AACD
Association of Anesthesia Clinical Directors

www.aacdhq.org

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# Newsletter








Our society provides a forum for partnership and advancement. The Association of Anesthesia Clinical Directors (AACD) recognizes that given the evolving healthcare environment in which we work, operating room (OR) efficiency, productivity, and cost containment are increasingly vital to our survival. The AACD offers physicians and other perioperative leaders with responsibilities and interest in the business aspect of OR management an opportunity to tackle common challenges, share ideas, collaborate with anesthesiologists and other perioperative professionals who have similar experiences, and to ultimately create solutions.

**Editor: Chinyere Archie, MBBS**

# Perioperative Anesthesia Leadership and Fellowships in the United States: Current Status and a Way Forward



**Chinyere Archie, MBBS**

Perioperative care in the United States is undergoing a fundamental transformation, creating ample opportunity for anesthesiologists to expand their leadership beyond the operating room. If you're reading this article, your engagement with this space, and with the AACD, is testament to your appreciation of the topic… but how do we develop a specialty-wide respect of the significance of our role here?

Traditionally, anesthesiologists have been recognized for their expertise in intraoperative management, airway safety, hemodynamic stability, and critical care.

However, the increasing complexity of surgical patients, rising healthcare costs, operating room capacity constraints, workforce challenges, and the growing emphasis on value-based care demand a broader role: leading the entire perioperative continuum, from preoperative optimization and influencing surgical decision-making to enhancing postoperative recovery and long-term outcomes.

The United States has made meaningful progress in developing perioperative medicine and leadership training, although opportunities remain fragmented and unevenly distributed. Several institutions offer dedicated fellowships in perioperative medicine, management, and leadership. Examples include the University of Alabama at Birmingham's Perioperative Leadership Fellowship, the University of Tennessee's Perioperative Medicine Fellowship incorporating executive business education, and programs at Duke, UCLA, and UC San Diego. Training opportunities generally range from 12 to 18 months and increasingly encompass preoperative risk assessment, enhanced recovery after surgery, prehabilitation, quality improvement, operational efficiency, healthcare economics, research, and multidisciplinary team management.

The expansion of MD Anderson's fellowship into Perioperative Medicine and Onco-Anesthesia further illustrates another example of evolution toward comprehensive, specialty-focused perioperative care.

Despite these advances, a major challenge is the lack of a universally established, standardized pathway for perioperative anesthesia leadership. Fellowship duration, curriculum, clinical responsibilities, business education, and institutional recognition vary considerably. Many programs are institution-specific and non-ACGME-accredited. Leadership development is still frequently acquired through informal mentorship and experience rather than structured preparation. Consequently, excellent clinicians may assume major administrative responsibilities without sufficient training in finance, negotiation, strategic planning, workforce management, informatics, and organizational change. Additionally, the impact of the currently offered fellowships on career progression, patient outcomes, operational performance, and financial sustainability requires more systematic evaluation.

Looking ahead, one may propose that a competency-based national curriculum be developed through collaboration among the American Society of Anesthesiologists (ASA), other professional societies, academic departments, health systems, and relevant business schools. Core competencies should include those mentioned above, with an emphasis on healthcare finance, operational analytics, leadership and communication, and digital health. To align with applicant priorities, institutions may consider establishing flexible fellowship pathways, such as one-year clinical perioperative medicine tracks and longer leadership tracks integrating executive education, mentored institutional projects, and protected leadership experience. Standardized competencies and transparent outcome measures would promote consistency without eliminating institutional innovation.

Certainly, leadership training must translate into meaningful organizational responsibility. Fellows should lead endeavors addressing operating room utilization, surgical cancellations, postoperative complications, length of stay, patient experience, and equitable access to surgery, to name a few. Furthermore, it would be remiss to not emphasize that mentorship and sponsorship should extend beyond academic centers to community hospitals, private practice groups, and underserved settings. In order for these programs to grow into increasingly sustainable and successful vehicles, professional societies and participating institutions may consider developing a national network to share curricula, mentorship resources, implementation strategies, and outcomes. Evaluation should be rigorous and include metrics for clinical quality, efficiency, cost-effectiveness, staff engagement, and patient-centered outcomes.

We should no longer view perioperative anesthesia leadership as an optional career extension, but rather a strategic opportunity for the specialty to shape the future of surgical care. The next step is to move from isolated fellowship initiatives toward a coordinated, competency-based, outcomes-driven national framework. By combining clinical excellence with collaborative leadership, business acumen and systems thinking, anesthesiologists can further distinguish themselves as lead architects of safer, more efficient perioperative care.

# Penny Wise, People Foolish



**Zachary Deutch, MD**

American medicine has an inherent philosophical and ethical problem which stares us in the face every day, whether we openly acknowledge it or not.

As a capitalist society, financial expediency and specifically the goal of making money are intrinsic to our national value system. However, the profit motive does not translate well to health care. When we care for patients, we treat the sick and try to heal them or at least alleviate their suffering. These acts do not have moral equivalency with selling cars, flipping real estate, and running a hedge fund. The concept of "caveat emptor" may be acceptable to those enterprises, but not to ill people seeking care.

Patients expect ethical, competent, and compassionate treatment. Health care workers have an ethical and moral responsibility to uphold this expectation. The "almighty dollar" is a confounding factor. External financial pressures significantly impact perioperative medicine, since operating rooms and procedural areas are generally the biggest net contributors to facility margins.

The current focus on maximizing procedural throughput and volume, at the expense of humanistic considerations, is problematic. Empathy, sympathy, and compassion should not be afterthoughts. Patients are often treated like numbers and rushed through the health system. After all, greater procedural volume means higher flow of revenue.

