. Our skills translate outside of a hospital's walls as well, where we can manipulate human physiology in unnatural ways to resuscitate victims of natural disasters. Our practical experience rescuing the human body from stygian depths guides our helping hands in hospital hallways, floor beds, and MRI scanners. Through these extra-operative efforts, we pour cement into the gaps of a healthcare system fragmented by superspecialization. And through our errors, we sometimes inflict calamitous injury that forever sustains our humility.

In the operating room, compressions continue. A pulse returns. A life resumes.