AACD
Association of Anesthesia Clinical Directors

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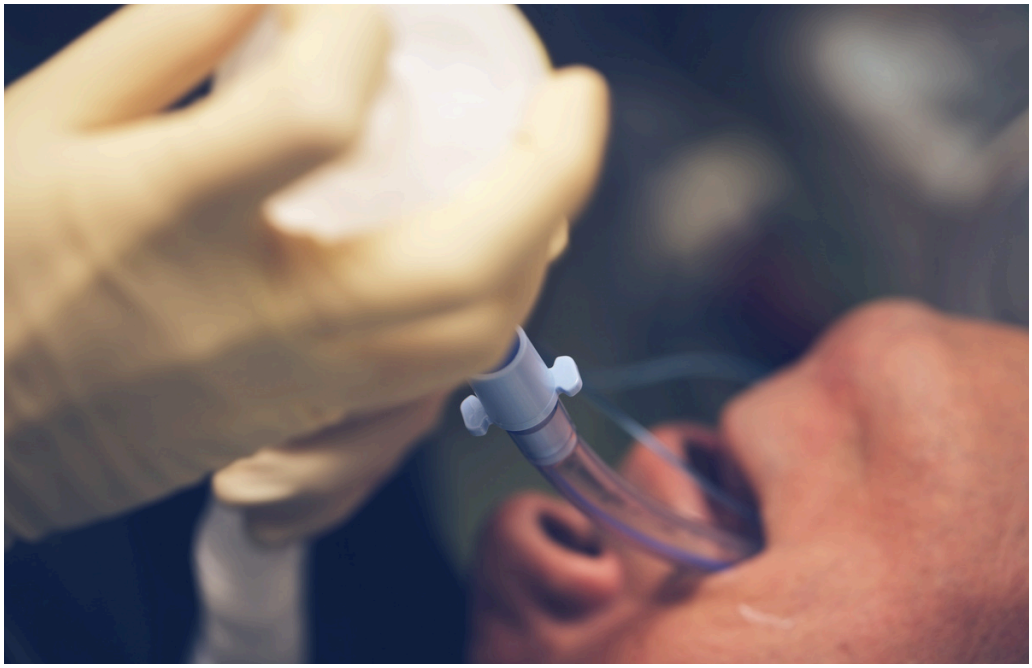
FALL 2025 EDITION

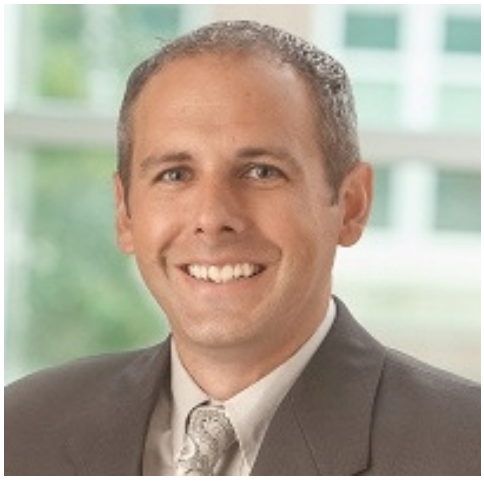
Newsletter



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 who have similar experiences, and to ultimately create solutions.

Editors: Chinyere Archie, MBBS
Veronica Zoghbi, MD

Our President-Elect



Thomas E. Schulte, MD
AACD President-Elect
Professor of Anesthesiology
University of Nebraska Medical Center

As a native of north-central Iowa, I never imagined myself running the operating rooms at a large tertiary care trauma center.

I attended Creighton University for medical school in Omaha, Nebraska, and then completed my residency just down the road at the University of Nebraska Medical Center. After finishing my training, I stayed on as faculty—and I've now just started my seventeenth year.

I'm a cardiac anesthesiologist who still revels in the intensity of trauma cases and overnight call. As the Anesthesia Director of Perioperative Services, I work closely with our Surgical and Nursing Directors to keep the operating rooms safe, efficient, and well-coordinated. Before taking on my current role as Medical Director of the ORs, I served as Clinical Director for four years.

