Leadership Perspectives

Fragmentation: Our Greatest Threat

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Although this is my ninth and final yearly contribution to Leadership Perspectives in the *ASA Monitor*, writing these columns remains a challenge. After eight previous officer contributions and 51 Monday Morning Outreaches during my year at the helm, it's difficult to imagine that I'd have anything worthwhile left to say!

In the early years, during my stint as Treasurer, I wrote about ASA's investment strategy, its Foundations, and its budgeting priorities. Mostly inside baseball, to be honest. In more recent times, I've focused on what I fear to be the greatest threat to our society, and indeed the profession: fragmentation. This being my final shot, I'm going to stick with that theme again because I think it's important to raise awareness of this peril facing ASA and our specialty.

Anesthesiology has evolved in significant ways since I first started. In those days, the specialty was far more homogeneous, and anesthesiologists were frankly more engaged in the management of their practices. Most members practiced general anesthesiology and worked in community-based private practices or academic settings.

As medicine and health care became more complex and specialized, so did we. However, in so doing, we have also become increasingly heterogeneous, and the pace of that change seems to be accelerating. We now practice a broad range of subspecialties in a growing number of practice settings. The change has often not been easy or smooth, as smaller practices have been amalgamated into much larger ones, and many academic departments have morphed into large, regional, multifacility practices. It's been tough for ASA, too, as this heterogeneity in the new models of practice has caused some anesthesiologists to question the value of membership to them personally.

In years gone by, most private practitioners owned, at least to some extent, the practices in which they worked – either as solo practitioners or members of small partnerships. I remember well the many private practice anesthesiologists I crossed paths with during my residency who were solo practitioners and used either an outside service or a spouse to do their billing. They shared call with other anesthesiologists in their hospital departments, but otherwise were independent businesses with a real stake in the business aspects of their practices. And, frankly, they relied heavily upon ASA for the information they needed to run them.

In just a generation, that paradigm has shifted dramatically. While some of us are still partners in our practices, a growing number are employees of either a health system or larger practice. In fact, nowadays, many anesthesiologists are employees of practices in which they have little or no equity, and over whose business affairs they have little say. To be clear, for many or most of these practitioners, this is the arrangement they prefer. They practice the medicine and leave to others the headaches of running a large, amalgamated operation in a health care ecosystem controlled by enormous corporations. But it's been a big change for the profession.

Heterogeneity can be a good thing. It signifies a vibrant, diverse specialty that is evolving to meet the needs of a changing health care marketplace. This has been particularly important in advancing subspecialty care. However, whether related to subspecialty practice or practice ownership models, this heterogeneity is also leading to increasing fragmentation, of both our specialty and our society. It's increasingly easy to view things differently from one another. So, we need to always remember that we are strongest when we can speak with one voice, and it is that powerful voice that is under threat.

I've written in the past about the *locker slammer* – the anesthesiologist who finishes their list of cases, changes clothes, and slams the locker on their way out the door, not to spend a moment's thought about the profession again until they return for the next day's shift. Whether we call it locker-slamming, shift work, or an employee mentality, it's the same problem. It's engaging in the practice of anesthesiology purely for its economic or social status benefits – more as a job than a mission – with little pursuit of, appreciation for, or engagement with the better angels of our calling. We cannot allow this attitude to define us.

From time to time, I hear calls for ASA to become a *union*, similar to the Air Line Pilots Association. During my year as ASA President, I heard from several members with misguided visions of ASA leading a strike against CMS or the large insurance companies to flex our muscles in our long-standing payment disputes. Unfortunately, federal antitrust laws just flat out do not allow such an action. ASA could indeed become a union, but it would only be able to organize labor action against our members' *employers*, not payers.

Is that what we would want, or would that only increase the threat of fragmentation? The mindset of an employee is quite different from that of a business owner.

