Managing Your Practice in a Time of Great Change

The Current and Future State of Anesthesiology: Good, Bad, or Indifferent?

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The answer to the question in the title is rhetorical, as it will be in the eye of the beholder. Each ASA member has his or her own unique practice situation, personal disposition, and life priorities, so the realities one perceives as "bad" might be "good" or "indifferent" for another. Still, it is useful to examine some of the widespread, pressing challenges facing our specialty – the exercise reveals sobering truths that reach across all practice settings.

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Financial challenges: 'Blood from a stone?'

The post-pandemic job market is burgeoning. For anesthesiologists and for CRNAs/CAAs, salaries in many areas have increased dramatically over the past 12-24 months. Meanwhile, practices incur significant costs unrelated to compensation: malpractice coverage, employee benefits, and administrative infrastructure (nonclinical staff for billing and human resources). Groups that operate "bare bones," without a significant administrative arm, will typically retain a billing/management company, which brings its own cost (typically a 4%-6% fee as a portion of revenue).

It is vital to minimize staff turnover, which is hugely negative financially and logistically, so anesthesia professionals should be kept content. This means paying competitive salaries, offering attractive benefits, and allowing for a reasonable amount of time off.

Of course, "all this costs money!" Actually, quite a bit of it, considering the median salaries for anesthesiologists and CRNAs/CAAs right now. Who is going to foot the bill? Hospitals have notoriously razor-thin margins, and most are not flush with capital. Health systems are rarely enthusiastic when bestowing scarce dollars on a medical practice that does not directly provide referrals. Who has not heard the refrain, or a variation thereof, "You don't bring patients into the hospital, the surgeons do." Many ASA members have experienced first-hand the difficulties of negotiating a contract with a C-suite when the proposed agreement includes a request for financial support.

What if we just abandon hospital support/stipends? Let's run our practices efficiently and prudently and count on billing/accounts receivable to keep us in the black! This might work if our coverage is limited to a cosmetic surgical center in an upscale community, where there is no off-hours coverage and patients pay up front. Note the intentional irony – not many of us practice in such a favorable environment. Most groups, whether academic or private, are asked to provide night and weekend call coverage, for general cases and often for specialized service lines like cardiac, obstetric, and trauma as well. Call usually includes a pre- and post-call day for the covering physician, leading in turn to one (or more) salary lines/FTEs allocated to an extended clinical time period that generates minimal (or no) revenue.

Let's put the burden of call coverage aside and focus on the copious reimbursements flowing into our coffers from doing scheduled daytime cases (again, intentional irony). As the U.S. population continues to age, and simultaneously the proportion of people in the active workforce (i.e., the privately insured) slowly declines, most practices find themselves with a generous proportion of governmental payers (Medicare/Medicaid) in their mix. The Medicare "33% problem" drives home the fact that public payer rates are NOT sufficient to sustain a practice anywhere in the country. Private insurers are the better option, but these companies, while "richer" than hospitals, are nevertheless equally reluctant to part with money. Further, conversion rates vary widely across the U.S., and the lower end of them is not necessarily a huge improvement over Medicare/Medicaid. Only those anesthesia practices at the higher end (who are getting hundreds of dollars per unit) find themselves with a degree of financial breathing room.

To sum up, it costs a lot to run an anesthesiology practice, and it is unclear exactly where the capital in question is going to come from in 2024 and beyond. Purely clinically based billing, obtained from aggregate base + time units, will not cut it.

Independent CRNA practice, medical title (mis)appropriation

These topics are familiar to us all, and not in a positive sense. Here in Florida, for the past 25 years running, advanced-practice RN advocacy and lobbying groups have introduced legislation proposing independent practice for APRNs/CRNAs. Each year, the Florida Society of Anesthesiologists expends time, money, and substantial effort to play "defense" on these bills. Fortunately, we have been successful each time around. A more recent but equally troubling nursing advocacy effort is the push to add terms to nurses' professional titles that are traditionally reserved for physicians, i.e., "nurse anesthesiologist" for CRNAs, and "doctor" for anyone who has obtained a Doctor of Nursing Practice degree.