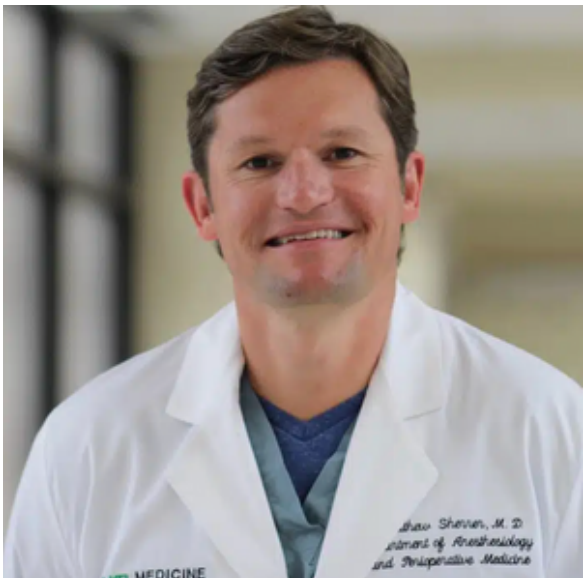
I've always considered myself a "Jack of All Trades." From performing anesthesia for heart transplants to caring for gunshot wound victims in the trauma bay, I thrive on variety. My research has focused on operating room operations and innovative applications and education related to transesophageal echocardiography.

Having strong mentors has been instrumental in shaping my career. They haven't all been at my own institution—some of my most impactful mentors are at other centers, which has fostered collaboration and sparked new ideas.

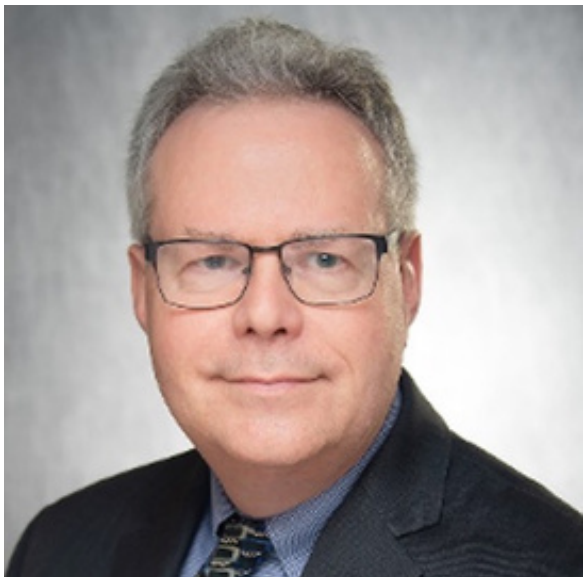
As the current President-Elect of the AACD, I'm both honored and humbled to follow in the footsteps of so many outstanding anesthesiologists and leaders in perioperative care. I joined the AACD twelve years ago as a young clinical director searching for solutions to the challenges I faced. I found not only answers, but also lifelong friends, mentors, and incredible opportunities.

Outside of work, my wife and I enjoy traveling, playing tennis and pickleball, and cheering on our four sons in their many youth sports activities. I also love golfing—especially with fellow AACD Board members—and traveling anywhere with my wife.

Ask the experts: For neurosurgical cases, is there evidence to support the use of specialty-trained neuro-anesthesiologists on weekdays and non-specialty-trained anesthesiologists on nights and weekends?



Matt Sherrer, MD, MBA, FAACD, FASA
Associate Professor of Anesthesia
University of Alabama at Birmingham



Franklin Dexter, MD, PhD, FASA
Professor of Anesthesia
University of Iowa

Sustainable staff scheduling remains a challenge for both academic and private anesthesia practices.[1] In academic institutions, such as the University of Alabama at Birmingham (UAB), the preference for decades has been for specialty-trained anesthesiologists to work within their subspecialty training. Concomitantly, the supply/demand imbalance in the number of anesthesia practitioners nationwide in the USA has altered market forces and the number of graduating anesthesiology residents choosing to enter the workforce immediately (rather than pursuing a lower-paying fellowship) is increasing.[2–3]

For perioperative leaders, the decreasing fraction of subspecialty-trained anesthesiologists and continued demand for coverage of subspecialty procedures creates a conundrum.

