VOICE OVER:

Welcome to ASA Central Line, the official podcast series of the American Society of Anesthesiologists, edited by Dr. Adam Striker.

DR. ZACH DEUTCH:

Welcome back to Central Line. I'm the guest host for this episode, Dr. Zach Deutch. I'm pleased to be joined today by Dr. Lilian Kanai, who's our guest editor for the July ASA Monitor. And the issue explores the topic of practice management and our changing organization of practice models, which will also be the topic of our show tonight. Welcome back, Dr. Kanai.

DR. LILIAN KANAI:

Thank you, Dr. Deutch. Thank you so much for having me.

DR. DEUTCH:

I'd like to start off, before we get into, you know, your area of expertise and this topic tonight, I would like to just ask you some questions, which I have a personal interest in, because I know you practice in Hawaii. Correct?

DR. KANAI:

That is correct.

DR. DEUTCH:

And which island are you on?

DR. KANAI:

So I'm on Oahu and I live in the city of Honolulu.
DR. DEUTCH:

Like a lot of people in the ASA, a lot of, I guess, mainlanders. We've only come out there for vacation a little bit. What's it like to practice medicine out there?

DR. KANAI:

Well, you know, I am very fortunate to live and practice out here. You know, we pay the Paradise Tax, which is basically that the cost of living is astronomical and reimbursement here is lower than the mainland. So, for example, commercial rate is about $65 a unit. I think one thing that helps us is that we have the Hawaii Prepaid Health Care Act. So if you work 20 or more hours a week, you must be provided health insurance. So pretty much everyone either has commercial insurance or Medicare or Medicaid. As far as the practice model, we tend to lag behind the mainland by about 10 to 20 years, I would say. And so our model is a little antiquated. What I mean by that is we do have some organizations where they have the employment model. We have some organizations that contract with a single group, but there are still a number of organizations that have the follow your surgeon open staff model. But what I've noticed is that that is quickly coming to a close. As you know, Covid hit and margins are thin. They're really looking for efficiency.

DR. DEUTCH:

So basically to sum up, it's a place where obviously some people want to live. Yet the cost of housing is incredibly high and the pay is not commensurate. Is that correct?

DR. KANAI:

That is correct. And we get a lot of people that move out here without any family ties. They end up staying for a couple of years and they end up moving back to the mainland. And that is not uncommon.

DR. DEUTCH:

Since you have a number of islands and a number of medical facilities spread out in terms of, for example, the Hawaii society, is it hard to get people together and to have meetings and to have kind of a professional rapport with everybody who's spread out among these areas?

DR. KANAI:
Absolutely. You know, first of all, the Hawaii society has been relatively dormant for a number of years. And I serve as the director for Hawaii. And I've been trying to get more people involved. But it's very difficult, especially now with the workforce shortage. Just our free time is very limited. So it's been a struggle, but I keep trying and certainly the geographical distance, because there are multiple islands, just adds a layer of complexity to it.

DR. DEUTCH:

That's interesting. Well, you know what? I'll move on to our topic, which, you know, is your area of expertise, which is practice management. So talking about our current state of anesthesiology in this country, what do you see as some of the main issues we face as a specialty? And, you know, how do you see our specialty evolving really right now?

DR. KANAI:

Well, think right now we have a number of challenges, you know, and let's start with the financial ones. I like to think of it as revenue versus expenses. So on the revenue side, you know, we have our government payers, we all know about the Medicare 33% problem, which is now actually the 25% problem. Medicaid pays very poorly and unfortunately the payer mix is going more towards government insurance because of our aging population. And hospital stipends, you know, they have very, very thin margins and even more so post-COVID. And so hospitals are less inclined to give a stipend to an anesthesia group. So revenue is a challenge.

And then on the expense side, you know, actually right now it's a great time to be an anesthesiologist or a CRNA because salaries are soaring because the workforce shortage. But that does not bode well for an anesthesia group that is trying to make ends meet.

