Ask the Expert

The View from the Other Side of the Drape

Zachary Deutch, MD, FASA John "Jack" Pirris, MD

All anesthesiologists realize that our relationships with surgical and procedural physicians can be strained, complicated, "love/hate," or all of the above simultaneously, especially in those clinical arenas that are high-stakes (e.g., cardiac, transplant, critical care) and which therefore tend to generate high emotional levels. But how do our colleagues across the table(s) approach these situations? Further, how do they view us, and what are their motivations, hopes, and fears? This month is a very special "Ask the Expert" column, where we are joined by a procedural colleague who will shed some light on the questions.

My co-author is Dr. Jack Pirris, a prominent member of an exclusive physician group – one often revered and occasionally maligned – namely, cardiac surgeons. Dr. Pirris, a man with an active personal and professional life, has decades of surgical experience, working in both the private and academic settings.

A reminder, I can be reached at ***zdeutch@yahoo.com*** *with any questions or feedback.*

Dr. Pirris (second from left) in Annapolis with four of his children, including son Luke (center), a midshipman at the Naval Academy and member of the football team.

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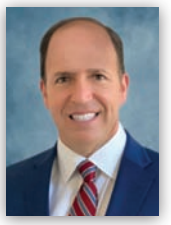

John "Jack" Pirris, MD
Attending Surgeon, Cardiothoracic and Vascular Associates, P.A., Jacksonville, Florida.

Jack, thank you for joining us. Please tell us a little about your background, and also describe your current position.

I am from Western Pennsylvania (Pittsburgh area) and am the son of an immigrant – more on all this later. My father and mother stressed education when we were growing up, so I and all my siblings graduated from college and obtained graduate degrees as well. I was the fifth of six children and was actually crazy enough to have six kids myself!

Right now, I am in private practice in northeast Florida where I do mainly cardiac surgery, with a thoracic case here and there. I can't shake off my academic longings, so I focus on challenging cases such as low EF, root enlargements, and complex aortic surgery.

What attracted you to a career in cardiac surgery?

I really enjoyed and understood the relevant anatomy and physiology as a medical student and later as a general surgery resident. I also liked the combination of clinic, operating, and ICU care.

You have expertise in cardiac, thoracic, and vascular surgery. This is not very common; can you comment on this and on your career trajectory?

This is actually becoming far less common. My vascular skills have really helped me with TAVR and minimally invasive cardiac surgery. I enjoy the added variety of cases that come with the additional competencies, including thoracic surgery. I also very much enjoy the collaborative atmosphere in the longitudinal arc of a cardiac surgery patient. Specifically, preop with cardiology picking the correct path of care; intraop working closely with anesthesia, nurses, surgical techs, and perfusionists; finally, post-procedural ICU care. Every aspect of the team is important, and we must all communicate and do our job well to achieve a good outcome for the patient. Teams come naturally to me. I always played sports as a child, went on to participate in football and wrestling in high school, and eventually wrestled at the collegiate level at the University of Notre Dame. While in medical school at the University of Pittsburgh, I missed that close camaraderie, so I was very attracted to the inherent team aspects of surgery.

I did my general surgery training at the University of Florida and quickly realized that clinical care was far more attractive to me than basic science, as I simply had far more interest in bedside medicine. Cardiac surgery was fun and exciting, and involved very little basic science research. I matched for fellowship at The Texas Heart Institute, which was a good fit for me because of their emphasis on outstanding clinical care, as opposed to bench research. Since I wasn't sure where I wanted to live after training, or whether I wanted academic or private practice, I wanted to train at a prestigious program that provided the most options. Work ethic is a strength of mine, so the demands of cardiac surgery never concerned me. As I mentioned above, I grew up in a small steel town south of Pittsburgh. I am the son of a foreign medical grad who came to the United States by himself at the age of 28 years old and simply outworked everyone, as immigrants usually do. My father is a great inspiration for me personally and professionally.

What is the biggest challenge you face as a surgeon?

Lifestyle. Cardiac surgery is really a life more than a career. I had an interesting career path in that I started in private practice, then went into academic medicine, and now I am back in private practice. I enjoyed academics far more than private practice, and it was a more fulfilling practice setting. Private practice is more of a job. I chose to come back to a private practice setting due to family concerns and the desire to spend more time with my kids. There are far fewer meetings and administrative burdens in private practice! Even though I perform many more cases in private practice, my workdays are much shorter, since I rarely have meetings and everything is more efficient in the perioperative setting.

What do you enjoy most about your practice?

