Central Line
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(SOUNDBITE OF MUSIC)

VOICE OVER:

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

DR. ADAM STRIKER:

Welcome to Central Line. I'm Dr. Adam Striker, your editor and host. Today I'm happy to welcome back to the show Dr. Mary Dale Peterson. Most of our listeners will already know her as past president of the ASA. And she's going to talk to us today about workforce hot button issues. And that is the topic of November's ASA Monitor. We're lucky to have her back on the show. Certainly no one more versed in issues affecting the specialty of anesthesiology. And she happens to be the guest editor of November's ASA Monitor. So to help us make sense of this important and timely topic, Dr. Peterson, welcome to the show.

DR. MARY DALE PETERSON:

Oh, thank you. Dr. Striker.

DR. STRIKER:

Before we get into the specifics of the workforce issue, why don't you tell us how you got involved specifically with the issue, how we came to be sort of a personal interest of yours?

DR. PETERSON:

Well, it goes back probably way more than a decade when I applied for and got to be on the Committee on Physician Resources, which is no longer in existence, we've replaced it with the Center for Anesthesia Workforce Studies. And at the time, I got interested in trying to sort out, you know, how do you know whether you are training the right number of people and and how do you look at workforce? And we got involved with a RAND study that initially was funded by Ethicon, but we did a big survey of anesthesiologists.

And that study was really pretty groundbreaking. And looking at, you know, all kinds of ways of looking at workforce. There's an economic approach. There's a different approach that can be used as well. And that study showed that we actually had probably maybe too many at that time. That was back in 2003. And then eventually ASA produced another RAND study, which we'll talk about a little bit more in the article, which did predict that we would start seeing some shortages, increasing shortages again around 2017.

So I've always been interested in that. I've served on the Texas Medical Association's Task Force on Workforce as well. I just find it interesting and humbling really, because I don't think central planning necessarily really works. I think we all know when we're in a shortage situation, but then how do you solve it and how do you kind of foresee some of that?

DR. STRIKER:

Well, and before we get to the solutions, let's talk a little bit about how we ended up where we are today. Obviously, the demand for anesthesia services has gone up. Some of that's driven by where we need to be, i.e. minimally invasive diagnostic areas or procedure areas that aren't necessarily in the O.R. But if you don't mind, talk to us a little bit about why the demand has gone up for our services over the past few years.

DR. PETERSON:

Yeah. So I guess we're a victim of our own success, so to speak. We should be proud of that, that people look to us as being the providers of safe anesthesia and sedation care, and we can do it efficiently. And so a lot of the procedural lists are leaning on us now where they used to do some of this on their own.

So I work in a children's hospital. And of course, we've dealt with this problem for for many years. There's no way that I would ever have the amount of anesthesia staff to be with every child for every fracture that is said or every lumbar puncture that's done. And so I've learned more recently that a lot of the newer physicians coming out in various specialties are really not taught any sedation skills at all. And so we've created a new program to try to do that, to extend ourselves. We still oversee all the sedation services in our facilities, but we're not all personally providing that. We're just making sure it's provided safely. So I think part of it is more proceduralists wanting our services. And then of course, we've got a lot of ambulatory surgical centers opening up. And of course we have the usual demand of surgeons all wanting their 7:30 start, but maybe not having a full schedule. So we've got some inefficiencies, I think, in how we schedule our O.R. and anesthesia staff as well.

DR. STRIKER:

And how has the pandemic affected all this?

DR. PETERSON:

Well, initially we saw the huge downturn, of course, when we canceled elective surgeries. And I think that really only pushed back the demand. And so now we see patients coming back for all of those procedures that they didn't have - the colonoscopies and maybe even cataracts and some of these other types of procedures. And it's very difficult, I think, right now for the specialists in those areas to fulfill all the demand that's out there.

DR. STRIKER:

I did want to circle back to one thing you mentioned in your previous answer about residency training or residents not being adequately trained in sedation techniques. Do you think there's overall an issue with how we're training our residents for the current practice of anesthesiology?