At UAB, regularly scheduled neurosurgical cases are staffed by fellowship-trained neuro-anesthesiologists. These cases are often complex neurosurgical interventions that balance appropriate depth of anesthesia with rapid awakening for neurologic assessment. However, the current night and weekend coverage model consists of “generalists” or anesthesiologists with

other subspecialty training who find themselves covering neuro-interventions that they may not have experienced during regular working hours. With the retirement of veteran neuro-anesthesiologists and the paucity of fellowship-trained replacements, providing neuro-anesthesiologist coverage is a current challenge for the department.

We review earlier studies examining the rationale for using specialty-trained anesthesiologists on weekdays and non-specialty-trained anesthesiologists on nights and weekends. To answer this question, on April 7, 2025, we conducted complementary searches in Scopus:
TITLE(anesthesi* OR anaesthesi*) AND TITLE(night* OR weekend*) AND TITLE-ABS-KEY(team? OR subspecial* OR specialt*)

Web of Science:
TI=(anesthesi* OR anaesthesi*) AND TI=(night* OR weekend*) AND TS=(team? OR subspecial* OR specialt*)

and PubMed:
(anesthesi*[TI] OR anaesthesi*[TI]) AND (night*[TI] OR weekend*[TI]) AND (team?[TIAB] OR subspecial*[TIAB] OR specialt*[TIAB])

The searches returned four publications. One article addresses statistical methods to predict how many nurse anesthesia providers are needed on weekends to balance coverage needs and avoid excess staffing costs.[4] While interesting, this study does not answer our question. Another addresses neuroimaging on nights and weekends, which is certainly a component of neuro-anesthesia care, but not relevant to our question specifically about neurosurgical care.[5] A third publication showed the large statistical power required to find similar institutions from state databases based on distributions of surgical procedures. [6] This means that the questions we studied relevant to UAB are likely similar to those of other hospitals across the country.

The fourth and most relevant article utilized data obtained through the American Society of Anesthesiologists' Anesthesia Quality Institute's National Anesthesia Clinical Outcomes Registry (NACOR). The investigators explore the logical inconsistency of using subspecialty teams during regular hours, but not on nights and weekends, given the increased risk-adjusted mortality for off-hours procedures. The diversity of procedures performed at most institutions during regular and off-hours was essentially the same. The findings applied both at individual hospitals and nationally. Therefore, the results show that there is no basis for having subspecialty teams on regular workdays but not nights at most hospitals and nationally. There was only moderate similarity in the procedures performed between these periods, both paired by hospital and nationally. As such, anesthesiologists who work within a single specialty during regular hours will likely not have much experience with procedures commonly performed during off-hours. Therefore, each hospital should consider not only the lack of evidence for the absence of specialty teams at nights/weekends if used during the regular workday, but also the opposite possibility that anesthesiologists doing single specialty work during regular workdays may be less prepared for the surgical procedures expected on nights/weekends.[7]

In conclusion, no published data supports the current approach to subspecialty training and coverage by neuro-anesthesiologists in neurosurgical cases during regular workdays, but not for nights/weekends.

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Building Better Teams: Integrating Moral Teamwork in the Perioperative Space

Britney Palermo, MD
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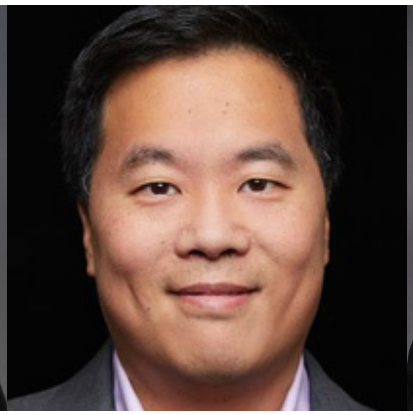

Larry Chu, MD
Professor of Anesthesiology
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"The greatest danger for most of us lies not in setting our aim too high and falling short; but in setting our aim too low and achieving our work."
– Michaelangelo

Despite the remarkable gains in anesthesia-related safety, preventable harm in the perioperative environment remains prevalent—not from lack of knowledge or tools, but from failures in collective action. The behaviors of perioperative teams are shaped by implicit social norms—unwritten moral codes that define what is acceptable, and what is not. Anesthesia providers, operating room nurses, and surgeons experience this every day around the world. Presumably, doing the right thing should not be difficult. Using the theory of mind, Tomasello points out that human civilization is based on joint intentionality.[1]

Once humans gather in large groups, joint intentionality develops into collective intentionality. In the perioperative services, these concepts should be familiar. Each day the team assembles and works toward seemingly common goals: surgeons consult and perform procedures on patients, anesthesia providers optimize and stratify patients before surgery then keep them safe throughout the operative course, and nurses assist in the delivery of surgical care. And yet, this collective intentionality rarely develops into a collective understanding.