The practice of medicine and the practice of nursing are discrete disciplines, with distinct training pathways and separate clinical roles. Traditionally, the two have been complementary, and professionals of the two disparate backgrounds have been able to work together harmoniously. Recently, however, such roles and relationships are threatened. Some believe that enough misleading rhetoric, the use of a particular title, and/or spending an arbitrary amount of time in a particular educational setting can magically transform people from one type of health care professional to another. In other words, if someone with a nursing background jumps through the proscribed hoops (*not* including attending medical school), he or she can then claim the responsibilities and titles that accompany physicians and have historically defined the practice of medicine.

These unfortunate developments pit anesthesiologists (and other physicians) as adversaries against nurses, who are supposed to be our indispensable partners in providing safe, effective, and compassionate care. Dismantling of the physician-led care team is, of course, a great concern for anesthesiologists who wish to maintain their clinical relevance and their livelihoods. However, the primary objection to autonomous nurse practice is not physicians' greed, pride, arrogance, nor anything of a base nature. Rather, it is the desire to preserve perioperative patient safety and autonomy. Put simply, each procedural patient is entitled to the care of an anesthesiologist, just as they rightly expect to be treated by an attending surgeon, GI physician, cardiologist, or other proceduralist. A patient would likely accept a PA or ARNP assisting a surgeon

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Sometimes you need help from an outside source. There are several great consulting firms, but how do you choose? How do they create and sustain change at the OR governance level? Given the expense, the decision to engage an outside consultant is often a hospital board-level decision, so it's important to have support of administration and your key perioperative leaders to go this route.

Create a vision for change

Once you have developed your team and garnered the necessary resources, it's time to define your mission, image of success, and value proposition. Priority number-one must be a culture of transparency. This is often a "trust fall" scenario between surgeons, administrators, nurses, techs, and staff, who all have varied understanding and perceived barriers to mission success. Many of you may be familiar with Franklin Covey's "Leading at the Speed of Trust" (The Speed of Trust: The One Thing That Changes Everything. 2008). High-trust organizations routinely see increased productivity and decreased cost. Decreasing trust gaps and increasing personal credibility lead to the ability to change. Where distrust and frustration are unchecked, you cannot lead, and you most certainly cannot get anyone to drink what you are selling!

Communicate the vision

Initially, gather the stakeholders and communicate the vision, but understand that the vision and the ultimate path to it must also be presented in a clear and concise fashion to all members of the perioperative team. During the initial communication of the vision with the stakeholders and/or governance team, be sure to provide the background for the change, need for the change, any anticipated barriers, and the plan for success. Keep the messaging simple and direct. Communicate with honesty, encourage questions, be open to feedback, and embrace challenges. Deliver the message through multiple avenues to ensure every member of the team receives the message.

Empower action

In order to effectively empower action and implement change, it is essential to remove as many barriers as possible. While empowering action, maintaining personal credibility and requiring it of each member of the perioperative team is a fundamental element in fostering a culture of trust and authenticity during the ever-evolving process of change. Barriers may be structural, systems issues, managerial, or related to skill sets. Removing or decreasing barriers can also lessen frustration, making the process of enabling action more streamlined and less arduous.

Create quick wins

Creating quick wins motivates stakeholders and demonstrates that the efforts are worthwhile. These wins offer encouragement and a "pat on the back" for those involved. Short-term successes can make it more difficult to block future changes, revert back to "the old ways," and provide evidence that the transformation is on track and will likely be successful. Quick wins build momentum and engender further support for the change. Next, continue to drive the momentum forward to build on the progress and achieve sustainable change!

