DR. ADAM STRIKER:

Welcome back. I'm Dr. Adam Striker, and this is Central Line. Today, we have a terrific episode for you. We welcome doctors Christopher Troianos and Grant Linde to the show. And these two happen to be guest editors for a very hefty Monitor supplemental issue involving economics. I've already perused the issue. It's out. I'm excited to talk about it because there is a lot to get to today. So Doctor Troianos and Doctor Linde, welcome to the show.

DR. CHRISTOPHER TROIANOS:

Thank you. It's our pleasure to be here.

DR. GRANT LYNDE:

Yeah, thank you, Adam. It's exciting to be back.

DR. STRIKER:

Well, let's delve right into it. The interesting thing about this monitor issue, this publication is divided into three sections that collate topics around various themes of interest, but centrally speaking, related to economics. It's economics and equity, economics and patient safety, and the general economics of anesthesiology practice. And these pairings reflect the innovative collaboration that took place between various ASA sections, both in terms of the work product and this particular issue. And so I want to start off by talking about that dynamic, working with the different sections to put together this issue that really covers a lot of ground. So let's start with Doctor Troianos. Do you mind talking a little bit about that?
DR. TROIANOS:

Yeah, there may be a reason why it has an economic focus and I'll get to that in a minute. But as we all know, the ASA is really dedicated, as we read from its mission statement, to raising and maintaining the standards of medical practice, particularly of anesthesiology, and to improve patient care as a result. ASA supports its membership of physician anesthesiologists and really all members of the acute care teams to advocate for patients who require anesthetic care, critical care, or relief from pain. The ASA Monitor publications is really one such way that the ASA supports his members, and this particular April supplement, I think, takes the publication to the next level.

In terms of the committee work you referred to, there's a natural overlap of committee work within a section through the oversight that I and Grant have as section chairs. So for example, a couple of committees within my section on professional practice are the Committee on Economics and the Committee on Practice Management. They often work together on the best ways to educate the membership on topics such as alternative payment models, and then inform the membership on how that affects or may affect their medical practice. And actually the two committee chairs of economics and practice management actually sit on each other's committees and they often contribute to each other's work products. But there are less obvious opportunities to develop ASA work products across different sections, especially within committees of other sections. And so Doctor Lindy and I really seized this opportunity to promote that collaboration across our committees within my section of professional practice and Doctor Lindy section on professional standards, which are all within the Division of Professional Affairs, which is led by Doctor Lois Conley, who serves as the ASA Vice President for Professional Affairs.

We're really pleased on how the topics evolve, where the various committee representatives work closely together to create extremely valuable insights into the issues that we face today as a specialty. We sort of just let them run with this. And then we discovered that the topics, as you mentioned, did lend themselves to grouping with some common themes. And so we created those three sections you mentioned: economics and equity, economics and business, economics and patient safety. And if it does sound like the supplement is is slanted toward economic issues, I think there may be a couple of reasons. First of all, I chaired the ASA Committee on Economics for a few years, so there may be some bias there. But probably more importantly is that economic issues are placing a huge burden on our specialty as a whole. When we consider the demand for caregivers, who command more competitive salaries for their services, while in the context of declining payments from government payers in particular, to the increasing complexity of our older patients who require more intense care and oversight within the operating room and preoperatively, it's really daunting.
Many groups, both private and academic, are increasingly dependent on hospital support to remain viable and we are very concerned that it's not a sustainable long term strategy for our specialty. So that’s really why I think there’s a slant toward economics in many of the topics in this particular issue.

DR. STRIKER:

I do want to get into the details a little bit before we do. Dr. Linde, how was your experience working across the silos this way? Do you think there's something new about it or does this evolve work products in the ASA in any way?

DR. LYNDE:

I think that's a great question. And I think that as we look forward, there are a lot of opportunities within ASA to break down some of the silos between groups. For example, something near and dear to my heart, the Committee on Quality Management, Department, Administration, or QMDA, intersects with federal regulatory bodies. And when you think about that, amongst the many things that occur regulatory wise, we deal a lot with equipment and facilities, which ASA happens to have a committee on that. And so, you know, as you think through, none of us really live in a silo, but we need the ASA. We need to work across the aisle with people who are experts in these different areas in order to really get the results we want and have the success that we want as an organization. So I really do think there's a lot here.