When we lack collective understanding in the perioperative services, each member of the collective is unable to relate in a meaningful way to one another, thus reverting to their individual perspective. Kehr describes that each person carries into their work both implicit motives (that is, the often unconscious and implicit preferences and impulses associated with one's personal affect) and explicit motives (explicit cognitive choices and preferences).[2,3] Collective understanding in the perioperative space includes awareness among all team members of the team's overarching goals (and resultant alignment of the team members' explicit motives), cognizance of each component member's perspective and capacity for contribution, and so on. It is easy to imagine why such understanding may fail to develop - surgeons often leave the OR to speak with families, anesthesia providers transfer patients to PACU while preparing for the next case, and nurses ensure the documentation for the current case is complete before initiating the process again for the next case. In each member's mind, everyone in the perioperative team is simply doing their job and fulfilling a need.

In "If Nietzsche Were a Narwhal," Gregg observes that humans possess the unsettling ability to reason our way into ethically indefensible positions, believing we are acting morally even when causing harm.[4] He refers to this as "false beliefs held in good faith." One powerful example is the forced internment of Japanese Americans during World War II,[5] which was justified as a necessary national security measure despite its clear moral and legal transgressions. Similar rationalizations have enabled widespread harms in other historical and clinical settings.[6–8]

In the perioperative setting where each person's mental and physical reserves are stretched-thin, their ability to counteract implicit motives in favor of explicit ones decreases[3] and it becomes easy for one to justify a rude comment or an undermining action because they perceive themselves to be acting in the interest of the greater good.

While the incivilities inherent in the norms of the perioperative setting may certainly be less egregious than the examples of moral reasoning gone wrong cited above, these examples help us to understand the human capacity to justify antisocial behavior. In short, human moral reasoning allows each member of the perioperative team to rationalize incivility (and enforcement of the hierarchy) with the belief that it will aid in patient safety. However, the literature has demonstrated that interpersonal conflict within the perioperative services negatively affects the care delivered and lowers the morale of the providers.[9–11] The means do not justify the ends.

To move from theory to practice, we propose three actionable strategies for embedding moral norms into perioperative team design. *Figure 1* illustrates the five core domains through which moral norms can be embedded into perioperative teams to foster ethical, high-functioning performance. First, institutions should incorporate team morality explicitly into curricula for residents, fellows, and faculty using real-case debriefs, moral dilemma simulations, and structured feedback on behaviors tied to respect and inclusion. Second, perioperative leaders should undergo leadership training that emphasizes emotional intelligence, inclusive decision-making, and psychological safety. Work by Pian-Smith and colleagues highlights the importance of explicitly preparing clinicians to speak up across authority gradients through simulation, graded assertiveness techniques, and inclusive leadership strategies.[12–15] Third, implementation science should be used to adapt successful models from other high-risk industries. For example, trauma teams and aviation crews use pre-briefs and post-event huddles not just for clinical readiness, but to reinforce norms of speaking up, distributed authority, and mutual respect. Ultimately, the responsibility for embedding moral frameworks into perioperative teams rests with multiple levels of institutional leadership, especially clinical directors who have boots on the ground day in and day out.

Ultimately, Gregg points out that sociocultural and historical context influences how humans decide what is right or wrong.[4] Our moral sense is not a monolithic code. While we may be unable to truly ever elucidate the root behind an individual's morality, we can certainly attest to the social norms underpinning behavioral patterns observed in the perioperative space.

When implicit motives around personal achievement and power do not align with explicit motives, patient safety suffers. These themes – the norms of the workplace and the field, the realities of human moral reasoning, and the motives underpinning individual behavior – all contribute to the problems facing the perioperative services. And they represent key levers that if pulled appropriately can contribute to building better teams.