And then there's medical title misappropriation. And, you know, nurses are an important part of the care team model, especially CRNAs. But the practice of nursing is very different from the practice of medicine. And we really need to think about when you need care, what would you want for yourself or your loved ones? And so just to give you some data, anesthesiologists versus CRNA. So anesthesiologists have 12 to 14 years of education after high school and CRNAs have 5 to 7 years. Anesthesiologists have 12 to 16,000 hours of clinical training versus less than 2000 for a CRNA. And as of 2025, a doctorate is going to be required of new CRNAs And so clearly they're going to push for being addressed as doctor because they will have a doctor of nurse anesthesia practice. And related to this medical title misappropriation is scope creep. And this is
where the CRNAs are asking for more and more autonomy. They have aggressive nursing advocacy that I feel, you know, they are giving misinformation to legislators and administrators.

Then moving on to something that was alluded to self devaluation. And, you know, really, this is about the fact that anesthesiology does not bring patients and hence revenue to the hospital. So we're really seen as an expense. But some interesting data is that up to 68% of a hospital's revenue comes from the OR or procedural areas, and up to 60% of a hospital's operating margin comes from the OR or procedural areas. And so what I see is the problem is really a lack of visibility and involvement with administration. I feel that administration really doesn't know what we do and the value we bring to the hospital. And so it's really up to us as a specialty to communicate our value proposition. And what that might mean is be proactive in process improvement. So, for example, I know ASA has been very active in the Perioperative Surgical home, and if you implement such a program, you can actually decrease cancellations and decrease length of stay, which is a huge cost savings for an organization.

And then finally, you know, workforce is top of mind for everyone. You know, we have a huge imbalance in supply and demand. Our supply has decreased, especially post Covid. People are retiring. The younger generation want a better work life balance. There's burnout. And then as far as increasing the supply, there's a finite training capacity of residents because most residency programs are funded by Medicare. And at the same time the demand has gone up where our baby boomers are needing more surgery and then the number of NORA procedures has increased precipitously. So those are the four areas that I think that are are top challenges right now in our specialty.

DR. DEUTCH:

Well, you said a mouthful and you said it very eloquently. Just out of curiosity. Again, coming back to Hawaii, are the workforce issues more pressing there based on things we discussed earlier than they might be in other parts of the country?

DR. KANAI:

I think it's about the same. You know, what has happened at our big hospital is that they are now changing, quote, the culture. What I mean by that is they are now scheduling cases based on anesthesia availability. So whether that culture sticks around or is transient, we will see. But I think we have the same challenges as the mainland.

DR. DEUTCH:
Yeah, that's a big thing that. That culture shift. And I've heard of that happening, you know, incrementally in certain places around here in North Florida, but not in any large sense. So yeah, we talk about, you know, in the ASA and in medicine in general, we talk about leadership, the importance, obviously anesthesiologists in a proper setting and in a proper role are perioperative leaders. They have roles in perioperative utilization and enhancing finances and logistics. So in your view, can you describe kind of the role that anesthesiologists should play in managing ORs, in helping institutions to change in a positive way?

DR. KANAI:

Yeah. And you know, I think this really speaks to we anesthesiologists are perioperative specialists and we can actually drive processes in the hospital. The way I like to think of this is pre-COVID. The OR revolved around the surgeon requests. Since they bring the revenue and surgeons could schedule elective cases at night. You know, surgeons are given two rooms if they're a busy surgeon and pretty much the anesthesiologists and or staff just basically did the cases. But post-COVID, you know, really people are looking for more work life balance. And it's not just the younger people think it's all generations. And so hence the early retirement. The millennials are quitting or going part time. They're doing quiet quitting, which is, you know, showing up and just putting in the minimal amount of effort. And so, you know, we have all these staffing issues. And so really what needs to change, as we talked about, is the culture. How do you shift the culture from the surgeon being the king or queen and scheduling when they want to to realizing that you have a finite pool of resources, of staffing and that you need to do a paradigm shift so that you figure out what staffing you have and then allow the surgeons or proceduralists to schedule cases. And think as perioperative leaders, we should be at the table to have these conversations, to drive these processes.

