

# December Is for Congregation, Celebration, Operation, Recuperation

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Practice management—specifically the application of sufficient (but not excess) labor to accomplish the required case load—is a financial cornerstone to successful modern anesthesiology practice. Professional revenues from practice might not cover the cost of provider compensation, so efficiency is required. Excess personnel will erode operating margin; too few will erode provider quality of life through compulsory clinical work; far too few personnel could erode quality of care.

In this issue of *ANESTHESIOLOGY*, Piersa *et al.*<sup>1</sup> make a discrete contribution to our knowledge of anesthesiology staffing and demand across the calendar year. They observe, over multiple years of complete data from a large private practice group practicing in Texas and Florida, that December is busier (more cases; more cases per day) than the other 11 months in the year by roughly 20% (at least when considering only elective cases).

The article by Piersa *et al.*, is interesting on many levels. One response from the anesthesiology community might be “Well, yeah. Who knew you could publish on things as obvious as ‘if you let go of an object while standing on Earth, it will fall to the ground?’”

Still, Piersa *et al.*, are to be commended for demonstrating conclusively that December is a very busy surgical and procedural month. The December rush is so much a fact of life that it might actually escape our collective notice as a specialty. In this author’s academic practice, the residency program and the certified registered nurse anesthetist program operate a defined log-rolling process whereby each role group covers for the other so that everyone can have a (brief) December vacation while the largest volumes of each year roll through the operating room. Such has been



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the case since this author joined his present department. In this author’s previous position, December vacation was at one point so hard to come by that a conscientious member of leadership undertook the delicate task of aligning people’s holiday preferences with the dates of observance, so that workload could be met and still provide rest to department members. This author dug further into memory, recently asking a buddy who started residency on the same day in 1995: “What was the busiest time of year?” to which the response was: “Fall and December.” “Why?” asked this author. “I don’t know; maybe people running down their insurance?” Confused at how this observation could be at least 26 years old and novel at the same time, this author did something he should do more often: He

asked his mom. “Mom, when you were a pathology resident in 1974, what was the busiest time of the year?” Mom: “December. They wouldn’t let us take vacation because the surgical load was so high they needed everyone in the lab.”

This author readily concedes that anecdotes are not evidence, but the December rush may be burned into the collective consciousness of health care to the point that clinicians have mostly normalized it. For a small- to medium-sized practice where people know each other well and have a sense of the ebb and flow of their workload over time, a twenty-percent increase in workload likely prompts communitarian acceptance of a few longer days, a few extra workdays in the month, or a month that has fewer “off” days built into the schedule. However, for an efficiently staffed, multihundred-clinician-employed group with thousands of anesthetic cases requiring coverage each month, a 20% labor shortfall can be a disaster. Large group and employed practices are increasingly prevalent. Hence,

Image: J. P. Rathmell.

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the work by Piersa *et al.* is important, if only because it validates the observation and gives a sense of how big the swing between normal workload and the December rush might be (at least in Florida and Texas).

When a practice is planning its labor deployment, what is most important? Is it the elective workload, or is it the total workload to which the practice must staff? In their primary analysis, testing the hypothesis that December is busier than other months for elective surgery, Piersa *et al.* take pains to exclude cases performed on weekends and federal holidays, as well as all obstetrical cases. The primary analysis proves the point but does not help the planner. Fortunately, the authors included a secondary analysis of ALL cases and again observed that December is the busiest month. For labor planners in Piersa *et al.*'s practice, the full December workload (including all cases) is roughly 5 to 11% higher in terms of absolute case numbers than all other months. This is a much more manageable swing and is consistent with day-to-day and week-to-week swings observed and managed in large practices.<sup>2</sup>

Piersa *et al.* are to be commended for teasing out potential explanations for why one might observe such large swings in elective case volumes between December and other months. For example, they nicely demonstrate that cases driven by pathophysiology (Piersa *et al.* used coronary artery bypass grafting as plausible example) are evenly distributed throughout the year (no December effect), whereas an arguably discretionary case type (in this study, colonoscopy) is performed most frequently in December. Piersa *et al.* go on to demonstrate *via* age-based analysis that patients with (likely) governmental payers have similar case rates throughout the year, whereas patients with commercial insurance appear more frequently in December.