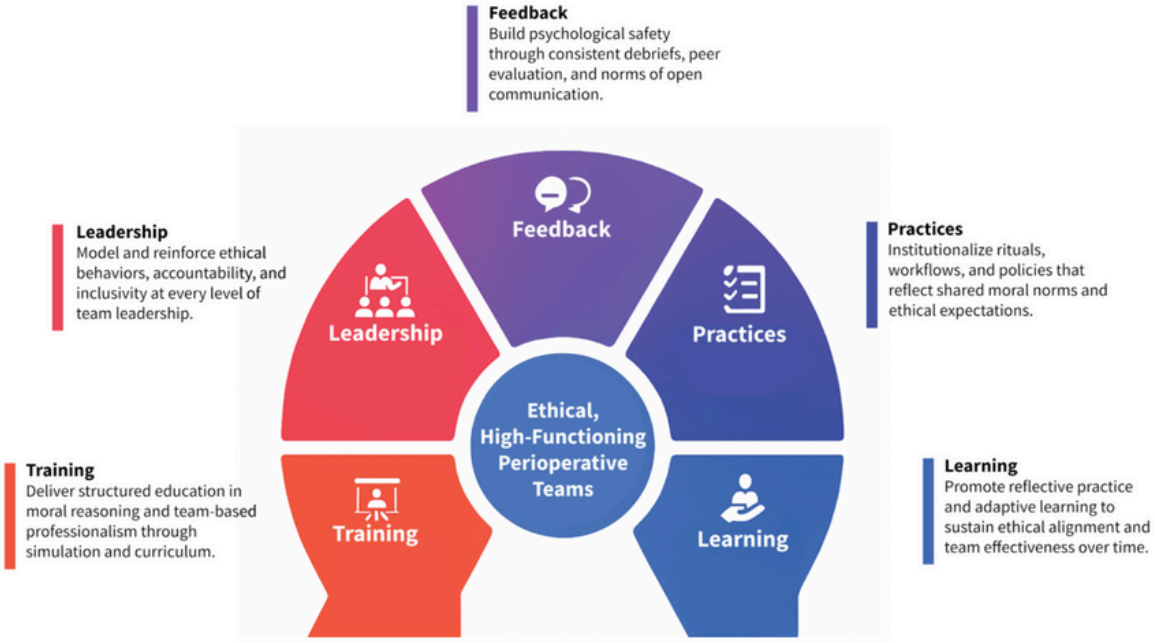

Figure 1: Framework for Operationalizing Moral Teamwork in Perioperative Care. This figure illustrates five core domains for building ethical, high-functioning perioperative teams. Training delivers foundational education in moral reasoning and professionalism. Leadership models and reinforces ethical behaviors and accountability. Feedback establishes psychological safety through debriefs and open communication. Practices institutionalize shared moral norms through rituals and policies. Learning fosters continuous reflection and adaptation to maintain team alignment and effectiveness. Together, these domains operationalize moral norms as drivers of safety, collaboration, and trust in perioperative environments.

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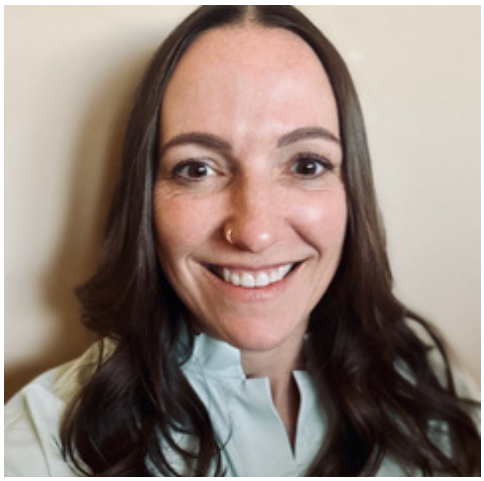
Positive Disruption in Anesthesia (Part 2)



Shannon Meron, MD
(Private Practice, Colorado)

Part 1 of this series was thought-provoking and engaging. Here, Dr. Meron returns to delve further into the complexities of our responsibilities. Thank you for staying tuned! Consider engaging further by sharing your thoughts in our newsletter as well.