As things currently stand, ASA is unquestionably an association of individual anesthesiologists. There is no official role for any practice entity. In the past, it didn't make much difference because, for many members, they were one and the same. But – and here's the rub – right now it's the *practices* that are some of ASA's most stalwart supporters. Over half of ASA members' dues are paid by groups. Our membership penetration is far greater with those who are members of organized groups. So, the question is, why would the practices, i.e., the employers, want to support ASA if it became a union representing the employer's workforce against them? I don't see an easy answer.

The challenges facing the specialty, including payment, workforce, and scope, are formidable. ASA is the only organization with the scale and reach to meaningfully impact advocacy and the marketplace. Accordingly, we cannot allow fragmentation to weaken ASA's voice. Those of us in governance need to take advantage of ASA's representative Board of Directors and House of Delegates to provide real opportunities for the diverse voices of the specialty to be heard within ASA, thus helping shape the most widely informed national policy for the specialty. We can and must do this to keep ASA the "big tent" for all of anesthesiology.

In recent years, we have made consistent efforts to reach out to our various constituencies to keep the specialty united. As examples:

- We are working more in partnership with our related subspecialty organizations. We have regular leadership meetings, and a growing number are meeting in conjunction with the ASA annual meeting. In 2023, we strengthened our relationship with ASRA Pain Medicine to include membership promotion and enhancement of joint efforts in public

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(144). However, clinical doses must also be considered.

- Because N_2O has relatively low potency, higher concentrations (and therefore mass quantities) are required to achieve clinical effects compared with volatile anesthetics. In clinically equivalent doses, ranked climate impacts: desflurane > nitrous oxide > isoflurane > sevoflurane.
- Life cycle greenhouse emissions from inhaled anesthetics are several orders of magnitude greater than for propofol.
- Mitigation strategies include:
  1) Avoiding inhaled anesthetics and using intravenous and regional anesthesia when clinically appropriate.
  2) If inhaled anesthetics are used, desflurane and nitrous oxide should be avoided unless there are clear clinical indications.
  3) Minimizing fresh gas flows.
  4) Abandoning central nitrous oxide pipelines and substituting portable tanks that remain closed between uses.
- Waste anesthesia gas capture and destruction technologies appear promising but require additional research to verify extraction efficiencies and overall emissions reduction benefits.

5. Fresh Gas Flow Management

Key points

- Minimizing fresh gas flows is an essential strategy to limit inhaled anesthetic pollution.
- Review the ASA Statement on the Use of Low Gas Flows for Sevoflurane (October 18, 2023).
- Safe, effective low fresh gas flow management requires continuous monitoring of inspired oxygen and expired anesthetic concentrations.
- The minimum fresh gas flow provides enough oxygen to match consumption plus any gases lost due to leaks in the circuit.
- Strategies to maximize efficient delivery of anesthesia occur throughout an anesthetic:
  - During maintenance, minimize fresh gas flow.
  - During induction, use high vaporizer concentration settings and low fresh gas flows, and consider pausing/turning off fresh gas flows during intubation.
  - During emergence, turn off the vaporizer early, initially maintain low fresh gas flows, and manage emergence timing with changes in fresh gas flow.
- Modern carbon dioxide absorbents are designed to support safe and cost-effective low fresh gas flow practices, including when using sevoflurane.
- Clinical consideration of the time to change blood and brain concentrations of the anesthetic in fragile or unstable patients must be part of the assessment of when and how to use low flow management.
- Reducing fresh gas flow should never take priority over maintaining safe and effective concentrations of oxygen and anesthetic in the patient.

6. Intravenous Pharmaceuticals

Key points

- Pharmaceuticals and their metabolites are commonly detected in the environment (air, soil, and water), including in tap water.
- Anesthesiologists should consider the harm to the environment when selecting medications.
- Anesthesiologists should avoid unnecessary use of medications.
- Anesthesiologists should avoid excess preparation of medications.
- The US Pharmacopeia (USP) sets guidelines for storage and handling of drugs (The Pharmacopoeia of the United States of America. 2nd Ed, 1820). Whereas drugs opened and prepared by anesthesia practitioners must be disposed of within a matter of hours, those prepared under Level V laminar hoods may keep for days to months depending on refrigeration conditions.
- Anesthesiologists should understand and comply with proper drug disposal methods to minimize associated environmental impacts.