DR. STRIKER:

Well, Dr. Linde, like I mentioned, I want to touch on all these categories. Let’s start with economics and patient safety. Patient safety is of paramount importance to what we do, and there is significant pressure on all of us to accomplish more with fewer resources. How do we know when production pressure is creating an unsafe clinical environment, and how can we preserve patient safety and provide our well-being and response to unreasonable production pressures?

DR. LYNDE:

Last week I was at the American College of Healthcare Executives Congress on Healthcare Leadership. And, quite frankly, this is a question everybody's asking because, you know, we’re under a lot of pressure, especially with the health care shortages, not only of physicians, of nurses, everybody. And hospitals are struggling to provide the services while they're under both financial pressures and staffing pressures. So if you think about it, just three years ago, our hospitals were doing pretty well. And
overall, they're making money and they were looking forward to working through alternative payment models. And, you know, we're really starting to think about this productivity model to a degree. But COVID happened and turned everything upside down. And, you know, as anyone who has looked at locums or hires locums, you know, our staffing costs are absolutely out of this world and inflation has hit the price of everything from ACE inhibitors to X rays. So there's a lot of financial hardship for hospitals across the country. And, you know, there are questions about how various hospitals can find their sustainability. And we all are probably asking all the same questions.

So our anesthesiology communities should consider having a personal checklist, asking some reflective questions before you get going in your day, like have you completed all your necessary important safety checks? Have you appropriately evaluated your patients? Have you communicated with your surgeons and nurses? Or even importantly, have I, if I anticipate any difficulties, do I have adequate backup for my plan B or plan C? You know, one of the other ones that's near and dear to my heart, do I feel well rested? And that can be a challenge in this environment, you know, having your basic needs taken care of. So I think we need to reflect on all these areas. And while we all want to take care of every patient and take care of our surgeons, sometimes we need to stop and take a breath before we move ahead. Because, you know, the reality is none of our patients wants to experience harm because we're rushing ahead and trying to do everything for everyone.

DR. STRIKER:

Well, when we talk about patient safety, that is something that's critically important to all of us. And I think that is a component of quality to me. When you define quality of anesthetic care, safe care is at the top of that list. And quality can encompass a lot of facets. And Doctor Troianos, it's a big topic quality. And if you don't mind talking to us a little bit about how you lead or develop a strong quality program, let's focus a little bit on leadership, how we, individual groups or we as a specialty, develop leaders to enhance their quality programs or utilize quality programs in such a way that it is beneficial to the practice at large.

DR. TROIANOS:

Well, that's a great question, Adam. And actually there is an article within the supplement that deals with that precise topic. But the bottom line is that there's an important balance between speaking up, you know, saying no to production pressures and the role of the leader to really support a just culture of speaking up. Anesthesiologists collaborate and interact not only with physicians of virtually every
specialty, but they also collaborate and interact with other stakeholders such as nursing, pharmacy, accreditation, risk management, biomedical engineering and operations, just to name a few. And it really behooves our health care systems to leverage our anesthesiologists’ comprehensive medical knowledge, their long history as patient safety advocates, and their operational expertise in the perioperative arena. Speaking of leadership, we are seeing more anesthesiologists serving in some type of hospital wide leadership role. They may become a chief quality officer, chief medical officer, chief operating officer. They could be presidents of the medical staff. And we know of several that are presidents, CEOs of a whole health care system. So it's really somewhat natural for us to use our interpersonal and interprofessional knowledge and communication skills that we use every day working in an operating room to create a hospital wide patient safety culture where we leverage our error analysis and prevention expertise to establish and implement high reliability systems to improve patient care.

I look at us as really being the center of the spoke, if you will, connecting the patient, the hospital environment and all who have some type of connection with the patient, whether it be the lab, radiology, cardiology, the surgeon or nursing. So that's that's the way I see ourselves as leaders within the health care system, particularly in this environment that, you know, advocates for patient safety and promoting quality.

DR. STRIKER:

And as I was reading these articles in the current supplement issue for the Monitor, a common theme amidst almost every article was the involvement of anesthesiology in hospital operations. Whether you call it the C suite, whether it's just clinical operations, administrative duties, whatever it is, it seemed like that was a common theme. Whatever the issue was, whether it's ethics, equity, safety, quality, that the anesthesiologists need to be involved in this decision making when it comes to organizational level decisions or local hospital level decisions. Would you agree?