DR. PETERSON:

Well, I think when I was referring to physicians not being adequately trained, I was really talking about mostly our our colleagues and other specialties of medicine like oncology, cardiology, that kinds of things.

I think our residents are trained but maybe not trained in the overall management of other professionals in sedation. And so I think as we look at new paradigms for taking care of patients and knowing that it's a CMS requirement that the anesthesia director oversees sedation in their facilities, whether they like it or not. I think some of that experience on looking at quality improvement and how you develop these programs would be helpful for residents, or at least when they get into practice. I think we need to offer those resources for folks.

DR. STRIKER:

What do you think just in general about the, you know, the conventional means of training anesthesiology residents? Like most of the time during residency, we spent our time in the operating rooms. But practice models are certainly shifting, especially with

the demands for anesthetic care outside the operating room. Does that need to evolve at all?

DR. PETERSON:

I do think it could evolve because I think we have a bent on providing more and deeper sedation when sometimes you might be able to use less and use it with different kinds of professionals. So I do think that's an area that that we should look at because that is a high demand area Overall. I think our residents are coming out really super well trained. You know, we had three new just finishing fellowship trained pediatric anesthesiologists this year and everybody's really impressed, and they came from all over the country. So it wasn't one particular program. So overall, I think we're doing a great job. And when it comes to how do you provide sedation for a non-painful procedure to keep it really light, we probably have less experience in those areas.

DR. STRIKER:

I imagine that there is going to need to be a multifaceted solution to the problem of workforce imbalance with the supply and demand. Let's talk about long term versus short term solutions. How would you classify those and what do we need to go about doing?

DR. PETERSON:

Sure. So I think on the supply side, the good news is, a really great news is, for our profession, is that we're matching basically 100% of residents. So almost 2000 folks matched this last year. It has been very high for the last few years. The bad news is or the opportunity I think that's out there is there's almost 3000 medical students that wanted to be anesthesiologists but did not match. And so I think that's our opportunity. And so how do we get there?

Many of you may know that the federal government, through Centers for Medicaid and Medicare Services, funds a lot of the residency programs in academic medicine. And those slots have pretty much been static since the Balanced Budget Act of 1997. And so you can understand why we've got an overall physician shortage and not just in anesthesiology. So I think we need to figure out a way of funding those slots.

Now, I think we have an opportunity with private practices. Private practices need more workforce, and I think that residents can be part of that workforce. Obviously, we have to provide the didactics, but you can do that by partnering with an academic institution.

So I think until the federal government can realize that we need more funding on graduate medical education, I think private industry can step up and do some of this. Certainly some of the hospital systems are doing this. If you look at HCA, Kaiser - they both are creating their own residency programs. So I think we can increase the pipeline. Now. That's not an immediate solution to all of that.

The other piece of that supply side is we've got to keep people in the workforce. And unfortunately, with the pandemic, we saw four years of retirements in one year. So we need to figure out a way - how do we keep people in the workforce. We've got a new generation coming into the workforce that thinks about work differently than maybe us baby boomers did. And so I think the key is going to be more flexible scheduling for people and really good listening and figuring out the governance structure in your group so people feel like they have a voice in the group structure and scheduling.

DR. STRIKER:

Let's take those pieces separately because I want to get back to the retention piece and how to how to retain physicians, also how to accommodate younger physicians in terms of a difference in expectations of of what work would look like. But back to the expanding of residency spots, number one, do you see any kind of pathway forward where the government can be convinced to fund more residency spots, or is that something that really is pie in the sky?

DR. PETERSON:

Well, I think it's possible. It's interesting. I had a conversation with Dr. Tracey Striker recently and she's on a government task force, interestingly, out of the Department of Education, because there are a number of American medical students, but they're going to school outside of the United States, either in the Caribbean or other places, and then they have some difficulty getting residency slots and then they have this huge amount of debt and they're getting evidently some funding or loans through the Department of Education. And so that is being looked at, which is different than the CMS funding them. So I think we push on that. That should be part of our advocacy legislative agenda to push the federal government to do that.