7. Waste Disposal Management

Key points

- Operating rooms are responsible for approximately 30% of total hospital solid waste.
- Ongoing staff education is essential to improve proper waste disposal segregation.
- Proper waste stream management reduces environmental and financial costs.
- In nature, waste from one system is feedstock for another. The circular economy principles seek to eliminate waste and keep materials in use as long as possible at their highest function and guide sustainable practices.

8. Donations

Key points

- The primary goal of any donation should be the benefit of the recipient. Using such a method to "green" an operating room is a distant second.
- Careful consideration, understanding, and communication are necessary to match the right type of donated equipment and supplies to the right facilities and caregivers.

9. Perioperative and Operating Room Design and Management

Key points

- Several organizations offer health care-specific green design guidance for hospital and operating room renovations, new construction, and operations.
- Abandoning central supply systems for nitrous oxide and shifting supply to portable tanks is one of the largest opportunities for mitigating waste and direct release of facility emissions.
- The setback of heating, ventilation, and air conditioning (HVAC) airflow change rates in operating rooms is one of the most cost-effective means of reducing energy consumption in a health care facility.

10. Sustainable Conferences and Meetings

Key points

- Minimizing the environmental impact of meetings can serve to raise attendee awareness of pollution mitigation opportunities and encourage action.
- The vast majority of medical conference emissions stem from air travel, which can generate between 235-733 kg of CO_2e per person, more than the total annual per capita emissions in some countries.
- Virtual gatherings save time and expense, reduce pollution, increase equity, and may potentially elevate the safety of anesthesia care globally through greater access to education.
- In-person meetings provide vast opportunities for networking, forging personal and professional relationships that cannot be replaced through virtual attendance. Hybrid gatherings can provide the most flexible opportunities.

The committees that plan in-person ASA meetings are communicating regularly with the ASA Committee on Environmental Health as we incrementally work toward the goals outlined in this document.

For the complete resource document, including the Anesthesiology Sustainability Checklist, the Perioperative Sustainability Team Checklist, the Sustainable Event Checklist, and 135 references, please see the ASA's Greening the Operating Room and Perioperative Arena: Environmental Sustainability in Anesthesia Practice (asamonitor.pub/GreentheORGORPA). ■

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education, advocacy, economics, and AMA representation.

- The No Surprises Act has adversely impacted large and small groups alike. Our approach to addressing this effort has required us to listen to and engage practice leaders from diverse groups in order to address implementation issues. Our "Working Group on Network Adequacy" is one such place where this diversity in practice helped us understand the law and more effectively advocate improvement through legislative, regulatory, and legal channels.
- In recent years, we created an Ad Hoc Committee on Independent Practice. That group has helped us better understand the challenges that traditional community-based practices face in the emerging environment and to develop resources to assist them.
- Four years ago, we established the Anesthesia Research Council to help unify the efforts of the International Anesthesia Research Society, Foundation for Anesthesia Education and Research, and ASA as they relate to strengthening the specialty's research resources and advocacy.
- Over the past two years, we have altered the format of our Board of Directors meetings to focus on discussion of strategic issues and making sure all points of view are heard and considered.

These are just a few examples of the work ASA has done across the spectrum of the specialty to make sure that every segment feels represented. We always strive to bring value to *all* of our members, irrespective of whether their practice is academic or private, and without favor based on practice size, subspecialty, or ownership model.

Without continuing, conscious effort, our future could be a fragmented one. We cannot allow that to happen. We need to band together, and stay together. We need to look for the subjects on which we can agree and raise awareness of the benefit to all of us in supporting organized anesthesiology, even if that support seems at times to be altruistic.

ASA is the only tide in anesthesia that can truly raise all boats. ■