DR. TROIANOS:

Absolutely. And we really, you know, shouldn't shy away from that. That is our future is to become leaders in this area. It's no longer a matter of, you know, how well can you squeeze the bag. It's it goes beyond in the operating room caring for that patient, but it’s interacting with that whole system. And the other people that intersect with that patient at that particular time, both before and after their surgery.

DR. STRIKER:
Dr. Linde, let's turn to equity. The existence of bias in medicine, it's prevalent. It's confirmed by numerous studies. There was a recent study, I believe, that found that 40% of first- and second-year medical students believe black people's skin is thicker than white peoples. And we have talked on this show a number of times about the ways biases can impact health outcomes. We’ve talked about it from a number of different angles. I'm wondering if you can talk about the need for a diverse workforce and and tell us where our specialty stands in the effort to diversify anesthesiology.

DR. LYNDE:

Yeah. As you point out, diversity is an incredibly important subject. And, you know, to many degrees, I think that the current political climate is preventing a thorough examination of many aspects of this important concept. At its core, diversity is recognition that no two humans are the same and that we all have different life experiences and may have different goals and prioritize our needs differently. And with that in mind, a particular interest to me is, is some of the artificial systemic barriers to inclusivity. For example, you know, our society in the United States emphasizes that you always need to progress in one’s career and that there's only one acceptable path to move forward. However, you know, we've really seen this as an arbitrary rule. There's no particular reason your path has to look a certain way. And, you know, there's certainly import to breaking that barrier down to allow our specialty to be more inclusive to people with young families, people who need to care for sick relatives or sick friends. And so this is a challenge that we need to work on as a whole. Anesthesiology has been improving as a specialty, but we certainly have a long ways to go. Despite the fact that women are around 50% of graduate medical school students. Only one third of the current residents in anesthesiology are female. And similarly, despite the fact that 30% of the US population identifies as black or Hispanic, only 14% of our residents identify as black or Hispanic. So, you know, I think there is a important direction that we all need to head to identify reasons for these barriers and ask ourselves, what are we doing to try to bring folks into the fold and to see what we can do as a specialty to say, okay, these are unacceptable barriers, preventing otherwise amazing people and amazing doctors from from joining us.

So ASA has taken many steps to increase diversity across the organization. Two examples I'll highlight right now is, first, the Committee on Professional Diversity sponsors a mentoring grant that successfully has developed many mentors and sponsorship pairings for a lot of impressive people involved in that, folks who are mentees and getting engaged in committees, their state components, and they collaboratively work on a project in the anticipation that gets presented at the annual meeting. Similarly, ASA, in its committee selection process, has improved the software that helps chairs to diversify their committees. And when I talk about diversity on
committees, I'm talking not only about sex or race, but also practice type. Private practice versus academic. Rural-urban. The geographic diversity and even career stage that people are at. And you know, when you think about it, why this is important, this diversity is important not only for our patients, because we are ultimately trying to provide safe care for our patients, but it's also important for our specialty because, quite frankly, there are issues that perhaps are very well known within a segment of our membership but may not be known or understood by another segment membership. And so by having diversity on the committees, it allows the committee work products to and ASA statements to represent us as a specialty and not any one particular group of individuals.

DR. STRIKER:

Let's talk a little bit about rural access, because that's another topic in this issue. You know, the economic realities of what is happening with rural access and specifically there's an article about pediatric rural access. And according to a recent study, this is cited in the article, nearly 10 million children in the United States live greater than 50 miles from a pediatric anesthesiologist. And that's certainly one example of how rural systems have limited resources available to them. So, Dr. Troianos, how do you reconcile the standards and guidelines put forth by national societies or specialties outside of anesthesiology with the reality of this limited resource in certain areas?