But I would say that we have had some success at the state level. I live in Texas and we've ranked poorly in physicians per capita for a number of years, and we're a very fast growing state. And so the state has put millions of dollars into graduate medical education funding, which has supplemented the residency programs in Texas, which doesn't completely get us to where we need to be, but is certainly helpful.

But I would also suggest that I think the numbers are there if you do the pro forma for private practices, working with academic institutions to fund some of these slots themselves, because I think it's less expensive labor than a nurse anesthetist or an AA, an anesthesiologist assistant, or other faculty. And so I think all three of those, we need to look at federal, state and private funding.

DR. STRIKER:

And then with regard to private practice helping to fund some of these spots, it certainly makes sense from a financial standpoint. But I know that there are a lot of programs, any practice, whether it's a program, an academic one or a private practice that really does just want to bolster their workforce. And so how do you parse that out, where we are fulfilling a mission of education and preparing young anesthesiologists for the future without having it be a foregone conclusion that they're going to have to go to private practice or academics. And I think it I mean, I imagine it might cut both ways. In other words, I think any program potentially could do this. They want to train their own individuals so they can fill their workforce. I guess what I'm asking, is there a conflict of interest there with with that kind of a partnership? And maybe there isn't. I'm just I'm genuinely curious.

DR. PETERSON:

I don't think there has to be. I think we have a lot of good examples of where it does work. So I'm in a freestanding children's hospital and really for decades we've had all of the military residents rotate through for their pediatric anesthesia training. We also have residents from UTMB rotate through and we understand what the educational needs of the residents are and we rotate them through the various services, you know, areas that that they need exposure to. And so I think it can work for private practices that are interested in doing that. I know that we're going to be meeting with a couple of private practices at the ASA meeting that are interested in this. And I think we also have some examples in the state where some of the large, big groups I know USAP is one of them that is working with one of the universities to incorporate residents in in their workforce in private practice. And so I think obviously we've got to make sure that the educational needs of the residents are fulfilled, that it's not just for service, but I think it can be done.

DR. STRIKER:

Well. I do want to talk some more about how we retain workforce, how we cater to maybe a newer generation of physicians. And before we do that, let's take a short patient safety break.

(SOUNDBITE OF MUSIC):

DR. ALEX ARRIAGE:

Hi, this is Dr. Alex Arriaga with the ASA Patient Safety Editorial Board.

Perioperative insulin administration in the pediatric population requires attention to detail. There are considerations pertaining to perioperative fasting, insulin formulations and dosing, and management of hyperglycemia, hyperglycemia, and other potential metabolic abnormalities. In addition, insulin pumps and continuous glucose monitors are becoming increasingly common. Attention to principles of patient safety can help avoid preventable patient harm regarding perioperative insulin administration. Avoid excessive reliance on verbal communications over those that are written. Have an ongoing mechanism to review insulin order sets and policies with attention to any insulin ordering practices that may be unclear. Provide clinicians with a means for updated and accessible education on the latest in perioperative diabetic management. By promoting patient safety and best practices in perioperative insulin administration, health care professionals can work together towards providing even safer anesthetic care to the pediatric population.

VO:

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

DR. STRIKER:

Well, we're back. So, Dr. Petersen, let's talk about some of the issues you touched on before with how maybe the younger generation looks at work as opposed to people that have been around a lot longer and and maybe some of the challenges with retaining physicians that you alluded to.