I have long felt uncomfortable with the trend to identify patients in our system as consumers, because if given complete freedom, many people shop not only for quantity and convenience but quality. And quality within the confines of a relationship is often not definable in terms of utility or productivity or even efficacy. Some component of relational satisfaction comes from feeling: feeling seen, heard, recognized, and then respected and appreciated. Maybe even loved. Sometimes in spite of ourselves and the poor choices we make when we could choose better, because we live in an environment where the good choices are hard to make: to eat right, and exercise, and sleep, and not drink or smoke or gamble or opt for the easy dopamine sources that tempt us on screens and in reality because someone profits when our willpower is exhausted and we cave.

This is vulnerability, and it is harder and harder to come by when there are so many people in our virtual and real lives who will not and do not hesitate to judge us for the moments when we are less than the best versions of ourselves. And so much of what we as doctors manage are things that by virtue of social mores feel taboo to share with another human: bodily and psychic disease and dysfunction. Suffering is by definition a vulnerable state, and the modern medical system has a long history of paternalistic judgement. It's no wonder then that as prices of health insurance have risen, patient-consumers have decided to see what else they can purchase with their money, both inside and outside of systemic constraints. Because within the system, they are not actually free to spend on the therapeutic relationships that feel most beneficial; instead, they are airport shoppers, a captive audience paying exorbitant prices for mediocre goods.

Thus, the current system is not producing an end result that satisfies anyone with respect to any aspect of care. Doctors feel like automatons following algorithmic prescriptions at the behest of ill-qualified representatives of health insurance companies, handicapped in their ingenuity and professional discretion by threats of withheld compensation. Patients feel like objects, increasingly of judgment and scorn and ridicule, especially if they have questions or anxieties or challenging or atypical disease states or difficulty adhering to treatment plans due to a variety of social, emotional, or economic obstacles.

The time is ripe, then, for positive disruption. For new ways of approaching illness and healing with not just an eye but a nod to the social, behavioral, economic, and psycho-spiritual aspects of the bodies they afflict.

New research and data analysis techniques are being employed to investigate so-called “natural experiments” to answer questions within their regular contextual complexity, as opposed to lab environments that are controlled, artificially simplified, and isolated from anything that resembles the real world and thus often fail in their extrapolation and reapplication. Increasingly, those answers point to the influence, much larger than we knew, of human connection in achieving medicinal ends and to the health of the caregivers as an essential prerequisite for the generation of authentic compassion and effective care.

A new generation of anesthesiologists is rejecting historical workplace presumptions, like uncompensated availability, that have grown unchecked by the voracious appetite of a system bent only on maximization. A new generation of patients is rejecting medical care that pejoratively categorizes them as diseased bodies created by the choices of flawed individuals. This is our opportunity to apply new modes of working, new technologies and techniques of data analysis and application, and new conceptualizations of our goals within a cooperative patient-healer alliance. I write as an anesthesiologist, because that is what I know, and locums is the freest version of a specialty that is by definition shackled to the complex environment of operating rooms within hospitals and surgery centers and other literal edifices of the healthcare industry.

For primary care specialists, though, the movement towards direct primary care is analogous in that the annual subscription fee effectively compensates for professional availability, while freeing doctors and patients to negotiate additional fees and services in the context of an unconstrained relationship between individuals choosing to collaborate for a common goal. We have accepted the prevailing healthcare-industrial economic schemata for decades because it seemed to produce benefits in availability of and access to care.

Now it has become a behemoth that detracts from the execution of what is for many of us ideally both a job and a calling and may in fact be making our patients sicker (though perverse incentive alignment is a topic for another essay). In that sense, then, leaving the workforce status quo is not a risk, but a moral responsibility to seek out different compensatory relationships that support more compassionate, and consequently more efficacious, caring.