DR. TROIANOS:

Yeah, that's obviously a big challenge. I mean, as we know, children younger than the age of one have the highest incidence of morbidity and mortality under anesthesia. They have increased risks of hypoxemia, bradycardia, bronchospasm. And that prompts many places to choose something like two years of age as the cutoff for an anesthesiologist with special training or experience to care for these younger children. The American College of Surgeons or ASC guidelines also reflect a decreasing anesthetic risk with increasing age and subspecialty training or experience in pediatric anesthesiology, local hospital resources and support staff are really some of the most important safety factors to help mitigate these risks. Besides that study, European studies have also shown that experience of the senior member of the anesthesia team is one of the most beneficial determinants in patient outcomes. But the premise of the ASC guidelines is that younger patients, especially those with comorbidities, can be more safely cared for in tertiary care centers, with advanced resources readily available such as ECMO, supportive surgical specialties and medical specialists. But the reality is that many children, as you pointed out, don't live near one of those types of tertiary care centers.
So what rural hospitals grapple with is that the decision to transfer a patient has to be weighed against the risk that a delayed diagnosis or delayed treatment could have on that patient versus the potential benefits of treatment at that more specialized pediatric center. So one example might be, you know, appropriate care of an urgent or emergent medical condition, such as a teenager with testicular torsion. That may favor actually keeping the patient in that rural center for surgery. These patients, as has been shown and referred to by the American Board of Urology, that they have a two and a half times increased rate of testicular loss when the transfer is beyond just 30 miles. So the ABU considers surgical treatment of testicular torsion to be within the bounds of core urologic care that should be offered at a rural hospital. Similarly, care of an uncomplicated child presenting for relatively noncomplex surgery should likely also be considered within core anesthesiology training, and often that would afford the best chance for the best patient outcome.

But on the other hand, you know, rural hospitals may not provide this full spectrum of pediatric services that might be necessary for a particular child. I'm thinking things like neurosurgery or complicated general surgery. And they may not staff intensive care units that are specific for pediatric patients following surgery. And so for that situation, community and rural hospitals often create transfer agreement with specialized centers to facilitate that transfer of patients.

Another approach for rural hospitals and higher capability, tertiary care hospitals, is to create a more standardized pediatric management protocol, established and maybe further the use of telemedicine and improve inter-facility coordination and information transfer.

Finally, the other thing to consider is that rural hospitals need that whole perioperative team of anesthesiologists, surgeons, operating room nurses, and PACU nurses to maintain at least a baseline level of comfort and expertise with the care of pediatric patients. And this is an argument why rural centers should perform at least some routine pediatric surgeries in order to maintain that proficiency in the overall perioperative care of the pediatric patients. So deliberate practice is a foundational need for the establishment of and maintenance of skill and comfort in clinical care and transfer of children at a high rate may prevent anesthesiologists and other members of the perioperative team from maintaining that important skill set which becomes necessary when an emergency occurs. So failure to use this skill set in a routine setting does put the patient at risk of failure from lack of experience when a true emergency arises. So the solution then is to involve those, even without a fellowship, to develop or maintain some level of expertise in caring for children.

DR. STRIKER:
It's a tough line to toe for institutions that do not have access to a full complement of expertise and resources. Just as a little bit of a tangent here. Do you feel that the ACS guidelines have done a decent job of what they're trying to do, which is ideally, you know, optimize care for children? Or do you think it's are rural centers paying for this and a little a little more than they than they should? And maybe there's no easy answer. I'm just curious to get your take on.

DR. TROIANOS:

No, I mean, they've they've served a purpose to elevate the awareness that, you know, you have to have some specialized training and expertise in caring for, especially the smallest patients under two years of age. So I think that's where that role is. But, you know, you also have to weigh that, as I mentioned, and be realistic on what those capabilities might be, what the situation is, and is there a risk, more risk of transferring versus keeping the patient locally. But in the end, you know, you should have some level of expertise. But things like neurosurgery, etcetera, everybody recognizes are best served at a tertiary care facility. So it's a constant balance between maintaining the expertise locally for the basic stuff and having some transfer arrangement where, you know where the patients are going to go when they have more complicated problems.

DR. STRIKER:

Well, I want to ask you both some questions about economics and a little bit more about the business aspect of anesthesiology. So if you don't mind, can you stay with me through a short patient safety break?

