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ARTIGO DE PERSPECTIVA

O Mal-estar na Anestesiologia Americana

The Malaise in American Anesthesiology

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INTRODUCTION

Seven years ago, I wrote an opinion column called "Don't Quit This Day Job" that appeared in the Sunday edition of the *New York Times*,[1] earning me a certain amount of fame or notoriety, depending on your point of view. The premise was simple: I rued the fact that more American physicians were choosing to work part-time - women more than men. I believed that they would miss out on valuable experience and opportunities for advancement, and that all of us owe some payback to the American taxpayers who invested heavily in our medical education and residency training.

Do I regret writing that article? Not at all. Would I make the same arguments today? No.

Over the past seven years, we have seen in the United States (US) a disturbing trend toward open disregard - contempt, even - for physicians, and a pervasive effort by legislators and hospital administrators to reduce their influence. American physicians across all specialties are feeling a deep malaise, and many are cutting back on their work commitment or quitting entirely. I can not blame them. Here is my view of the top three reasons why this is happening in anesthesiology:

- Loss of autonomy;
- Anti-intellectualism in America;
- Economic threat.

LOSS OF AUTONOMY

Over the past 20 years, there has been a remarkable shift in the US toward consolidation of hospitals into large healthcare systems, and absorption of private anesthesiology groups into corporate healthcare delivery organizations.[2] Anesthesiologists are more likely today to be paid a fixed salary with some incentive component than to be paid for services provided in an "eat what you kill" model. They have far less power to control their own call and vacation schedules, case assignments, equipment purchasing, and other decisions that affect their daily lives.

If the organization purchases an electronic health record system that is not user-friendly, there is little that anesthesiologists can do about it. Unless they reach high leadership positions, they have little say in the quality and production metrics by which their performance may be measured. The pressure to increase production - to do more cases in less time - can lead to faults in preoperative evaluation and case preparation, and the threat of malpractice lawsuits. The trend in the US to evaluate physicians based on patient satisfaction scores has had the perverse effect of incentivizing physician actions that are not necessarily in patients' best interests.[3] For emergency room physicians, this pressure can lead to over-prescription of antibiotics and opioids. For anesthesiologists, it can lead to the fear of angering a patient if a case is delayed or postponed for any reason. All these trends contribute to increasing rates of exhaustion, frustration, and burnout.

Evidence-based medicine has played an unexpected part in physician loss of autonomy. Today, individual decision-making is devalued, and the application of protocols is considered best practice. No doubt decision-support technology eventually will help us reduce uncertainty in clinical care, as machine-learning becomes more sophisticated. But the front-line anesthesiologist knows that there is no technology available today - or on the horizon - with the capability to process all the clinical variables involved in managing a high-risk patient having complex surgery in real time. This is the sticking point where today's clinical guidelines and "evidence-based medicine" become more hindrance than help.

In the US today, there are thousands of published guidelines.

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Many of them overlap, and not all of them agree. Some are tainted by conflict of interest.[4] The experienced anesthesiologist learns that "evidence-based" protocols in the US come and go, often at the whim of outside accrediting organizations like The Joint Commission. A few years ago, we were supposed to give beta-blockers to everyone with any cardiac risk factors; now we are advised that aggressive perioperative beta-blockade is associated with increased risk of stroke and mortality.[5] Our hospitals mandate the use of an expensive, proprietary blend of chlorhexidine and alcohol for skin cleansing despite the fact that the US Department of Justice fined the manufacturer $40 million in 2014 for making false claims about its effectiveness.[6]

Medical research, including the anesthesiology literature, sometimes proves to be flawed or even fraudulent. Large treatment effects shown in early trials often disappear when studies are replicated with larger populations.[7] This phenomenon is known as the "Proteus effect".[8] Yet policy decisions and clinical habits are tough to reverse once an "evidence-based" protocol has been widely adopted, even if the evidence is later disproved. Physicians resent the fact that regulators and administrators who never touch patients have the power to define quality care by equating it to compliance with protocols. Physicians know that there may be no correlation between following a protocol and actual outcome improvement. (The protocol mandating that physicians advise patients to quit smoking is an obvious example.) When pay and advancement are linked to externally imposed rules that cannot be quickly overturned even when they are misguided or wrong, it is easy to see how physicians can become cynical.