Make it stick

Generational differences coupled with evolving employment models post-pandemic directly impact OR staffing and create challenges related to effective staffing and OR utilization. Effective governance is required to institute the change and "make it stick." In order to achieve this, the governance team must develop strategies to foster collaboration and create a culture of harmony among all members of the perioperative team, and this cannot be achieved without trust between parties. An imperative outcome of creating a harmonious culture and instituting change is prevention of physician burnout. By recognizing how differences in values can impact employee burnout, the governance team can ensure that once the change is instituted, it is sustainable. To create sustainable change, it is vital to understand and address topics such as flexibility in compensation

and scheduling as well as the differences in generational personalities, modes of communication, and clinical skills. An effective perioperative governance team should have open and honest dialogue, demonstrate a personal interest in the staff, present clear goals and concrete rewards, provide opportunities for growth and creativity, and offer feedback and recognition as warranted. Most importantly, leadership must ensure that changes become a part of the fabric of the organizational culture. Buy in from all members of the perioperative team is essential. As such, we must create the connection to the larger purpose and goals of the organization. ■

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in abdominal exposure but would not accept these same individuals performing a bowel anastomosis! The practice of nursing is NOT the practice of medicine, and patients in our ORs have the right to physician expertise on both sides of the drapes. This is what we would want for ourselves and our loved ones.

Attempts to confuse the public, present inaccurate/inappropriate terminology, and claim nurse-physician equivalency are not going away. The most concerning scenario is when RN interest groups interact with uninformed/naive health executives, governmental regulators, and elected officials and tout independent practice as the solution to (real or imagined) provider cost and access-to-care issues.

Self-devaluation, losing ourselves in negativity

There is not a high level of awareness and recognition among lay people about what anesthesiologists do. This fact was the impetus for ASA's campaign to rebrand us as "physician anesthesiologists." We function in a shadowy background role, meet our patients briefly on the day of a procedure, and often do our most important clinical work unnoticed, while patients are unconscious or sedated. Indeed, if we are barely noticed during the workday, most of us would consider that a resounding success. It may happen that unenlightened hospital systems and administrators may dismiss our specialty as a necessary evil – an underperforming loss-leader that exists only to facilitate proceduralist case flow. It is a fact that our specialty is mostly hospital-based, with no extended continuity of care, providing little to no source of patient referrals. In this context, assertions that we are clinically equivalent to advanced-practice nurses (and therefore superfluous and an unnecessary expense) constitute another blow to our profession's image and standing.

The negativity swirling around us can be insidious and demoralizing. For example, when a practice feels guilt or trepidation in negotiating financial support that is necessary and essential given the scope of coverage requested, it is an example of self-devaluation. Simply because we are a hospital-based specialty, must we in effect apologize for our very existence and "take the fall" for a suboptimal perioperative financial climate, over which we have little to no control? Other hospital-based disciplines exist, such as pathology, radiology, emergency medicine, and critical care. Like anesthesiology, not all these specialties necessarily *directly* make money for a hospital, but unlike anesthesiology, they are generally properly recognized/valued for providing essential services and for their *indirect* support of clinical and financial mission(s).

Consider also how anesthesiology is treated via hospital capital budgeting and resource allocation processes, in contrast with the surgical disciplines. It seems unlikely that a busy joint surgeon would be denied a particular set of implants (or instruments) that he/she deemed essential. Meanwhile, anesthesiology departments are often denied ready access to important medications such as intravenous acetaminophen and sugammadex. Similarly, requests for crucial, life-saving equipment such as videolaryngoscopes are not always granted. When we accept this double standard, we tacitly endorse a damaging external devaluation of our profession.

Regarding intrusive, unrealistic expectations from health systems and insurers, what happens when these entities pressure us to significantly change/alter our practices purely for the sake of what they perceive as appropriate cost-containment? If we agree, is this not a devaluation of ourselves? Put another way, what should be the proper response to the challenge, "You all are too expensive – you need to do X, Y, or Z to become cheaper"? Abandoning medical direction for medical supervision in procedural areas (e.g., unwillingly increasing staffing ratios above 1:4), delegating off-hours in-house obstetrical coverage to nurse anesthetists, and/or changing a group's structure from MD-only to care team model are all examples of misguided "cost-cutting" proposals that have been forced onto groups. Anesthesiologists by nature and training are excellent stewards of patient safety and of perioperative efficiency, and we should not allow others, who lack proper expertise and priorities, to dictate practice models or parameters to us based on incorrect operational/financial assumptions.

In closing, I thank Dr. Lilian Kanai for the opportunity to contribute to this important issue of the *Monitor*. I hope readers find this article thought-provoking and that it motivates all of us to work for a more positive, more secure future. ■