PRESIDENT'S MESSAGE

"Damage Control": Anesthesiology Challenges in the United States

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Greetings and welcome to the Fall 2005 issue of *TraumaCare* with a focus on damage control surgery. I would like to thank our guest editor, Dr. Richard P. Dutton, Chief of Trauma Anesthesiology at the R Adams Cowley Shock Trauma Center, and his assembled panel for their contributions. The advent of damage control surgery signaled a dramatic change in the surgical approach to the critically injured trauma patient. This relatively recent strategy of resorting to the operating room to treat only immediately life-threatening injuries in the severely coagulopathic, hypothermic, and/or metabolically deranged patient has been accepted to yield improved survival rates. Damage control surgery decreases the likelihood of the dreaded "successful surgery, but the patient died" scenario and instead offers the chance to win the war despite losing a battle.

As I read the assembled collection of articles contained herein, I am struck by how, under a different rubric, anesthesiologists in the United States have been practicing "damage control" anesthesiology, continually struggling to preserve anesthesiology and quality patient care in the face of a continually expanding array of competing medical, political, and financial interests, yet seemingly unable to seize opportunities to perform definitive action. For example, in my personal experience as president of a state society of anesthesiologists, my colleagues and I continually deal with external forces hostile to anesthesiology through meetings, discussions, and negotiations. A significant portion of time is spent with state and federal governmental officials, fighting to stave off changes detrimental to anesthesiology and to patient care. Even modestly sized state societies utilize the assistance of a lobbyist, often their largest single expense. Recent concerns include both financial and regulatory matters. West Virginia anesthesiologists recently repelled an attempted retroactive, arbitrary reduction of anesthesia reimbursement by more than 25% for state programs, yet still were forced to accept an average reduction of 8%. The newest challenge is a proposed change in state regulations requiring a staff anesthesiologist to be physically present for the entirety of the case when an anesthesiology resident or nurse anesthetist student is involved in the care of the patient. This contrasts to the current nationwide supervision standard allowing supervision of more than one room; being present for induction, emergence, and all critical portions of the case while being immediately available throughout. These significant negative economic consequences would likely result in the closure of anesthesia training programs.

On a larger scale, the past decade presented even more challenges to anesthesiology in the United States, including expansion of nonphysician anesthesia providers, increasing regulatory environment, diminishing financial resources, and diminishing of scope of practice. Anesthesiology in the United States is still trying to recover from big hits that occurred in the 1990s. Early in that decade, the federal government, via the Centers for Medicare and Medicaid Services (CMS), arbitrarily decreased reimbursement for anesthesiology resident medical care in contrast to other medical specialties. This selective reduction in anesthesiology reimbursement decreased academic department revenues by up to 50%. The American Society of Anesthesiologists and its members have been lobbying for anesthesiology resident services to be reimbursed in a fashion consistent with other medical specialties ever since. Now, after more than 10 years of effort, it appears that our work may pay off and CMS may revisit this issue.

The 1990s also witnessed a dramatic proposal to restructure the United States health care system. Although in the end no significant changes occurred, concerns at that time regarding the possible detrimental financial effects nonetheless had a radical impact on anesthesiology. Departments and groups exerted fiscal restraint in the face of the unknown, and graduating residents found less-desirable job opportunities. Most groups offered decreased salaries and benefits, while many elected not to make any hires at all. Furthering the tension, a *Wall Street Journal* article inaccurately described anesthesia residents as unable to obtain jobs on completion of their training, counting among the "unemployed" those entering fellowships, the military, or practicing as locums tenems. These increasing anxieties, along with a projected oversupply of medical specialists and a major drive by medical school deans (overwhelmingly primary care physicians) for medical students to enter primary care fields devastated anesthesiology resident recruitment in the mid-to-late 1990s. Anesthesiology resident match numbers fell to less than 25% of what they were in the early 1990s. Within a short time, a severe shortage of anesthesiologists in the United States resulted, impacting anesthesiology to this day and demonstrating the folly of such reactionary thinking.

Training programs dramatically altered their behavior. At the peak of the manpower shortage, even some of the most prestigious programs gave substantial financial inducements to residents to enter their programs, largely so there would be bodies in operating rooms to "squeeze bags." Given the continued shortfall of residents to cover the rooms in teaching hospitals, hospitals markedly increased the presence of certified registered nurse anesthetists and anesthesiology assistants, with many teaching hospitals remaining reliant on nonphysician anesthesia providers.

Residency programs made their programs more attractive in other ways as well. Changes such as expansion of educational programs were viewed positively by some, yet considered "spoon-feeding" by others. Lessened work hours and reduced schedules produced a generation of anesthesiology residents often working fewer hours per week than their faculty, and certainly less than when their faculty were residents. Many programs promoted a "kinder and gentler" system in which the residents did not take in-house call on weekends, but instead calls were covered by in-house faculty. As programs and hospitals scrambled to fill the void, an unfortunate result is a generation of anesthesiologists who found anesthesiology residency programs pulling out all stops in their efforts to recruit them, and subsequently, departments and groups recruiting them with lavish packages on completion of their training. Recent anesthesiology graduates often are unaware that the primary source of anesthesiologists' income increase of more than 50% over the past 5 years is the result of hospital and university subsidies to keep

operating rooms open and remain competitive in their markets. Currently, anesthesia departments in level I trauma centers routinely receive subsidies in the millions of dollars. Academic departments, in general, today receive on average over one hundred thousand dollars subsidy per faculty member to recruit and retain faculty. Few residents and recent graduates anticipate that as the anesthesiology shortage eventually abates, such subsidies will almost assuredly disappear as market forces come to bear.