ANTI-INTELLECTUALISM IN AMERICA

There is a long-standing tradition in America of distrusting higher learning and intellectual achievement. More than 50 years ago, Richard Hofstadter wrote a Pulitzer-prize winning book called "Anti-intellectualism in American Life",[9] noting that the problem is "older than our national identity." People emigrated to America to escape the control of their educated upper-class rulers. Many Americans have an ingrained distrust of "eggheads", a derisive term applied to intellectuals who are out of touch with ordinary people. Since the 18th century, the dismissive label "bluestocking" has been used to disparage and marginalize intelligent, educated women.

For a long time, physicians were exempt from anti-intellectual disdain because people respected their knowledge and dedication. Popular American television shows in the 1960s celebrated physician heroes, including neurosurgeon Ben Casey, family physician Marcus Welby, and the dashing young intern, Dr. Kildare. However, greater opportunities for women in medicine over the next decades coincided with a decline in public respect for physicians. Education as a value in its own right is under siege today, with widespread cuts to funding for public education since the onset of the 2008 economic recession. University education is criticized as impractical unless it focuses on specific job training. The ability to read in depth, think critically, and synthesize complex ideas is no longer America's goal in higher education. How to accomplish tasks quickly and cheaply is the main objective in healthcare.

It is easy to make the mistake of thinking that American anti-intellectualism is found solely among religious fundamentalists and poorly educated people in rural areas. America's strong libertarian streak sometimes leads to distrust of experts even by educated people who would describe themselves as liberal or progressive. A perfect example of this phenomenon is the high rate of unvaccinated children in some of America's most affluent areas, while poor neighborhoods typically have high vaccination rates because children must be vaccinated to enter public school. Though the "evidence" associating vaccinations with autism has been thoroughly debunked, some affluent parents ignore medical advice to vaccinate their children, believing that they know better than their doctors. They feel no social responsibility to contribute to herd immunity for everyone else's children.

In this context, the rise of advanced practice nurses as a cheaper alternative to physicians in healthcare delivery makes perfect sense, driven simultaneously by the aim to tamp down America's high healthcare costs and to undermine the intellectual authority and influence of physicians. In American anesthesiology, advanced practice nurses with training in anesthesia are referred to as "Certified Registered Nurse Anesthetists." In some American states, including California, nurse anesthetists can give anesthesia without any physician oversight at all. Their professional association is advocating stridently for "independent practice" nationwide, refusing to acknowledge the obvious gap in education and training between nurses and physicians. Physicians who raise concerns about the potential risks of independent nurse practice have been disciplined or even fired by their employers. This has had a demoralizing effect on anesthesiologists, to no one's surprise.

ECONOMIC THREAT

One major reason why healthcare is so expensive in the US is because of the tangled web of private insurance companies, each with its own different rules and documentation requirements, in addition to the government-run insurance system for the elderly and disabled known as the Centers for Medicare and Medicaid Services. It requires leagues of employees in every physician office and healthcare system to code and submit claims to all these entities, respond to their questions, resubmit denied claims, and track payments.

The cost, complexity and dysfunction of the payment system

has led to an outcry for the US to move to a single-payer system, often referred to by followers of Vermont's Senator Bernie Sanders as "Medicare for All". Many questions arise. What would happen to the thousands of Americans currently working for insurance companies and medical billing offices? Are American taxpayers willing to shoulder the burden of paying for comprehensive healthcare for everyone in America?

The inconvenient fact that weighs most heavily on the minds of American physicians is this: their practices have balanced the books up to now by compensating for inadequate Medicare and Medicaid payments with the higher payments they usually receive from private insurers. However, payments from private insurers are declining steadily, with no relief foreseen.