At many institutions, proceduralists have authority and influence that varies directly with their contribution margins, while personal and professional accountability varies inversely. Actions that are to patients' detriment, but are operationally or logistically desirable to surgeons, may be overlooked or even condoned.

Let's frame the issue in a more personal and compelling manner. Virtually all physicians have been patients at one time or another. How would we feel if on the "wrong end" of the following real-life scenarios?

*Gastroenterologist requires all his 12 patients to arrive at GI suite by 7:00 am because "there might be no shows" and "we can't have down time." Exhausted, dehydrated, bowel-prepped patients wait for hours in waiting room and pre-procedural area before their endoscopies*

*Patient with painful renal colic is npo yet waits all day for cystoscopy and stone manipulation, despite OR availability, because urologist has clinic until 4 pm*

*Joint replacement patient sees orthopedist for 5 minutes in pre-op visit, which is mostly conducted by medical assistant and, to a lesser extent, PA. During later operation, surgeon is scrubbed in only for 30 minute "critical portion" and leaves as soon as possible to attend to case in nearby "flip room"*

*Busy ophthalmic procedural suite has high procedural volume. Waiting in pre-op, the last patient of the day (#35 out of 35), notes that it is past 5:00 pm, staff are visibly fatigued and appear irritated and brusque*

*Surgeons who are part owners of an ASC decide that OR start times will be 6:00 am, "so we can get more cases in." Numerous perioperative staff members do not live close by, and are forced to get up before 4:00 am to continue working there*

A common thread above is the impetus to push as many patients as possible through a procedural mill, regardless of whether this proverbial conveyor belt tends to make their experience excessively burdensome, unpleasant, or downright frightening.

Additionally, proceduralists who arrive late, run over on booking times, improperly manage "flip" rooms, or mistreat those around them may not be called to task for these misdeeds. Administrators greatly fear losing them as a referral base and revenue generator and will be reluctant to correct or reprimand these behaviors.

None of us are oblivious to the pragmatic realities of American healthcare economics and the struggle "to keep the lights on." But, in responding to fiscal challenges, have we lowered the system's financial costs while raising the emotional and physical costs for patients? Doesn't the system exist to serve patients, not the other way around?

# Collaboration Highlights: The NORA Society



**Diana Anca, MD**



**Claudia Fernandez Robles, MD**



**Chinyere Archie, MBBS**

The AACD is pleased to highlight a thriving ongoing partnership with the NORA (Non-Operating Room Anesthesia) Society. We joined forces about one year ago and continue to collaborate with the NORA Society to expand benefits to members, share resources, develop solutions to commonly encountered challenges, and to increase our impact in the perioperative leadership space. We are here to serve you, our members! Please reach out if you have ideas or interest in special efforts and stay tuned for future updates!

The purpose of the NORA Society is to maintain a strong community of practice among NORA leaders across the country. Society membership meets regularly to share clinical dilemmas, practical solutions, resources, and innovative ideas. Members represent both academic and private hospital settings throughout the United States, bringing expertise that spans pediatric, cardiac, and other high-acuity subspecialties.

Beyond discussion and knowledge sharing, the Society fosters active collaboration among members who work together on academic initiatives including publications, conference presentations, and educational projects such as resident curriculum development. Members frequently collaborate on scholarly work that is presented at both national and international meetings, further advancing the field of Non-Operating Room Anesthesia.

Through collaboration and peer support, the Society works to strengthen their ability to advocate for patients, procedural partners, departments, and hospital leadership. A particular focus is on inpatient and high-acuity NORA cases, recognizing the unique challenges of delivering safe, high-quality anesthesia care outside the traditional operating room environment. The group strives to elevate standards, promote safety, and lead the continued evolution of NORA practice nationwide.

# NORA Membership Publication Corner

The society's members publish broadly on non-operating room anesthesia, with a strong emphasis on the practical, system-based, and safety considerations of providing anesthesia outside the traditional operating room environment. Major themes include pre-procedural optimization, infrastructure and logistics, anesthesia techniques, medication safety, patient positioning, checklists, emergency preparedness, and the evolving complexity and volume of NORA care. Interestingly, members also examine how NORA practices vary internationally and how education and training are evolving, including the use of adaptive learning and simulation.

A second major theme is interdisciplinary collaboration and the management of specialized procedural environments. Publications range from addressing teamwork, crisis resource management, clinician safety and NORA leadership, to the nuances of anesthesia for specific procedural areas – cardiology/ electrophysiology, advanced endoscopy, interventional pulmonology, interventional radiology and pediatrics. Across these areas, scholarship focuses on optimizing anesthesia care, improving safety and team performance, and otherwise adapting anesthesia practice to best suit nontraditional locations.

Check out a couple of articles **here** and **here.**
Take a look at their website **here.**

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# 2027 AACD Perioperative Leadership Summit

March 5-7, 2027
Charleston, SC

Learn More

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## Collaborations

SPAQI
Society for Perioperative Assessment & Quality Improvement

ASRA
PAIN MEDICINE

PGA PostGraduate Assembly in Anesthesiology



# Institutional Membership

- Includes Annual Conference Registration for up to 7 active physicians PLUS 5 resident physicians within the same organization.
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Fresh Flow takes listeners beyond the basic science and clinical application conversations to explore timely, thought-provoking topics that impact anesthesiology and perioperative medicine, both now and in the future.
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## Your Voice. Your Expertise. Our Community.

Great ideas deserve to be shared! Help inspire fellow AACD members by contributing articles, research, and insights that advance anesthesiology and perioperative leadership.

**Send your submissions to the AACD office: krc@aadchq.org**

## Stay Connected!

Check your email for news, updates & the next newsletter!
**Contributions are invited!**

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