This environment has contributed to unrealistic expectations, potentially making new graduates less well equipped for entry into the postgraduate world of medicine than their immediate predecessors. An increasing strain has been noted between recent anesthesiology graduates and their established brethren. The American Society of Anesthesiologists' 2005 Practice Management meeting acknowledged such difficulties by providing a breakout session devoted to generational issues.

Perhaps more importantly, however, during these disruptions, anesthesiology saw an accelerated reduction in scope of practice in the United States in comparison with our international anesthesiology colleagues, particularly in regard to trauma care. The relatively new acute care specialties of emergency medicine and critical care medicine were originally outgrowths of anesthesiology. In many parts of the world these practice areas remain fully integrated within the anesthesiology's purview. In contrast, department leaders in the United States often appeared grateful to unload some of their commitments in the face of the dramatic anesthesiologist shortage. Regrettably, apparently well-intentioned leaders, in many cases, now appear myopic in retrospect.

I have the pleasure of frequent discussions and communication with international colleagues along with hosting international anesthesiologists. They are uniformly shocked and amazed by the reduced scope of anesthesiology in the United States. They are further shocked to find anesthesiologists in the United States constantly striving for respect from medical colleagues. They find the notion that nonanesthesiologists could replace anesthesiologists inconceivable, given the breadth of acute care medicine anesthesiologists practice elsewhere. While recognizing that economics have played a significant role in shaping anesthesia's current position in medicine in the United States, both in the evolution of relatively new fields such as emergency medicine and the reduction of anesthesia involvement in critical care medicine, the future of anesthesiology will be ensured by making the United States' anesthesiologists as indispensable as anesthesiologists elsewhere.

Again using trauma care as an example, anesthesiologists typically are the leaders of the trauma care teams for a large portion of the world. Anesthesiologists not only care for trauma patients in the operating room, but are also first responders at the out-of-hospital scenes of trauma. They coordinate trauma care from the receiving bay in the emergency department through the critical care unit. In this role, not only are anesthesiologists indispensable, but also are uniformly held in higher regard by their medical colleagues. Anesthesiologists in the United States once led medical advances in trauma care. They have now largely deserted or allowed themselves to be marginalized in many aspects of trauma care, perhaps in part as a result of anesthesia resources being stretched so thin by the ongoing shortage of anesthesiologists. The question is whether, when this shortage is resolved, as it likely will be with anesthesiology match numbers in the United States now approaching record numbers, will anesthesiology ever regain what is has given up? Emergency medicine physicians provide prehospital and hospital-receiving care, even supplanting anesthesiologists in many centers as emergency airway management experts. Readers may recall receiving a mass mailing from an emergency medicine physician inviting anesthesiologists to attend his difficult airway management seminars, heretofore anesthesiology's calling card.

Another area of acute care medicine originally led by anesthesiologists, yet now with continually diminishing anesthesia involvement in the United States, is critical care medicine. Despite a recent thrust to staff critical care units with full-time intensivists primarily from economic pressures exerted on health care systems by groups such as the Leapfrog Group, a consortium of more than 100 private and public sector health care purchasers finding health care costs to be reduced in hospitals with full-time intensivists, critical care continues its trend of nonanesthesiologist intensivists staffing most of the critical care units. Although perceived as financially attractive for some medical fields, anesthesiologists in the United States can at this moment generate more revenue per hour providing anesthesia care compared with critical care services. Those anesthesia departments still successful in critical care tend to be those with substantial commitments from hospitals or universities to do so. Additionally, while the American College of Graduate Medical Education's (ACGME) Anesthesiology Residency Review Committee (ARRC) recently recommended increasing the critical care months required in residency from 2 months to 6 months, and leaders in the American Society of Anesthesiologists have been leading the charge for a renewed emphasis in critical care medicine, it appears that largely by political and financial reasons, including academic chairs' desires to not lose anesthesia hands on providers to the critical care unit, that such efforts have been largely abated. This is unfortunate not just for anesthesiology but also for our patients. Anesthesia intensivists' unique background as perioperative physicians, daily adeptly managing ventilators along with the rapidly changing physiologic conditions of exceptionally ill and traumatized patients, offer an unparalleled skill set to care for the critically ill and injured.

Events of the past 15 years should serve as a wake-up call to all anesthesiologists. Rather than practicing "damage control" in the political and regulatory worlds, it must be the goal of all anesthesiologists to ensure the vitality of anesthesiology. Strong, visible leadership is necessary. We must provide mentorship and be role models for those now entering medicine and anesthesia. We cannot count solely on our elected or designated leaders. Leadership and mentoring are most effective when individually demonstrated daily. We must commit to lead by example and proactively advocate for anesthesiology and for our patients. The challenge begins today. We must learn from our mistakes, else we are doomed to repeat them. Such effort will be rewarded not just by a change of mind of those in anesthesiology, but also by a change of heart, and will thus renew anesthesiology's vigor and position in medicine in the United States.

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