(SOUNDBITE OF MUSIC)

DR. SCOTT WATKINS:

Hi, this is Doctor Scott Watkins with the ASA Patient Safety Editorial Board. Medication errors remain one of the greatest threats to patient safety in the operating room. Anesthesia providers often recognize drugs by the size, color, or shape of the packaging and use standard color labels to designate classes of drugs. For this reason, look alike, sound alike, medications are one of the leading contributors to medication errors in the operating room. Strategies to prevent errors from look alike sound alike drugs include: arranging drug trays so that look alike sound alike drugs are separated; use of color coded labels with tall man lettering; use of pre-filled medication syringes; using technology to scan barcodes and or vials; and using generic rather than brand names. Finally, no discussion of safe medication practice will be complete without a
reminder to always observe the five rights, the right patient, the right drug, the right dose, the right time and the right route.

VOICE OVER:

For more information on patient safety, visit asahq.org/patientsafet22.

DR. STRIKER:

Well, we're back. Let's talk a little bit more on reimbursement. Let's talk about the shift away from siloed fee for service arrangements toward quality and efficient programs or HQEPs. Dr. Troianos, do you mind telling our listeners a little more about this and how anesthesiology groups can leverage their expertise to enter HQEPs?

DR. TROIANOS:

Oh, certainly. So the concept is and the organizational frameworks we have, I think the ASA has done a nice job to educate people through the concept of the Perioperative Surgical Home. That serves really as a launching pad for collaboration with our surgical colleagues on process improvement, quality assurance, cost effectiveness to really optimize surgical outcomes. Co-management agreements, and as you mentioned, hospital quality and efficiency programs, the so-called HQEPs and clinically integrated networks, CINs, are three examples of organizational relationships that allow anesthesia groups to collaborate with perioperative stakeholders in health systems as a whole on shared goals. Co-management agreements do not require a high level of integration, but do allow the anesthesia groups to collaborate with health systems on achieving those goals. HQEPs build upon that collaboration as the hospitals bill alignment across clinical service lines and departments. In terms of compensation, specific compensation to a group or individuals could be construed in a number of ways. They can consist of fixed payments for their time spent on those administrative functions, or the arrangement can be in the form of variable payments to that individual or group based on achievement of predetermined quality or efficiency objectives. And these incentive-based compensation arrangements are usually with respect to a single service line, whereas the hospital quality and efficiency programs are broader in scope and involve multiple service lines across the health system. The target performance objectives that require coordination of care across multiple service lines therefore need to be broader in scope. The bottom line in all this is that as time goes on, we're going to see less fee for service arrangements where we just get paid for doing more, and more of a focus on quality outcomes and efficiency programs such as the HQEPs do for us.

DR. STRIKER:
Well, let's delve a little bit into politics, which is not something we often talk about on the show. You know, politics has always played a role in medicine to some degree, but I feel like the last decade it's become increasingly important for a number of reasons. Economics is certainly one of them, but there's also societal culture tentacles, regulatory tentacles to government influences. And I'm sure there's a lot of new ways in which politics and health care are now intersecting. Dr. Linde, I'm going to direct this to you. Number one, why is this happening? And number two, what can we do as clinicians to navigate all of these different stressors and hurdles, if you will?

DR. LYNDE:

Yeah. I mean, it's incredibly hard for me to think of a topic that doesn't have some sort of political angle these days. You know, whether it's a car you drive or the grocery store you shop at or even the type of vacation you take. You know, it seems like partisan politics are everywhere and people from both sides of the aisle have preferences that are part of their identity in that partisan politics. You know, beyond that, you know, why do we have disinformation? I think when you reflect on it, you know, some of this information exists for individuals to have fame or perhaps for financial gains. And then not to dive into conspiracies too far, but there is a degree that some disinformation is done as part of advertising campaigns by organizations or even by groups of people that are trying to sway large public interest in something for a variety of reasons. Sometimes it makes sense. Sometimes it's hard to even decipher why they're doing it.

