Anaesthesia’s existential crisis

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A brief history of anaesthesia
Anaesthesia is now a science. It was once an art. (Before that it was a contact sport). Enlightened individuals rendered a dangerous pursuit safe. Progress moved anaesthesia on. More daring, heroic surgery was performed and we expanded surgery into the chest and brain, to the very young, then the very old. And still that was not enough. It burst out of the operating room and built its own intensive care clinics for pain and threw its weight around on the labour floor. All the while anaesthesia was refined and refreshed becoming cleaner, leaner and meaner. Unthinkable operations are casually performed with great results. ‘Easier’ work is now handed to non-physicians. But now – a quandary. A stable speciality is fragmenting. ICM has moved out and is considering a divorce. Pain is in the spare bedroom. The remnant, anaesthesia, is under threat, with external viewers now questioning the need for so many anaesthetic doctors. One option is to make ourselves more relevant, to look outside the theatres again, to take on new tasks and deliver them in a different way. To this end we have the notion of perioperative medicine. But quite what is it?

The RCoA has released a ‘Vision Document’ with accompanying animation. Reading this, it seems as if the very foundations of anaesthesia as a specialty are being challenged: its meaning, its purpose, its value. If you change what we call ourselves, and we change what we actually do, then we are undergoing an existential crisis. If that is the case then a little bit more thought is required. More discussion. More consultation. In real life, an existential crisis is met with a period of deep introspection. Not just buying a second-hand copy of Sartre. Rather, meditation, questioning, researching, disassembling then reassembling one’s essence. Anaesthesia must do the same. If the specialty of anaesthesia is going to change so fundamentally, it needs to be done with a clear mandate. We understand that the ‘conversation is just beginning’ and that the ‘Vision’ is just that – not a plan. We look forward, therefore, to being part of the consultation and offer this as a constructive opener.

Laudator temporis acti
We are not old stick-in-the-muds. Nor do we have subscriptions to the tricky vein society. By nature we really are not mensheviks. Sitting diametrically opposite the awkward squad, we don’t think we have a Cassandra complex. But, regarding the College and perioperative medicine we feel that we are re-inventing the wheel somewhat. Part of the push of perioperative medicine is to smooth out and boost the post-operative care of the high-risk patient. Ramp up level 1, some short term level 2, maybe level 3 critical care. Flexible, tailored, timely. Perhaps delivered in a specialised unit with aggressive pain management and attention to the principles of enhanced recovery. We agree with this. Wholeheartedly. But put it another way, bring critical care and pain more into the fold. Let it mesh better with anaesthesia. This strikes us as rather odd. The College has wittingly or not, admittedly or not, cleaved off ICM. Pain too. These Faculties act like separate colleges in the making. Rather than being inside the tent they seem to be kingdoms who protect their territory. Hence the push for more and more training in ICM, making it less and less possible to perform both ICM and anaesthesia to a high level. Likewise the plethora of rigid definitions of critical care standards that must be adhered to receive the necessary tariffs from commissioners.

And more worryingly, the dogma of the FPM which relates that acute-pain rounds can only be performed by those with higher pain competences. The way it appears is that good, seamless, flexible perioperative care has been hampered by internal walls that have been erected by the College and Faculties. (Don’t get us wrong – for good intention). Instead of knocking these walls down, and loosening the training and appointment requirements, will this perioperative push serve to build more barriers? Fellow posts and Masters courses in perioperative medicine have already begun, and we all know there will be a desire for a faculty of perioperative medicine. To cut to the chase, are we empire building? If you want good general perioperative care, you do not achieve this by developing further sub-specialties. ‘Tear down this wall’ as Ronald Reagan had it.

...the sense we are being sold something must be addressed
The reality is more important than the ideas

Perioperative medicine appears to emphasise care from the community through the hospital to the community again – a concert of multi-disciplinary professionals with the perioperative physician as its conductor. Sounds great and, for those who have not had the pleasure of watching the video, it looks great too. But there are issues. First, to put it bluntly – do you not think we had thought of this? Yes, our patients should see a smoking cessation service, yes, an exercise programme. Doubtless, in time, protein shakes and electrolyte fizzy drinks. Pulse contour analysis, CPEX, Suggamadex, Post-Anaesthesia Care Units - yes, yes, yes. But bundling it up in a wrapper and calling it ‘perioperative medicine’ is not what is stopping us. What does is moolah. We have limited resources. We would do all of these things if we could. We do not lack coordination, ambition, intelligence. We lack greenback.

If you are demanding a change of emphasis, if you are re-designing the machine, this requires a change of components. This is a switch of resources. Whether you like it or not, and whether you mean it or not, then this will move resources away from arguably more important but less sexy areas. Jaded critical care consultants (are there any other kind?) will jump at the chance to run PACUs. Nobody ever lay awake at night dreaming of a pre-assessment clinic, but they may do if running a perioperative outreach service. Careful what you wish for.

Throughout this, are we not marginalising the surgeon? Kehlet in July’s BJA makes the point politely that the word surgeon rarely appears in these documents. However, surgeons have been the prime movers in enhanced recovery programs. A multi-disciplinary project needs to be just that. The leadership is based on those who demonstrate the expertise rather than the ‘sole responsibility of a single profession’. Teams work efficiently when team members take the lead when required. We all know our roles we do not need to preach about the importance of team work and then unilaterally declare ourselves captain, it has an unsteady effect. Let’s all be very careful this does not escalate to a turf war.