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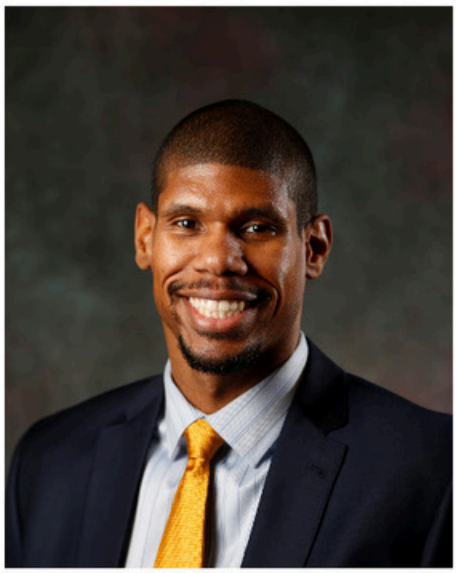

"Physician leaders must be visionaries; creating collaborative culture, innovative ideas, and empowering people. Having a business acumen not only allows physicians to see things from a different perspective, but it also allows them to find creative solutions and lends them credibility in their respective organizations."

Jarrett Heard, MD, MBA

Physician, Associate Professor of Anesthesiology, The Ohio State University Wexner Medical Center

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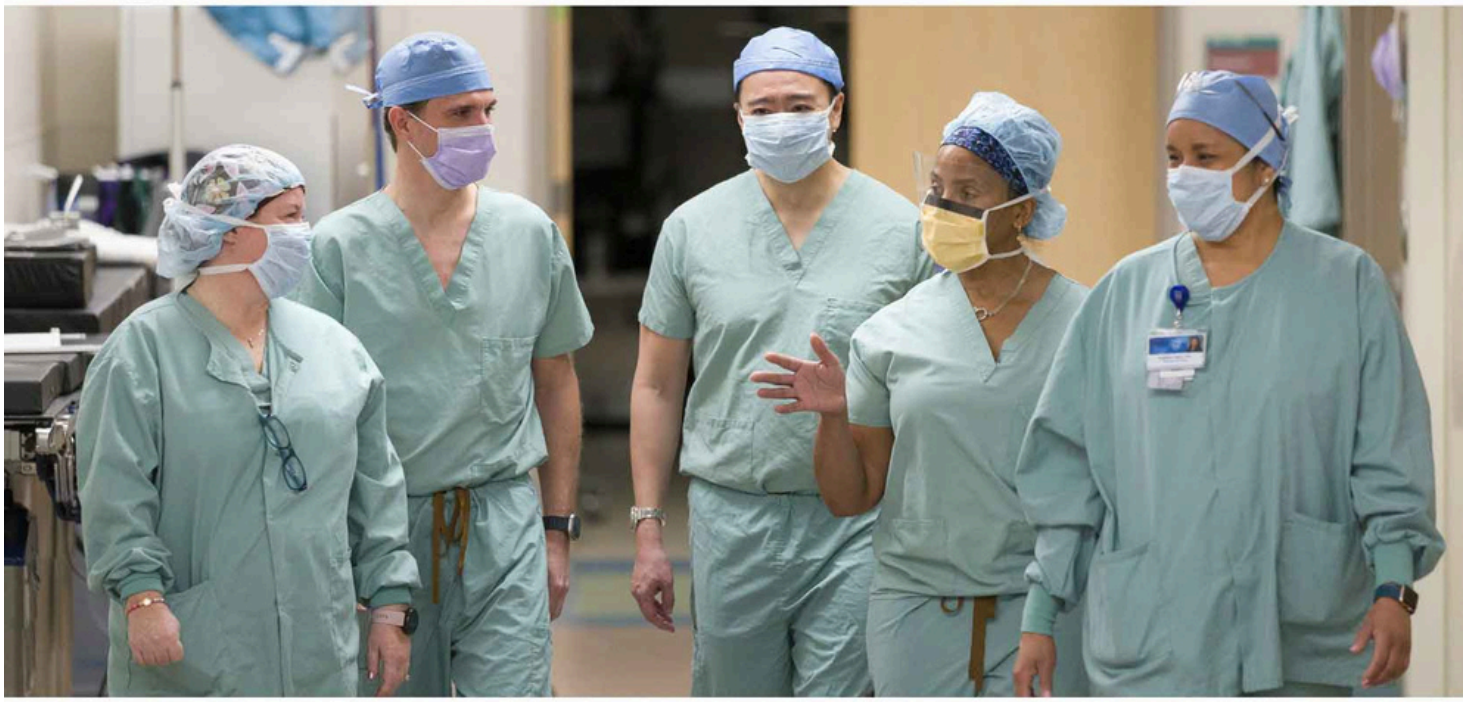

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