So why does this persist in health care? You know, I think, first of all, our studies in health care are difficult for laypeople to decipher. Most recently, one thing that's sticking out in my mind is the Cochrane Review on whether or not face masks are helpful in pandemics. And the conclusions of this study were essentially, no, they aren't. But what's fascinating in that article is, is the authors of that particular article actually had a political agenda. The studies that they included were not very well controlled. And in fact, most of the studies that they included were actually from before COVID. And so I think it's difficult for anyone who really is dug into that one particular article to come away from it believing that face masks for general public have no purpose. But I highlight this article because it highlights some of the challenges in extinguishing some of the misinformation or disinformation that's out there. For example, you know, again, a layperson is going to find it difficult to be able to read all these supporting articles and to understand it or to understand some of the politics behind the authors and their own conflicts of interest. It also took a lot of time for me to read beyond the headlines and actually dig into some of the underlying data that that supported it. You know, when I think of Cochrane Review, I think of a very trustworthy organization. And on the surface, I want to trust what I see coming out of Cochrane or let's say Anesthesiology or JAMA.
You presume these are strong, peer reviewed manuscripts, and others have done some of that hard work and heavy lifting for me. So when claims are made by trustworthy groups or organizations, it’s hard to overcome that.

And finally, you know, social media spreads information incredibly quickly, and it causes misinformation to persist for extended periods of time. And that’s also another challenge that we face. And I think it’s just a completely new era from ten years ago or 20 years ago, where it took longer for information to trickle down through more centralized sources of news.

So how do we address. First of all, I think we do need to continue and strengthen their peer review process. You know, ASA and other medical organizations need to do their very best to be out front and be the pillars of truth and help clarify when these misperceptions are out there. I think we as individual clinicians also need to continue to have presence on social media. You know, some of the changes that have happened on Twitter since Elon Musk took over have made Twitter less attractive platform for for many of us to be on. However, I still think it's important that we all have a presence to try to point out when when misinformation is out there. And finally, you know, never, never discount that one-on-one campaign with patients. So, you know, I think back when I was in medical student in the 1990s, thinking how it was kind of a waste of time sometimes to talk to a patient who had been chain smoking, that they should give it up. But, you know, through talking with every patient who comes in door with a history of smoking, you will eventually convince folks that that that's not the thing to do. And and look where we are today. You know, the incidence of smoking in our country is much lower and we’re all much healthier for it. So just one example of of how we as individuals can affect the broader landscape of misinformation.

DR. STRIKER:

We mentioned social media. I notice sometimes on social media where you have reputable physicians that will make commentary on whatever topic that might be. It might be pertinent at the time. And they may even be an expert in the field. Then you see a lot of responses to that for whatever reason, whether it’s political, whether it’s selfish, whatever, probably from many people that don't have the same expertise. And this is not unique to medicine, but I'm focusing on it because that's what we're talking about. But how do we as physicians, how do we as a specialty, maintain that degree of reputability, that degree of authoritativeness amidst all this noise? Because I do feel that the more we sometimes try, the more it ends up just working against us, because all it takes is one other person who may have a little credential or may cite some other study or some other fact that gets a lot of traction and it just sort of washes away or dilutes the opinion or the insight of of a person that does have that expertise and reputation. And
so how do we as a field navigate this? You mentioned we need to be more involved. Do we need to be more involved than we are? Do we need to be less involved? Do we need to target our involvement? What do you think?

DR. LYNDE:

Yeah, that's incredibly tough question. I am one who believes that we need to be more involved or more than just more involved I'd say more engaged, you know. And I think that there's a degree that we need to be comfortable saying, I don't know or we don't know yet. One thing that's interesting to me right now is this conversation around what's the origins of the COVID virus? You know, did it come from a lab? Did it come from nature? You know, where did it come from? And there are a couple of things that I noticed in social media. One was this idea of of, you know, did it come from one place or another? And I think today it's still impossible to know with absolute certainty the origins of the virus. We have some hints and clues. One of the questions I actually keep asking is, why does it matter and how certain do we need to be before you can plant your flag in it? And it doesn't seem like anyone really has a good answer to that. Now, another piece I've seen in this discussion, though, is when people are engaged in this, they are pointing out, let's say, lack of knowledge at the time as a lie. So one thing that I saw recently was they quoted President Biden from I think it was two summers ago, and he was on television saying that if you got vaccinated that you wouldn't get COVID. And, you know, clearly several of us, many of us have have had the vaccines and are fully vaccinated and still can get COVID. And what we've learned since the time that the vaccines came out is that the severity of COVID following vaccine is much lower than what it would could have otherwise been. It may reduce transmission of COVID, but the degree of that is unclear. But it's certainly clear that you can get COVID despite being vaccinated. Was that a lie at the time? Absolutely not. You know, President Biden and the CDC said what they thought was was correct, that, you know, the COVID vaccine was going to be like the polio vaccine or, you know, measles vaccine, that if you're vaccinated and you have a good immune response, that you're not going to get that disease. But clearly, it's COVID doesn't work that way and certainly wasn't a lie. But at the same time, it was we didn't have all the information at the time. And that is a piece that we as health care providers need to be open about is when we have incomplete information about a particular area.

