Our Tormenters Have Been Chastised by Their Peers: Lucy Richards and the AANA

To the editor: A beautiful black-and-white photograph of AANA Past President Lucy Richards appeared on the cover of the April 2014 issue (Vol. 82, No. 2). On page 92 of that issue, a blurb containing just 2 sentences traced the photograph to a brochure published by the AANA in 1956 entitled “Nurse Anesthetist… Career… Celebrating the AANA’s 25th Anniversary.” Although that description is true, I believe there is a bigger story behind the brochure that deserves attention.

Following World War II, prominent anesthesiologists launched what the historian Marianne Bankert described as “a vigorous public relations campaign that was pro-anesthesiologist and anti-nurse anesthetist. Their message to the country was that anesthesia was safe only when delivered by a physician.”1 Throughout 1947 articles critical of nurse anesthetists appeared in popular magazines. The historian Virginia Thatcher listed them: Look, Readers Scope, Cosmopolitan, Good Housekeeping, and This Week. Thatcher added that although the campaign did not diminish the reputation of nurse anesthetists in the eyes of surgeons or hospital administrators, it did “discourage many capable nurses from entering the field. In 1949 there was not one third the needed number of qualified anesthetists to meet the demand of hospitals throughout the United States.”2

The campaign prompted varied reactions among AANA Board members. President Lucy Richards acknowledged that some wanted to “retaliate with an intensive publicity campaign.” Others urged “inaction.”3 Treasurer Gertrude Fife, who served 15 consecutive terms in that office, wrote: “We do not wish to behave like the ostrich, nor do we wish to engage in fruitless rebuttal. The publication of such articles should certainly be discouraged.”4 The Board of Trustees chose to navigate a “middle course.”

The “middle course” involved 2 strategies. The first was to continue a recruitment effort begun earlier to overcome the nurse anesthetist shortage created by World War II. Between 1945 and 1961, the AANA published recruitment brochures like the aforementioned “Nurse Anesthetist: World-wide Opportunities in a Top-Flight Professional Career,” (its full title). Other brochures included “Anesthesiology: A Specialized Field for Professional Registered Nurses,” “All About Nurse Anesthetists,” “You Can Be A Nurse Anesthetist,” and “Anesthesia: A Special Type of Nursing.”5 These brochures were disseminated through schools of nursing to entice graduate nurses into anesthesia school.

The second strategy involved hospital administrators and surgeons, who were (to say the least) alarmed by the anesthesiologists’ campaign. They responded with publications of their own that criticized the anesthesiologists.6 The resolution went on to assert: “This attempt to persuade the public that there is grave danger in a surgical operation if the anesthetist is not a certified medical specialist is already decreasing the number of efficient well-trained nurse anesthetists and forcing surgeons to perform recently developed complicated operations with anesthetics administered by young hospital interns or general practitioners, neither of whom have special training or experience in the administration of anesthetic.”9 The overall impact of these strategies has not been closely examined. It’s not known, for example, what effect the brochures had on recruitment, although the AANA membership passed 5,000 in 1950 and 10,000 in 1960. The second strategy caused Lucy Richards to write that “our tormentors have been chastised by their peers and we have maintained our professional integrity.”3

My point in writing this letter is to compliment the AANA Journal for publishing such a lovely photograph, but also to encourage the inclusion of more background material. With the full story, a photo takes on greater meaning.

REFERENCES
report HCAHPS results. Today, patient satisfaction surveys account for 30% of the US governments “Value Based Purchasing” program.3

Anesthesia organizations project that patient satisfaction has the potential to not only effect reimbursement but also impact competency.4,5 Currently, the American Board of Medical Specialties and Accreditation Council for Graduate Medical Education are constructing new guidelines to assess competency. One category of competency is communication of the provider. Patient satisfaction surveys could fulfill a portion of this requirement.4

Previously, there have been attempts to study patient satisfaction surveys in anesthesia. However, most literature questions the reliability and validity of nearly all existing surveys. Barnett et al6 have offered suggestions based upon their quantitative analysis but indicate a clear need for further research. To date there is no gold standard for assessing anesthesia patient satisfaction.1,2,4,6