DR. PETERSON:

Yes, I think it's a challenge, you know, on both ends of the spectrum, really. I think people that are close to retirement age and then maybe young people coming in who have got young families and all the pressures that entails. I think the pandemic really was a stressful event for young families when schools closed down, daycare centers closed down. And so I think we need to figure out a way of supporting folks in the workforce that are at those critical stages in their career. So how do we accommodate what we need and getting the services done and our operating rooms and other non

operating room areas, but be able to make some accommodation for their needs and every group is going to be different. I know some people are looking at having nocturnes so you have less night call. Some might be where you have a different schedule where maybe people come in a little bit later in the morning and stay later. Kind of a swing shift. But I think offering some flexibilities is helpful. And then on the retirement end, I think looking at job sharing, whether it's a two for one or a four for three, a lot of groups I know are doing that and have done that very successfully so that people have less call and a little bit more free time. So I think those are areas where we obviously it's more of a challenge from a management perspective, not having a cookie cutter, everybody exactly the same. But I think offering those flexibilities will make groups more attractive and we'll be able to retain people.

The other thing is kind of from an institutional perspective. I know from my staff, I'm Chief Operating Officer at our children's hospital. Having child care on site is a big help for our physicians and other staff. And it was a great help during the pandemic because we never really closed it and we were able to offer actually more support for the older children, the school age children, when schools didn't reopen. We basically hired schoolteachers and people could bring their kids to either our auditoriums or some of the workspaces that had been vacated for people working from home where we had school teachers overseeing their work and they were in a safe environment. So I think we need to look at being more family friendly to the younger workforce, but also valuing the older workforce as well.

DR. STRIKER:

Well, I imagine it's a little bit of a paradox because when you want to implement these innovations or policies, you need staff. I mean, the more staff you have, the easier it is to be flexible. But it's going to be hard to get the staff without implementing the policies. And so how much institutional support is there, or should there be, to at least help subsidize some of these innovative ways of staffing so that the workforce can be accommodated or or evolved to accommodate the newer generation? You're in a great position to maybe talk about that with your administrative roles, but I imagine that that's easier said than done. If a hospital doesn't want to shut down sites or surgeons don't want to operate at different times, you know, when you're trying to maybe get to a more stable situation.

DR. PETERSON:

Yeah, I think it is a huge challenge right now. I don't want to understate that. I think the way I look at it is, I'm better off having a part time person than having a zero FTE. And so I think some of it, where you can try to plan ahead, you should. So, you know, I

personally went to, you know, folks in our anesthesia group and, you know, I have proposed different models that are out there because I know that I have a number of people that are at or technically past so called retirement age, whatever that is, that past the age of 65 at least. And I said, I want you guys to think about this and because I want to be able to plan ahead. And so eventually four people did come and said, we would like to do a job sharing arrangement. But, you know, that gave me a year to plan ahead. So then I know that when we're recruiting, I can recruit those extra FTE positions and I'm not going to burn out people and have somebody quit with only a 90 days notice. So I think some of it is you may not be able to do it right away, but if you can work with a group and say, let's work towards this goal, you might keep people engaged until you can get that workforce that you need.

I think from an institutional perspective, you know, this kind of gets on the demand side. We've used some of our other physician staff, like our pediatric intensivits, is to help us with sedation in children because I don't have enough anesthesiologists. And that's not a paid service by Texas Medicaid currently, because they're not registered as as anesthesiologists. And so I may not get a professional fee for that, but it certainly gets children their studies that they need to get done. So it increases patient satisfaction. And on the hospital side, I basically subsidize it with the facility fees that we get. So some of this does involve making sure you've got your finance team on the right page with you, but you know, the operating rooms and ICU are your high margin areas. And if you can somehow improve the number of patients that you see going through those areas, even though it may require more of a subsidy, I think most hospitals can figure out that that is still overall a winner for them.

DR. STRIKER:

Well, let's talk a little bit more about O.R. efficiency. You mentioned this earlier about optimizing the efficiency in any given clinical environment and how that can be important. But talk a little bit about the things we can do to help with those efficiencies as anesthesiologists.

