Anaesthetist as a perioperative physician: A new perspective

In the current era of ever increasing competition in all medical specialities, field of anaesthesia is no immune. Days have come where Charles Darwin's theory of survival of fittest has come to play a role in a magnanimous way. We are precisely at the crossroads of transformation from an anaesthetist to a perioperative physician. It might sound as a bit of an exaggeration but my senior colleague rightly predicted this situation a couple of years ago. The American Society of anaesthesiologist' "task force to identify possible anaesthesia paradigms in 2025" headed by Ronald D. Miller, MD, emphasized that anaesthesiologists need to diversify their practice paradigms in order to ensure a future leadership position in medicine.

What actually is compelling us to become a perioperative physician? Let us explore the fundamental concept. The total life expectancy is increasing simultaneously surgeries are becoming more complex as well. Which essentially means we are treating sicker and older population with multiple comorbidities. 80% of perioperative complications are attributable to the underlying medical conditions which constituted the "avoidable harm" and these add burden to the resources. These are also called as unmet needs! The rest of mortality or morbidity is due to anaesthesia and surgery. Timely and effective management of these perioperative complications are to be dealt by the perioperative physicians.

By definition a perioperative physician is the one who addresses the continuum of medical care of the surgical patient and focuses on the patient's status before, during and after or may extend beyond the index admission for surgery. They predominantly address the most critical issues, hence needs more expertise. Gone are those days when we seeked opinion from cardiologists or pulmonologist to assess and optimize the patients and would look only into intraoperative care of the patient.

Adesanya and Joshi [1] predict hospitalists and anaesthetists to play a collaborative role which has nurtured from the intensive care unit culture in the development of critical care. They analyzed that most of the anaesthesia residency programs even in USA are not equipped nor positioned to train perioperative physicians. Moreover some anaesthetists also lack enthusiasm and are sort of unprepared to handle the problems of postoperative care. There is no single college or medical training scheme currently offering this option.

By default, anaesthetists are the natural perioperative physicians. What makes us unique? I can't think of anyone better than an anaesthetist placing themselves in this position who possesses a perfect armamentarium of technical skills, expertise and vast experience. It's just like owning a whole big pandoras box! Anaesthetists in the preoperative assessment clinic are the ultimate risk stratifiers using various scoring systems. Maintaining meticulous records and thorough documentation by anaesthetists also goes a long way in identifying the exact moment of patient deterioration. We are probably one of the most lucky speciality which has divulged into numerous subspecialties like cardiac, neuroanaesthesia, paediatric, pain, critical care, Palliative care, oncoanaesthesia and transplant anaesthesia. Thus no other field gets such a vast exposure in treating the young and old and sick and fit ones.

We need to hone our existing skills, build upon them and simultaneously develop new ones by attending hands on workshops. Ultrasound and echocardiography is one such skill I strongly suggest each one must pick up and start implementing in day to day practice. At the grass root level, perioperative medicine should be incorporated in the form of modules for further education, training and certification.

In the recent time, India has virtually seen an uprising of workshops enabling the anaesthetist to develop skills like transthoracic echocardiography, transesophageal echocardiography and point of care ultrasound. A special mention about The Anaesthetist Society

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which conducts nerve block workshops for masses simply using a needle and local anaesthetic empowering anaesthetist from peripheries who do not have access to modern gadgets enabling then for smooth and better outcomes for high risk patients. Royal College of Anaesthetists too have started a wonderful initiative which explores perioperative medicine and how we could improve care for high risk surgical patients. This would simultaneously need education of patients, public and other healthcare professionals.

Due to overlap in care with multiple specialties attendant medico legal risks should be looked into slowly. Further clarification of roles and practice which may seem outside our scope may lead to differences of opinion with surgical and medical colleagues. On the flip side being a resource intensive field which needs 24 h cover, many would argue that is a non income generating activity. Needless to say any change is difficult in the beginning. Thus proving the hospital management about how an anaesthetist led perioperative model would improve outcome may prove an arduous task for us to be remunerated appropriately.

Undoubtedly if we broaden and embrace the speciality of perioperative medicine into our care pathways we will definitely be able to consolidate our position as a respected speciality amongst our surgical peers. I personally foresee a decade from now, anaesthetists at the top of surgical pyramid adding further value towards the better care of the patients.

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