DR. DEUTCH:

Um, the thing you said that I found most interesting is that concept of quiet quitting. We've talked about that at our work before. I think whoever came up with that, it was brilliant. And we can all kind of relate to that. Whether we've actually done it, we feel tempted to do it. For example, you know, you used to come to work in a tie and now you come in sweats and flip flops, you know, that type of thing. So that's a concept I think everybody in medicine can relate to.

So we're on the topic of leadership and also transformations and healthcare paradigm shifts. So becoming a physician, getting the clinical training, that is a very clear path, you know, kind of a very rote step by step process. But being a leader is a little bit
different, a little bit more personal and can be idiosyncratic and really dependent on
good fortune or just luck or, you know, whatever happenstance. So there are a lot of
approaches to that leadership path and professional development, different places you
can go with it, whether you know, clinical and non-clinical, different types of
administrative. What opportunities for leadership do you see for people in the ASA
across a variety of of tracks, whether it be clinical, non-clinical, inside hospital, outside
hospital, do you see as as valuable and important?

DR. KANAI:

Yeah. So, you know, with this topic, what I want to start out with is just some data that I
find very interesting, which is that 5% of hospital CEOs are physicians and some of the
highly ranked hospitals, for example, Cleveland Clinic and Mayo Clinic are run by
physician CEOs. And it's been shown that quality scores are 25% higher in physician
CEO hospitals. So as you said, you know, the pathway for someone to become a
physician is very prescribed. It's very straightforward. But to become a leader, it's not so
clear. So the ASA actually has a number of resources available. The Committee on
Professional Development started the Leadership Academy, and there are two modules
available and I believe it is complimentary for members and I'm also under the
understanding that they are working on further modules.

Also have a special place in my heart for advance, which is our practice management
meeting and it takes place every January, so it will be in Las Vegas January 26th
through 28th, 2024. And I encourage everyone that wants to become a leader or are
interested in the business aspects of anesthesiology to attend this meeting.

Also, what I feel is important is to attend annual meeting or advance to network.
Networking is very important. You know, it's where you develop these relationships that
you will need later.

Also, you could possibly go get an advanced degree, you can get an MBA, a MHA,
MPH. And I think what this does is it enables you to think differently. And also you would
be able to fill the niche between administrators and physicians. So, for example, when I
went to get my MBA in my interview, they asked me, why do you want to get an MBA?
And my answer was, you know, hospital administrators typically are not physicians and
they speak the language of business. And we as physicians, you know, we're clinicians.
And so we know medicine well. Administrators are not going to go to medical school. So
I feel I need to go to business school to be able to speak their language. Some other
resources outside the ASA include the American Association of Physician Leaders,
where you could be certified as a physician executive or the American College of
Healthcare Executives, where you can become a fellow of which is considered board certification in healthcare management.

So those are some of the resources. But as far as a plan, this is what I would recommend. So first and foremost, I think anesthesiologists should focus on clinical excellence, because if you have that under your belt, you will have more credibility as you go down that leadership pathway. Second is you need to learn emotional intelligence. You know, it's been shown that EI is actually more important than IQ in leadership development. Third, know and identify your strengths, weaknesses, interests and goals. Then engage a mentor and create a roadmap for your pathway. And finally, leadership usually starts informally without a title so you can have influence without having a title. And typically what happens is you need to show value. Show them what you can do, do some process improvement, and that would be a steppingstone towards formal leadership.