DR. STRIKER:

This is a big problem for a number of fields, not just medicine, but there's so much information out there, so much information and so much access to information. And it is being wielded and utilized in many different manners and not oftentimes with the
nuance and expertise that is necessary to utilize it as appropriately as it should be. So this will be something we'll have to continue to talk about.

DR. TROIANOS:

Well Adam that's exactly right. And if I can add to I think the take home message is that that our patients are friends, families are going to question things more than maybe they did 10 or 20 years ago because they have such ready access to that information and because there's so much information out there. So one of our pain doctors told me about a patient who came to see her not because of a pain problem, but she wanted to know whether she should take the vaccine. And she trusted that doctor's opinion, despite, you know, everything that was in in the press. It's that kind of thing that sometimes we lose when we don’t have that personal long-term relationship with our doctors that we once did.

DR. STRIKER:

Yeah, absolutely. Well, it is a meaty supplemental issue. And and this discussion is just skim the surface. There's there's articles in there discussing the No Surprises act, the impact of that, the future of the specialty as it relates to the economic realities of what of what we will face. Because we just skimmed the surface and we don't have an unlimited amount of time, I would love if each of you could tell me one thing you learned or took away from working on this project or something that you'd like our listeners to know about or something that you think is important. Dr. Troianos, why don't we start with you?

DR. TROIANOS:

Sure, sure. Well, the one take home message, I think, is that we are truly at a crossroads within our specialty. And, you know, we know the challenges in trying to recruit health care workers in general in our specialties. And we know that payments are being challenged as well. But those who lead well during these challenging times will provide great benefit to our health care systems and our patients for years to come. The good news is, is that anesthesiologists are especially well suited to lead their hospital systems right now and to guide the right decisions being made that will allow for a financially viable approach going into the future. And we know it's in our DNA to serve and protect our patients in order to ensure those best outcomes. Those are the biggest take home messages that I had from this supplement. And the one other thing is that, my goodness, the ASA is filled with such talented individuals that are willing to probably spend time at home weekends, evening writing these articles, sharing their insights and knowledge and support of our specialty, our patients and our members to being the best
they can be. And I specifically want to thank our ASA leadership, particularly Dr. Connolly, for entrusting Dr. Linde and me to shepherd this important project for our members. So thank you for the opportunity to do that and for sharing our thoughts here during this podcast.

DR. STRIKER:

Of course. Of course. Dr. Linde.

DR. LYNDE:

I think what really stood out to me was how absolutely incredible our organization is and how incredible the people within the committees are and what wonderful things you can see when you take people and you have them work on a task together and outside their silos of one single perspective. I think that this is one of the best series collections of Monitor articles that that I've read. And granted, I'm kind of biased here, but, um, you know, I think that these articles, there's something in it for everyone. And I think that there's, there's a lot for the members of all the professional affairs committees can be proud of. And I'm very hopeful for where we're headed as a specialty based upon what I read here. And I think that the best is yet to come.

DR. STRIKER:

Well, I completely agree. I think this issue is it's a it's a fantastic issue. It's well done. Covers a lot and chock full of information. I certainly highly recommend to anybody listening to this podcast, read this this particular issue of the Monitor, even if you don't read the whole thing, there's plenty to pick and choose from, and I guarantee you're going to be the better for it. And I just want to thank both of you for joining us today and giving us some insight on the production of this issue, but also the content of it. I just really appreciate you both both joining us today.

DR. LYNDE:

Thank you very much.

DR. LYNDE: Thank you so much.

(SOUNDBITE OF MUSIC)

DR. STRIKER:
You can check out the monitor issue at asamonitor.org. It is out now online. We will be back next week. So please tune in again next time. And thanks to all our listeners. Take care.

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