Anaesthetist and perioperative medicine

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The practice of anaesthesiology goes through major upheavals every few decades similar to other medical disciplines. Historically anaesthetists were the glorious surgeon's unsung companions keeping the patient still during surgery. As the science progressed, the process of anaesthesia became more refined and predictable. It also became safer than ever before.

As a result of this progress, challenging surgery in patients with challenging co-morbid conditions is undertaken routinely now. Increase in overall life expectancy also adds to the list of physiological twists that interact with the stress of anaesthesia and surgery.

A growing concern now is the ability of a single surgeon to be a good surgeon as well as a good cardiologist, nephrologist, haematologist, and so on to take on complex organ dysfunctions in the perioperative period. It is nearly impossible to expect majority of the surgeons to be masters of all trades as the progress of science in all fields is growing exponentially.

How is it then that the idea of making the anaesthetist "the master of all trades" finds favor among many?

Let's examine the tenets on which this concept has been based.

Is it possible?

A designated physician can see a patient coming up for an elective surgery and manage his medications before and after his surgery. At present, the patient's general practitioner fulfils this role. Going forward, if anesthetists want to take this function over, can they be any better?

Is it practical?

Anaesthetist's major clinical task will be giving anaesthesia. Then, there may be those who would wish not to give anaesthetics but to play the general practitioner more often. They would be ideally suited to take on this role. However, the expectation will be that the care provided will be at par with that provided by a qualified and accredited cardiologist, endocrinologist, or nephrologist. As we saw previously, a surgeon cannot become all these while still trying to keep abreast with the advances in surgery. Why is it then thought that anaesthetist can somehow take overall these responsibilities while the surgeon cannot? A few decades ago, anaesthetists who were good at inserting tubes and catheters in various body parts were convinced that all the critical illnesses and organ failures that need such intervention were somehow best treated by the anaesthetists and not by the respective medical specialists. Thus, the anaesthetist managed critical care medicine.

Is it legal?

Whereas the surgeon making the post-operative rounds is not legally accredited to treat the patient's post-operative myocardial infarct, neither would be the anaesthetist. Hence, if the same advice has to be sought from the same accredited cardiologist, does is matter much who signs the referral request? Furthermore, recognizing signs of organ dysfunction arethe remit of all doctors-whether they choose to become surgeons, anesthetists, or rheumatologist in later life .

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