DR. DEUTCH:

So really what you're talking about is people that are really engaged in their practices. And so honestly, kind of like the opposite of quiet quitting, like really carrying the flag for your practice or your hospital or for your profession. And this type of engagement obviously increases physician retention hasn't been shown to have positive financial benefits and improving cost savings and increasing quality metrics in a hospital. So that's all well and good. But one of the problems we have is as anesthesiologists, we're busy running our rooms, either doing it ourself or supervising or directing or whatever we're doing. Being involved in this non-clinical administrative work really doesn't pay necessarily. There's some value, but there's a financial gap there. So do you see this as changing? And can you comment on any kinds of mechanisms that exist to help defray this financial problem for physicians that want to get involved in this way?

DR. KANAI:

Yeah. You know, as physicians, we're all type A individuals and we we always want to do more for our patients, you know, do what's right. And so part of that is getting involved in non-clinical activity. And unfortunately, historically, it's been either not compensated or very poorly compensated. Now, my understanding is that is slowly changing on the mainland. I've heard of some private practice groups that will actually compensate their physicians for non-clinical work at clinical rates, but I think that is the exception more than the rule. And so when you think about, you know, mechanisms for compensation, so for example, in an academic environment, typically the anesthesiologists have time carved out for research. But unfortunately, during this workforce shortage, they're being pulled more and more into the OR and have less time
for this research. In a private practice, you may or may not have a formal position, and the hospital can either pay the physician directly or pay the group directly. And then the group divvies out the payment to the physician. But you know, what it comes down to is, you know, what is the culture of your group? Do they understand the value of non-clinical work and the time and effort it takes to go out and develop these relationships and to go to meetings, to be on committees, to show administration what our value proposition is. And so, you know, in my mind, there are several reasons why this inadequate compensation exists. Number one is, you know, it's the way it's been done. Right? And we all know change management is difficult. So people think, well, why should I pay for something that I've been getting for free? Second is something I alluded to, which is administration and our colleagues do not understand the value that we bring when we do this non-clinical work. And so really, the solution, again, is, you know, sometimes you have to do a project and do this work uncompensated until someone sees your value and then they may offer you some compensation, you know, or a position. But, you know, in this day and age of workforce shortage, I think that in the good old days, years ago, where we were compensated very well and we had, you know, time off, we would freely give our time, you know, But that paradigm has shifted. So my hope is that engaged anesthesiologists will continue to show their value and be able to communicate that effectively so we can see this paradigm shift.

DR. DEUTCH:

Uh, so far. You're giving us a lot of really good information, very well presented. And I'm myself, and I'm sure our listeners will be looking forward to hearing more. But right now, we need to take a short break, though, and we'll be back in just a second.

DR. KANAI: Great. Thank you.

(SOUNDBITE OF MUSIC)

DR. JEFF GREENE:

Hi. This is Dr. Jeff Green with the Patient Safety editorial Board. OR medication errors such as syringe swaps can cause severe patient harm. Reduce the chance of a syringe swap by aligning the syringe and label on an IV stopcock so that the name and concentration of the medication is directly facing the anesthesiologist. If a manifold is being used to administer several medications, the syringes and their labels can be oriented in the same direction and placed in the order of their planned use, particularly during induction of anesthesia. While injecting the medication, the anesthesiologist should read the label, rechecking the concentration and calculated dosing as a quick and easy safety step. These simple steps can decrease risk by removing common
causes of syringe swaps, such as failure to read the syringe labels, using unlabeled syringes, or relying on color coding or labels alone.

VOICE OVER:

For more information on patient safety, visit asahq.org/patientsafety22.

DR. DEUTCH:

Okay. You touched before on the topic of emotional intelligence, which is big in many, many fields, not just medicine, and certainly something that I'm continually working on in my own personal life and professional life. So we know that physicians that have emotional intelligence at a high level do well and organizations that have an understanding of emotional intelligence and emotional quotient, EQ, also do well for those who maybe haven't spent as much time looking at this or just heard it in passing and are not quite sure about these concepts, can you explain both and EQ and tell us how this might affect us professionally as anesthesiologists?