Surgeons appear to be positioning themselves for the potential impact of patient satisfaction questionnaires. Notably, they have developed the Surgical Care Survey (equivalent to a surgical CAHPS). In June 2012, the National Quality Forum endorsed The Surgical Care Survey. Interestingly, this survey contains anesthesia performance evaluation questions. Experts suggest if no standardized survey is formulated then the Surgical Care Survey could be utilized to evaluate anesthesia performance. Additionally, the American College of Surgeons market the survey as a valuable tool for “incentive” programs for payers as well as a means for surgeons to “maintain credentialing.”5

If indications are correct, it is the responsibility of every anesthesia professional to educate themselves in regards to patient satisfaction surveys. There is substantial evidence that patient experience will likely impact anesthesia reimbursement and competency in the future. Individuals and groups should strive to construct a multidimensional psychometric survey focused patient satisfaction survey that can be systematically utilized nationwide. Hospital systems and facilities have initiated and should continue to strengthen programs to improve patient satisfaction. Finally, CRNAs need to be aware that patient perception is a fundamental and ethical responsibility. With this responsibility, CRNAs are accountable to implement the best patient experience possible.

**REFERENCES**


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Patient Satisfaction: Implications for Anesthetic Practice

To the editor: Soon after emergence, patients begin to evaluate their anesthetic. Based upon this perception, an opinion of their experience is contrived. Now more than ever, this judgment impacts anesthesia. In fact, patient satisfaction is already an integral component to measure quality in the United States healthcare industry.1,2 In 2002, the Center for Medicare and Medicaid Services (CMS) in conjunction with the Agency for Healthcare Research and Quality (AHRQ) developed the Consumer Assessment of Healthcare Providers and Systems (CAHPS) and the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS). The goals of these assessments were to standardize and measure patient satisfaction in the US. Subsequently, by 2008, hospital reimbursements were beginning to be significantly affected by CAHPS and HCAHPS. Specifically, eligible hospitals subject to inpatient prospective payments systems (IPPS) were subject to a 2% reduction in reimbursements if they failed to

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A multidisciplinary program of perioperative surgical care. The goal of ERAS is to accelerate the recovery of surgical patients while decreasing complications and reducing hospital length of stay. Therefore, ERAS results in savings to the healthcare enterprise. It has already been shown to benefit patients undergoing colorectal, urological, gynecological, orthopedic, and vascular surgery.

Multiple studies including randomized controlled trials have demonstrated that ERAS programs may significantly reduce the postoperative hospital stay and reduce postoperative ileus and cardiopulmonary complications.1-3 The evidence proved that enhanced recovery speeds convalescence and reduces morbidity and cost while maintaining patient satisfaction and quality of life.4

What are the key components of ERAS? The underlying principle of ERAS is to enable patients to recover from surgery and leave the hospital sooner by minimizing stress responses on the body during surgery.5 It is essential that the patient is in the best possible preoperative condition for surgery, receives the best possible intraoperative management, and experiences the best postoperative recovery.5 Key elements of ERAS include: preoperative patient education, reduction of preoperative fasting, omission of bowel preparation, goal-directed fluid management, reduction in perioperative use of nasogastric tubes and drains, early removal of Foley catheters, multimodal analgesia to minimize opioid consumption, early postoperative mobilization, and early oral nutrition.

How does ERAS components work? Preoperative education: It is important that the patient and their family have made the decision to have surgery and understands all the options, including non-operative, available. A partnership between clinician and patient and their families requires understanding and respecting each patient’s unique needs, culture, values, and preferences. Patients and families are core members of the care team. As such, they are fully informed partners in establishing and actively participating in care plans. They become key partners in driving the pace and quality of the care delivered. Coordination with primary care physicians can help to support the patient and family in making the right decision on whether or not to proceed with surgery.