President Obama's Affordable Care Act requires insurers to issue comprehensive policies, and offers no option for consumers to buy cheaper policies with limited coverage. Since comprehensive coverage is more expensive, insurers began to write new policies with far higher deductibles than patients ever paid in the past. Millions of people who were uninsured could now get coverage, but many bought plans with deductibles of $1000 or more. In 2017, 43% of private-sector employees were enrolled in high-deductible plans, compared to only 15% in 2007.[10] The result has been that many patients receive care but cannot afford to pay the balance of their bills from hospitals and physicians. Personal declarations of bankruptcy by patients and families due to healthcare debt have skyrocketed. So have hospital bankruptcies and closures. The hospital business is low-margin, and non-payment of deductibles has contributed to an increase in bankruptcy activity by 123% since the end of 2010.[11]

The drop in payments - both by insurance companies and by patients who cannot afford their high deductibles - explains why many physicians are abandoning private practice to seek shelter in employment. "Physicians are losing their shirts," wrote Elizabeth Woodcock recently in the *Medical Economics* blog.[12] Academic departments, including my own at University of California, Los Angeles (UCLA), have seen a surge in job applications by anesthesiologists who want to escape from the risky fee-for-service environment. However, the security afforded by employment is likely to be short-lived. Large corporations and universities may enjoy fair payment rates now, but the next round of contract negotiation with third-party payers will probably bring further downward pressure on physician salaries in all specialties.

From the American anesthesiologist's point of view, the worst-case scenario would be the adoption of "Medicare for All". The reason is that Medicare pays physicians on average at least 40% less than private insurance rates. But Medicare does not pay all specialties at the same rate compared to "usual and customary" payments by private insurers. Anesthesiology (for no logical reason) is paid at the lowest rate of all: approximately 33% of the commercial payment rate. The prospect of a 2/3 pay cut would be devastating, especially for young physicians who typically graduate from American medical schools with student loan debt approaching $200 000. It is unclear whether the proponents of "Medicare for All" have truly paused to consider the cost to taxpayers. These include the idealistic young medical students who recently championed single-payer care at the annual meeting of the American Medical Association.[13] Americans are accustomed to no limitations whatsoever on expensive treatments such as dialysis, organ transplantation, implantable defibrillators, or intensive care. Rationing health care has never been politically palatable in the US, and there is no reason to expect that attitude to change in the interest of cost control. An estimate in *The Wall Street Journal* predicts that doubling individual and corporate income taxes still would not cover the bill - even with payment to physicians pegged at Medicare rates - and considers it likely that the implementation of "Medicare for All" would disrupt the availability and quality of healthcare.[14] The prospect of lower income and higher taxes is doing nothing to bolster physician morale.

MORE MALAISE = FEWER CLINICIANS

The flaws in today's electronic health record systems, and the fact that American physicians now spend hours every day functioning unhappily as data entry clerks, could be the subject of another entire article. So could the fact that women in anesthesiology continue to be paid substantially less than men in the US, even when hours worked are similar.[15] I wonder every day if we are doing today's college students any favor by encouraging them to go into medicine, and if we are doing today's medical students any favor by steering them toward anesthesiology.

Today's trainees in anesthesiology see the dissatisfaction all around them, and they note the increasing number of anesthesiologists who want to change careers or work part-time. Many residents are looking for pathways out of clinical care from the start, obtaining additional degrees - such as a master's degree in public health, informatics, or business administration[16] - that can lead to careers in government, hospital administration, or pharmaceutical corporations. Some young physicians have turned away from traditional clinical medicine to become entrepreneurs in businesses from smartphone app design to delivering IV therapy for hangovers in mobile vans.[17] A few physicians - such as Drs. Sanjay Gupta, Kevin Pho, Ken Jeong, and Zubin Damania, better known as "ZDogg" - have carved out enviable careers in social media and entertainment, leaving physicians feeling like chumps if they stay behind to take care of the patients.

Despite all that is going wrong in American healthcare,

personally I still find it a pleasure and an honor to work in the operating room every day, to take care of my patients, and to teach residents how to practice the profession of anesthesiology. At the same time, I think America forfeits the right to demand a return on taxpayer investment in medical education unless there is some sign of a positive change in the national attitude toward physicians. I continue to hope that American physicians will not quit their day jobs, but today, as opposed to seven years ago, it is clearer to me why they might.

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