DR. KANAI:

Sure. So which is emotional intelligence is essentially the same as EQ, emotional quotient. And so that is very different from IQ, which is a measure of your cognitive abilities to acquire knowledge. So I actually was coined back in 1990 and it was popularized by Daniel Goleman. And I'm sure everyone has heard or read his books. And really emotional intelligence accounts for 90% of what sets high performers apart from their peers with similar technical skills and knowledge. So EQ may in fact be more important than IQ as far as leadership. And what it is, emotional intelligence? Well, there are four core competencies. So the first is self-awareness. You need to understand yourself, your strengths, your weaknesses, and your emotions. Second is self-management. You need to be able to manage your emotions, stay cool under pressure, and stay positive. And third is social awareness. You need to be able to recognize the emotion of others. And finally, it's relationship management, being able to influence and mentor others and resolve conflicts. And the good thing is that much of emotional intelligence is learned. So if you don't have it, you can learn it. And it takes practice, practice, practice and emotional intelligence for organizations is really similar. It's not talked about a lot, but I know that Alex Choi, this is an area of passion for him. So really, organizations can't rest on their laurels or they'll become obsolete. And the same is true for individuals. So really the organization needs to make an assessment of their
strengths and weaknesses from not only internal stakeholders, but external stakeholders to understand what are they doing well, what can be improved and really, this is all about process improvement. And organizations typically don't think of their own emotional intelligence, but think it goes hand in hand with individual emotional intelligence.

DR. DEUTCH:

Okay. Something important for all of us to think about. The concept of self-awareness and reading a room. We talk about that a lot at work, and you don't want to be on the wrong end of those aspects of social behavior for sure.

Let's move just quickly to current events. We have heard in the news that the FTC proposed a ban on non-competes, which are a very controversial topic in medicine. Can you talk about why this is come up? Why is the government considering this? And how do you think if this is enacted, this ban would impact anesthesia practice in this country?

DR. KANAI:

Yeah, so just a little history. So federal and state antitrust laws promote competition. So the Federal Trade Commission, they're concerned about non-compete beats, probably started about ten years ago, and they consider non-competes to be an unfair method of competition by suppressing wages, hampering innovation and blocking entrepreneurs from starting new businesses. So in July 2021, President Biden issued an executive order on promoting competition in the American economy. And then in January 2023, the FTC voted 3 to 1 in favor of the proposed ban on non-competes. And again, this is a proposed ban. So what is the proposed rule? Well, what it includes is that it is illegal, or it would be illegal for an employer, to enter into a new non-compete or maintain an existing non-compete. And now this applies to not only employees, but also independent contractors. And this applies to the post-termination period. Now some employers are exempt. For example, some nonprofits and state and local government entities. The non-compete would also apply to other agreements. A couple of examples are confidentiality agreements and non-solicitation agreements.

As far as the effects on anesthesiologists and their practices, it would increase worker mobility. For example, if you're employed by a group and you terminate your employment, you can seek employment with another group or the hospital in the same geographical area without a non-compete. If you have a non-compete, my guess is the non-compete would prohibit you from doing so. So it does give you more mobility. Now the downside is on the effects of smaller group practices. A non-compete essentially protects them. So if let's say they lost a contract at a hospital, then their employees are
independent. Contractors would not be able to seek employment by the new group or by the hospital. But without the protection of a non-compete, these anesthesiologists would indeed be able to go and seek employment elsewhere. And for example, you could have a big company, a private equity firm that comes in and hires away all your anesthesiologists. So it would have a negative effect for smaller practices. So it is a very, very controversial topic.

One little addendum that apparently just came up May 31st, the National Labor Relations Board general counsel apparently issued a memorandum asserting that the use of non-compete provisions in employment contracts and severance agreements violates the National Labor Relations Act except in limited circumstances. So certainly there's going to be a lot of discussion. I'm sure there will be some litigation. We have not seen the end of this. Again, this is a proposed rule. So we will just have to wait and see how this plays out.