Engineer or oily rag

Perioperative medicine appeared with the fanfare of a new Apple iPhone. Slick, sleek and a little bit slippery. A product being advertised. Marketing is usually the process of selling you something you do not particularly need – why is this any different? Where was the consultation? Instead there was a media blitz. There was no evolution; it just arrived as a fait accompli. There was no meaningful dialogue, rather there are religious zealots (just look at the evangelical twitter feed of #rcoaperiop!). Not that there was nothing to admire. We give a tip of the hat to the person who coined the phrase ‘perioptimist’. Likewise the animation is smooth. And again, trying to improve care is why we are here. But it sticks in the craw. Who are we trying to convince – the outside (surgeons and patients) or the inside (anaesthetists)? Either way it was far too light on science, research, figures. A cartoon man rocking up for his big case and suffering renal failure is counterpointed by the same figure undergoing vigorous perioperative medicine interventions and surviving cancer-free with a healthy renal system. You are entitled to your own opinions, of course. You are just not entitled to your own facts.

This sense that we are being sold something must be addressed, by telling us what it is we are to become. We could start with a rock-solid definition. But there is not one. So is the aim to improve perioperative mortality and morbidity (especially in high risk cases)? Who could possibly take issue with this? Not us. But in the same way there is no problem with aims to end poverty, stamp out bigotry and stop wars. Erstwhile, but actually not helpful unless we have more detail. And that seems to be lacking. If the change in what we do is as grand as the media puff then we need to know what we are signing up for. When a concept is ill-defined but attractive there is a tendency for all solutions to all problems to be projected onto it. How do we solve the M&M problems highlighted by NELA? Answer – POM. How do we solve the NHS budgetary problems? Answer – POM. How do we reduce the burden of surgery on ITU? Answer – POM. And while all this may be prove to be true unless we have a great deal more precision in what is being asked then, it will not become true and disappointment will follow.

One area where the definition needs to be firmed-up is around the word ‘medicine’. The phrase perioperative physician is being used. Is your post-operative pneumonia to be treated by us? Personally one would prefer a respiratory physician. Likewise for perioperative acute coronary syndrome, see a cardiologist. Or is this in addition to the medical back-up? Are we there as an extra layer? Do we have the resources for that? I have heard some prominent speakers peddle the line that if we extant anaesthetists are not happy to take up this mantle then the acute medics will. Really? Acute medicine has problems but not as bad as this. Orthogeriatrics really is just a niche that cannot expand further.

But perhaps that is to misrepresent it. The perioperative physician perhaps is the engineer of a complex machine, not the oily rag. The signpost to the smoking cessation clinic, the triager of risk, the conductor of the post-anaesthetic care unit. Although not a novel concept we should mention that that was once the job for surgical SHOs. What has changed for them, and for us? Now, if the teaching of medical students, the resource crisis, the education of specialist nurses is not up to scratch, it does not mandate that we plug the gap in what hardly sounds like a gratifying job.
‘What is so hard about pushing propofol anyway?’
...as one proponent of perioperative medicine once said. Despite the assurances that anaesthesia delivery is central to the model there seems precious little evidence of this. Anaesthesia is easily denigrated, disrespected, undervalued, marginalised, pushed to the side. Yes, perioperative care is enabled by preoperative clinics; it is aided by solid postop care. But the major determinant is the anaesthesia. We must not let our magpie gaze rest on the shiny periop bandwagon, when it should be firmly locked on our core, solid work which happens in theatre. Time and time again senior trainers and examiners complain of neglected basics: nerve stimulators not used, cannulas not flushed, airways poorly handled. The lack of attention to detail in our stock-in-trade will not be helped by concentrating elsewhere.

So why has this raised its head? The College for a long time has felt the need to respond to the constant clamour to make our specialty more visible, more important. We have been down this route before – it resulted in World Anaesthesia Day, which is best left unrepeated. Do we need to promote ourselves? Like film directors, referees and ninjas – you never notice the good ones. Should it be the same for the specialty as a whole? We are now in a strange position where units are ‘re-branding’ themselves ‘Departments of Perioperative Medicine’ without actually knowing what it is. It feels like style over substance. It might not be, but it feels a bit like that.

The College should be saluted for trying to set an agenda, for setting priorities. But equally it could be criticised for the opaque manner in which this has happened. Was there outrage of the Fellows about the issue of perioperative medicine? Not from trainers meetings. Was it a burning issue from patient groups? No, but patient safety is. Were the Clinical Directors getting het-up demanding progress in perioperative medicine? No, quality improvement is their thing. Periop medicine – less so. The benefits to patients are not clearly drawn; nor the risks. But are there benefits to others? To the specialty? Is this simple specialty imperialism? To sub-sections? – is this a haven for burnt out intensivists? To greasy-pole climbers? – there are reputations to be made after all. To researchers? – fellows are needed, grants will doubtless appear? We don’t believe in conspiracies but the benefit to the patient has to be clearly drawn and more apparent than the benefit to some sections of the specialty.

If we want to improve patient perioperative care can this not be done simply by the mandarins of the College? Make pre-assessment a mandatory block, reduce the stipulations by ICM and pain, tweak the curriculum here and there. Focussing on patient safety and quality improvement will then take us to where we want to go. Let local people take local decisions, put the right person in charge at the right time. When new initiatives come along implement them in isolation. This is what we have been doing for a long time. Retain some of what made the good old days good. If we want to promote medicine, actual medicine, go further and demand the ACCS project a success and mandate it. There is absolutely no need to create a new science. Using POM as a wrapper, as a shorthand, for the College to gain leverage within Whitehall makes some sense, but not just to sound grander, not at the cost of other initiatives and certainly not to create a war with our surgical colleagues.