Medical optimization: For the best results from enhanced recovery, the patient should be as healthy as possible before surgery. All types of chronic diseases (heart disease, asthma, high blood pressure, diabetes, anemia) should be controlled as well as possible. There is evidence of faster and safer recovery associated with smoking cessation, alcohol abstinence, medically informed weight loss, and monitored exercise.6 Coordination with the primary care physician can help to ensure medical optimization of patient condition.

Pre-admission test: All patients undergoing elective surgery should undergo preoperative assessment. The preoperative assessment service should ensure accessibility for patients to their anesthesia care provider to review findings and create an individualized management plan. Appropriate preoperative assessment can reduce surgical cancellation and delays, reduce unnecessary testing and its expense, and provide better preoperative patient care and outcomes.7

Intraoperative anesthesia considerations: NPO status; Patients are encouraged to eat normally up until 6 hours before the operation. Clear oral fluids should be allowed until 2 hours before surgery.

Premedication: In the preoperative area, minimizing anxiety is important. Anxiolysis with benzodiazepines has been shown to reduce postoperative nausea and vomiting (PONV) and improve quality of life metrics.8

Intravenous fluid management: Any fluids lost before, during or after surgery are carefully replaced. This allows circulatory volume and organ perfusion to be maintained with the minimum of administered fluid, which minimizes fluid accumulation in the tissues. Euvolemia is important for the improved outcomes.9,10

Anesthetic agents: Quick offset agents should be used to allow a quick recovery from anesthesia.

Multimodal regimen pain medications: Regional anesthesia, neuraxial or a peripheral nerve block, or both, are important components of a multimodal regimen. Local anesthetic administration into the wound has been used as part of a multimodal regimen. Long-acting opiates should be avoided. NSAIDs, including COX-2 inhibitors, and tramadol provide opioid-sparing to reduce opiate requirements. The quality of analgesia from the combination of NSAIDs and opioids is better than that achieved by opioids alone.11,12,13 There are several articles stating that the administration of gabapentin14 and ketamine15 can prevent chronic pain.

Prevention of hypothermia: Routinely monitoring the patient’s temperature in OR and utilizing an air-warming system, along with intravenous fluid warmers prevent hypothermia (core temperature ≥36°C).

PONV prevention: Nitrous oxide should be avoided in at-risk patients.16,17,18 Intraoperative anti-emetics are the key of PONV prevention. Using more than 1 antiemetic decreases the incidence of nausea and vomiting significantly.19,20

Post-operative care: Patients should be allowed oral nutritional supplements from the day of surgery until normal food intake is achieved. Initiation of early feeding...
all contributed to acceleration of gastrointestinal function. Patients should be helped to sit in a chair on the evening of surgery. It is recommended that patients be moved out of their bed for 2 hours on the day of surgery and 6 hours thereafter.

Discharge criteria: The patient should be able to tolerate diet and oral fluids, to mobilize, have pain adequately controlled on oral analgesia, have their bowels functioning or flatus passed, be confident in their ability to manage their post-operative care, and fully agree to go home. Discharge planning should be proactively managed to avoid unnecessary delays in discharge.

Continuing care, education, and support after discharge are needed to maintain patient confidence. It is important to coordinate with the patient’s primary care physician and the home health service.

Audit (research and measurement): A systematic audit should be performed at regularly scheduled times to allow direct comparison internally and externally of the ERAS program of care. Improved adherence to the standardized multimodal ERAS protocol is significantly associated with improved clinical outcomes.

Why is ERAS important for the anesthesia care provider? The new healthcare delivery system requires greater integration (interdisciplinary healthcare) to improve quality of care, and lower overall healthcare expenditures. Anesthesia providers can partner with patients and their families and actively support patients in their decision-making for their own care. ERAS can implement a comprehensive and integrated approach to the management of patients undergoing surgery. ERAS promotes an inter-disciplinary team working across many other specialties. ERAS can improve early patient engagement, clinical outcomes, post-procedural care, and care coordination. ERAS also reduces morbidity and costs.

REFERENCES

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