DR. DEUTCH:

And this impacts on something that I've talked to trainees about for a while, which is the idea of taking a job in a larger versus small market. The non-compete actually complicates it even more. But for example, if one takes a job in Chicago, Illinois, and it turns out that it doesn't work out for you, well, there's, you know, countless other jobs available in this very large area. If you're in Cairo, Illinois, it's a completely different story. There might be only one place to work. And if it doesn't work out, you're going to have to uproot yourself. Adding in the idea of non-compete versus having versus not, it changes that equation as well, you know, possibly favorably.

DR. KANAI:

Yes. Yes.

DR. DEUTCH:

I have two more questions for you. First off, having edited this issue of the Monitor, did you learn anything from doing this? Is there any particular part of the process that stood out to you or any particular part of that, that issue that you want people to pay particular attention to?

DR. KANAI:

Well, I think overall what this highlighted to me is that challenges in our workforce and change, it's inevitable. And really, you know, do you want to be blockbuster, which is
obsolete or Netflix? And so we really need to embrace change, as uncomfortable as it is. And really what you need to do is try to understand the bigger issue and listen to the views of all the stakeholders. Then figure out, you know, what is your vision of the future? What would you want your direction would you like to see this go? And then develop a plan. And then, you know, be proactive, get involved so you're at the table and not on the menu. And really, I'm going to leave you with one last thought, because this is a saying that I absolutely love. So Wayne Gretzky -- he was an NHL player for 20 years and some referred to him as the greatest hockey player of all time. And his quote was, I skate to where the puck is going to be, not where it has been. So really, you know, look at where things are going. Don't get stuck in This is where we are. This is the way we've done things, because you will become obsolete. Our specialty will become obsolete. If we do that. We need to look at the market forces and be able to adjust appropriately to be able to secure our future.

DR. DEUTCH:

That's well said. And I know that as chair of Practice management, you spend a tremendous amount of time doing a variety of things, but certainly planning the ASA ADVANCE meeting. And you touched on that earlier, I want to give you a chance for a final plug for that meeting. Can you briefly tell our listeners and members who should attend? What should they expect to get out of it and just how great it is?

DR. KANAI:

Yeah, I think any ASA member should attend. You know, it really focuses on the business side of anesthesia, which we are not taught in residency. And really, again, to gain that knowledge and have a seat at the table I think is critical. What we do with this meeting every year is we look at the feedback. We literally go through the feedback and summarize it, and then we change the program every year. So there is something for everyone. There's something for residents, for administrators, you know, for for the active clinician. And one of the biggest pieces of feedback that we got from this year's meeting is they don't want just lectures, they want workshops. You know, they want more interactivity. So we're creating more sessions where they're going to be case studies and you work through problems. And then we've doubled the number of roundtables that we have where we're going to bring in the experts from the lectures to moderate that roundtable to talk about the things you know that are top of mind for you. So I encourage everyone to come. It's going to be fantastic. We are putting the finishing touches on it, should be complete by the end of this month and hopefully you will start to see the marketing on that towards the end of summer. But it's going to be a fantastic meeting and no one should miss it.
DR. DEUTCH:

I'm looking forward to attending and I'm really glad to hear that about the small groups and the round tables, because I've always found that to be really a very, very valuable part of the meeting. So I'm really glad that that's going to be a bigger part. And I'm glad that you all are following up closely with ASA members on this.

It's been great having you here today. You really presented a lot of information in a very digestible, very eloquent way for our listeners. And it was really enjoyable for me to be able to speak with you. Thank you so much for joining us.

DR. KANAI:

It was my pleasure. Thank you so much.

DR. DEUTCH:

And for our listeners, if you want to hear more about the topics that we talked about, you can access the issue online – asamonitor.org And of course, we're always here at the Central Line to provide useful and thought-provoking information for you all. So please continue to tune in.

(SOUNDBITE OF MUSIC)

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