I truly love my job and believe that I am able to make a huge difference in people's lives. Patients and families always remember their cardiac surgeons and are so grateful. It's very fulfilling.

How would you describe your relationship(s) with anesthesiologists and other anesthesia team members?

As I mentioned, cardiac surgery is the ultimate team sport. Everyone must work together at the highest level to achieve success for the patient. I depend on anesthesiologists' expertise with TEE pre- and postop, as well as their intraop hemodynamic support. These aspects can be quite complex and demanding when we treat sick patients. I tend to focus on high-risk cases, so I really need their help.

What aspects of anesthesia care are most critical to your patients' (and your) success?

Performing a great technical operation with excellent blood pressure control and good cardiac index maintained throughout matters most for the overall outcome. The anesthesia team manages hemodynamics and informs me of critical findings on preoperative TEE that could affect or alter my planned procedure. TEE evaluation postoperatively also reassures me that everything was done correctly.

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APSF: Symbiotic Feedback Loop

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Turning to progress

The good news is that this is a very high priority for ASA, as evidenced by the June 2022 workforce summit. In March 2023, ASA sent recommendations to Congress on how to improve staffing shortages in anesthesiology, which included funding research on improving efficiency within the OR, providing additional funding for training of anesthesia providers, and increasing the size of existing residencies. Interestingly, the recommendations also included allowing for reciprocal board certification of physicians from mature national health care systems such as the United Kingdom, Germany, and Australia (asamonitor.pub/44Jl2s7).

The problem of staffing shortages in anesthesiology does not occur in a vacuum; rather, shortages in nursing, for example, lead to long waits for recovery room beds that can exacerbate burnout in specialties like anesthesiology and surgery, leading to burnout and attrition. In order to address these shortages, there must be tactical cooperation on a national scale among leaders in nursing, surgery, and anesthesiology. In the interim, while solutions are being explored at the national level, there must be local intervention. Hospitals should make dedicated, visible efforts to acknowledge and embrace the existence of the staffing shortage problem, invest in efforts to maintain and improve health care worker mental health and well-being, and explore creative strategies on how to address surgical backlogs and meet the needs of our patients while maintaining a healthy workforce.

We aim to bring the interconnectivity of anesthesiology, other medical disciplines, patient safety, burnout, and staffing shortages to the forefront. It remains certain that addressing staffing shortages within our specialty could positively moderate burnout and patient safety outcomes and likely vice versa. As leaders in perioperative medicine, we find ourselves uniquely positioned to optimistically impact future anesthesia providers, our colleagues, and patients. ■

Disclosures: *Dr. Abcejo is a grant recipient of the Anesthesia Patient Safety Foundation and receives author royalties from UpToDate. Dr. Methangkool receives consultant fees from Edwards Lifesciences and author royalties from UpToDate.*

Ask the Expert

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How do you view the future of cardiac surgery, given disruptors like invasive cardiology and fluctuating reimbursement? Positive, negative, neutral?

Most cardiac surgeons have embraced less invasive procedures. TAVR, MitraClip, and PCI have encouraged cardiologists to treat more coronary and valvular disease, which has dramatically increased the number of patients overall. Working as a heart team with the cardiologists, we decide together whether surgery or catheter-based therapy is best for the patient. I think the future of cardiac surgery is certainly more catheter-based and minimally invasive, so you must embrace this technology if you want to keep working. We all know that the U.S. population is becoming much sicker, so there certainly is no shortage of cases. We set record volumes last year – my partner and I did 748 total pump cases and TAVRs. This is far more than we actually want to do, so we are hiring a third surgeon. In addition, we were just named a 3-star STS program, so I'm sure our referrals and patient volume will continue to grow as that word gets out. I guess it's good to be busy, but honestly, it's getting a bit too busy.

Can you describe a particularly interesting or challenging case you managed?

To answer the question in a general sense, with the improvements in ECMO and temporary assist devices, we are now able to help sicker and sicker patients. As long as the patient is not in multisystem, multiorgan failure, we can offer procedural intervention(s). We have embraced the Impella assist devices and, with this and other technologies, we can now get most patients through an operation we never would have even considered before.

As a proceduralist in a demanding field, how do you stay current, given rapid advances in medical knowledge and science?

Fortunately, we live in the Information Age, and using social media and attending conferences (live or virtual) make it much easier to keep up.

What do you do for fun, outside of work?

Well, I have six kids, so most of my free time is spent with them doing family activities, sports, and traveling. I wouldn't want it any other way.

Any parting words for ASA members?

We (cardiac surgeons) greatly appreciate you, whether we admit it or not! ■