Piersa *et al.* hypothesize "high deductible" commercial insurance plans underlie the "December effect." Basically, patients pay through their deductible in small increments throughout the year, consciously or unconsciously deferring large expenses until their deductible is met, and then schedule large expenses such as surgical procedures at the end of the coverage year. Intuition is persuasive; people on a budget try to avoid large incremental expenses. Piersa *et al.* provide circumstantial arguments from literature to demonstrate that patients defer elective care to the end of calendar years.

Is it necessary to implicate high deductible insurance plans as the sole or predominant reason why patients delay care until December in any given year? Many factors coalesce to make December a significant discretionary health care month. Families with school age children are on school break but on a relatively short break less conducive to vacationing. Older children, siblings, and parents are also likely to have schedulable discretionary time available in December to assist a patient with a recovery. Employed patients (who are likely to have commercial insurance) will likely have a brief December break as part of their benefits,

or they may be able to string together holidays and weekend days to have a procedure without too much interruption of work. No one factor necessarily underlies Piersa *et al.*'s observation. Rather, a common thread of commercial insurance with managed benefits, employment that provides constrained discretionary time, and potential dependence for recovery assistance upon children or similarly employed friends and family illustrates a nonutopian reality for many employed Americans.

The implications of Piersa *et al.*'s work for anesthesiology are relatively straightforward: Using one or a few years' worth of prior data, practices can anticipate and plan staff to accommodate the estimated up-swings in future December volumes. The details of how additional anesthesia are deployed depend on the setting. Facilities with idle capacity can open rooms, but it is more likely that additional cases will be performed in facilities with high usage by extending hours or working on weekends. Both tactics are used in this author's institution and can be managed with advance planning.

Shifting to the bedside and patient perspective, how should the observation that December is the busiest month for elective surgery influence our practice? It is important to take the patient's perspective. For any elective procedure, the patient has prepared themselves, made arrangements for assistance and time to recover, potentially affecting friends and family, and potentially aroused some attention from an employee by arranging time off. Anesthesiologists have a duty to keep patients safe and prepare them as well as possible for surgery. Occasionally, deferring surgery to improve preparation must happen. However, anesthesiologists may not fully appreciate the disruption a cancellation can cause in a patient's life. "Avoiding a bad outcome is always worth it" is a common thought, but in collaborative decision-making, patients and anesthesiologists might agree that a modicum of well-discussed and mutually understood added risk is acceptable to all parties to allow the planned procedure to occur. Toward the end of an insurance term year, the stakes will be higher. If a cancellation effectively means the patient loses the ability to pay for the procedure, how does the anesthesiologist respond?

Where should the anesthesiologist's concern about the consequences of our decision-making, from practice management all the way down to individual patient-level shared decision-making, be focused? Again, this author would argue that the higher-level questions, such as "should we make extra efforts to meet the December demand?" are easier than the patient-level questions. Preservation and restoration of health motivate all medical specialties, and American medicine tends to mold itself to the needs of consumers in pursuit of those goals. Meeting extra demand also makes economic sense, so we staff to perform the cases. We should be concerned about the potential impacts of haste and fatigue if we are over-working to meet additional December demand, and vigilance is required to identify and mitigate any risk. And finally, again, we come to the individual patient-level

considerations and the concern that December is a special month to some patients in more ways than being a month of holidays, celebrations, a bit of schedulable time off, and the end of an insurance year. Anesthesiologists could redouble their efforts to learn the full scope of the patient's goals and concerns about their upcoming surgery during the preoperative interview, including concerns that might not be obvious to the clinician but pressing to the patient and unique to the season. As David Chestnut articulated in his 2017 Rovenstine Lecture, two or three extra minutes in genuine, listening conversation with patients will guide shared decision-making and are always warranted—in any season.<sup>3</sup>

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