DR. PETERSON:

Well, I think we're the experts in that area or we should be. And I think working hand in hand with your top nursing administration and really working every day, every week on scheduling is very helpful, you know, making sure that your OR governance is done correctly so that block scheduling is is done efficiently. I think looking at how do you account for a scheduled time on a case? So the surgeon schedules for an hour and it takes 2 hours -- that wreaks havoc on the OR schedule. We don't really want to have gaps, but we don't want people to have to stay late and pay overtime either for my

nursing and other staff. And so I think really working towards making sure you've got cases scheduled appropriately during the day, as well as, obviously, having that OR culture where you're you're starting on time. And that's a shared responsibility, as we all know, between the surgeons and the anesthesiologists. Everybody has a part to play in that. And obviously the turnover time. I get surgeons complaining to me about, you know, so-and-so is too slow turning over. But I think trying to get the right metrics that you measure everybody by and then you try to … and sometimes you can help turn over times with other things, like do you need more housekeeping staff to mop the room or do you need more anesthesia techs to help the anesthesiologist? So there's other things that can be done that are maybe people that are a little bit easier to hire to help with that turnover time. But everybody, I think, likes to have an efficient day, and I think scheduling is a really key piece of that. I think anesthesiologists get really frustrated when they're their first ones there, you know, 6 or 6:30 and they're ready to go. And then the surgeons late or maybe they do start on time, but then there's cancellations or there's breaks in the schedule. They can't go home and be with their family. They have to stick around. But when there's gaps in the schedule, nobody really likes that.

DR. STRIKER:

Mm hmm. Certainly. How do you feel overall about the outlook on all this? Are you optimistic? Do you think we're we're going to be in for it for a while?

DR. PETERSON:

Well, I'm the ultimate optimist. So the good news is, is we have so many great young people that want to be anesthesiologists. So I really think we need to open up that pipeline. I think we need… this is the opportunity that we have really capitalizing on our leadership during COVID, where we hopefully work more closely with our hospital administrators to really sit down with your leadership and your hospital and the surgical leadership to try to make OR scheduling efficient for everyone, not just the surgeons. We want it to be efficient for them, but for everybody. And working really as a team to do that and then really looking at some different paradigms on how we deliver that sedation type services and the rest of our facilities that may not require an anesthesiologist to be present or even an anesthesia professional like an AA or CRNA. But potentially, if it's moderate sedation, you develop teams of sedation, nurses, and extra training to the doctors. And ASA'S got a great sedation module that can help with that training.

I think that it will get better. We will work through this, we'll work on our backlogs and we'll get through it. But we do have to think differently in the future so we don't burn

people out. I think we have to be very careful about burning out the people. We do have that. That's a death spiral and no organization wants to be in a death spiral.

DR. STRIKER:

No, absolutely. Well, before I let you go, I do want to touch on the November ASA Monitor. You're the guest editor for November's Monitor. Is there anything in that issue that surprised you or are there any ideas that you want to talk to our listeners about that we didn't cover in our conversation yet?

DR. PETERSON:

I don't really think so. We've really got a couple of articles on the supply side, some ideas on how you can incorporate residents in your practice and have more flexible staffing as well as, on the demand side, how how you can deal with that. And of course we have a whole meeting almost devoted to that that used to be called the practice management meeting. Now it's ADVANCE that we have in January and that's really all about OR metrics and how you make it more efficient. People that want more in depth, they can certainly attend those types of meetings, but hopefully this will give people an idea of where you can go with your institution. We do think that we need more in our workforce. I think we're overall, though, in a place of goodness that we're well respected and people want to be anesthesiologists. So kudos for our profession.

DR. STRIKER:

Well-stated. And thank you for joining us. It's a great and pertinent topic. I know it's on all of our minds and so appreciate you sharing the time and certainly your expertise with us.

DR. PETERSON:

It's been my pleasure.

DR. STRIKER:

Thank you to our listeners for tuning in to this episode and please tune in next week for our special live from annual meeting episode of Central Line. And in the meantime, please remember to review us, tell a friend about us, follow us on your favorite podcast platform and certainly don't forget to visit asamonitor.org to read more about all the workforce hot buttons we touched on today and a whole host of other issues that the Monitor covers. Thanks again.

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