

SPRING 2026 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 and other perioperative professionals who have similar experiences, and to ultimately create solutions.

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# OUR NEWEST COLLABORATION: The NORA Society



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**Claudia Fernandez Robles, MD**  
Yale School of Medicine

The AACD is pleased to announce a new partnership! We are collaborating with the NORA Society to jointly 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, and look forward to the fruits of this venture! Learn more below and stay tuned for future updates!

## **Who Founded this Society?**

Fueled by their dedication to advancement and recognition of the importance of Non-Operating Room Anesthesia (NORA), a small group of leaders from academic institutions across the country came together to form the NORA Society. Although practice settings may vary geographically, many NORA-related challenges are shared nationwide. It is encouraging to see leaders in this space come together and share solutions. Dr. Diana Anca is a founding member of the NORA society and served as the first president of the organization. Other founding members are Dr. Claudia Fernandez-Robles, who is the current president, Dr. Candace Changisi-Chang (the immediate past President), Dr. Patricia Fogarty Mack, Dr. Emily Methangkool and Dr. Cristian Bartoc.

## **The NORA Society: Who Are We?'**

The NORA Society was founded in 2020 in the midst of the COVID-19 pandemic, when a group of NORA medical directors came together with a shared mission: "to improve quality of care and enhance both patient and staff safety in remote procedural areas". What began as a response to unprecedented challenges quickly evolved into a national community dedicated to advancing standards and supporting one another in complex and rapidly changing practice environments.

The purpose of the NORA Society is to maintain a strong community of practice among NORA leaders across the country.

Society membership meets (virtually) monthly 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.

**E-mail:** [members@norasociety.org](mailto:members@norasociety.org)

**Website:** <https://norasociety.org>

# The 'Arts' of Leadership



**Jay Mesrobian, MD, MBA**  
**Advocate Aurora Health**

If the practice of medicine is both art and science, then how might the humanities provide foundational support for practicing clinicians and physician leaders?

Current executive development often focuses on either technical expertise or business 'healthcare management'. Healthcare leaders, however, often face challenges around value conflict and the human spirit, more moral than technical. With the rise in moral injury, institutional financial pressures and broad regulatory requirements, education that strengthens judgment, moral compass, and the human spirit becomes critical for successful leadership.

Peter Drucker, one of the founders of modern management theory, long ago recognized the essential value of humanities-based leadership development (The New Realities, 1989).

*"Management is (thus) what tradition used to call a liberal art - "liberal" because it deals with the fundamentals of knowledge, self-knowledge, wisdom, and leadership; "art" because it is also concerned with practice and application. Managers draw on all*

*the knowledges and insights of the humanities and the social sciences - on psychology and philosophy, on economics and history, on ethics-as well as on the physical sciences."*

*"But they have to focus this knowledge on effectiveness and results - on healing a sick patient, teaching a student, building a bridge, designing and selling a user-friendly software program. For these reasons, management will increasingly be the discipline and the practice through which the "humanities" will again acquire recognition, impact, and relevance."*

To align individual, organizational and social values, leaders need to understand priorities that may be different from their own. Self-awareness and empathy are intellectual skills difficult to teach yet able to be learned, practiced and internalized. The capacity to recognize one's own emotions and their effects upon others is critical to leaders' success. **These tools and skills are essential competencies.** Study of the humanities—philosophy, history, and visual arts—has been shown to help physicians navigate ambiguity, enhance decision-making, and improve working relationships. Great works can 'read the reader', building self-awareness and rekindling one's humanity.

AACD is the pre-eminent organization supporting and educating Anesthesiologists as operational leaders in their organizations. I look forward to meeting you at the AACD Summit in Austin, TX March 27-29!

*"The spirit of the humanities is the greatest single gift in education." -Dr. William Osler*

# Ask the Experts: Anesthesia Staffing for Bronchoscopy and Other Non-Operating Room Procedures to Meet Patient Access Targets



**Patrick Hussey, MD, FASE**  
University of Alabama at Birmingham

Many anesthesia departments provide services in non-operating room anesthesia (NORA) locations such as bronchoscopy suites, endoscopy units, and diagnostic imaging areas. Unlike operating rooms, these procedural areas often have variable physician availability and are geographically dispersed. Consequently, anesthesia departments are often asked to provide staffing for procedural services that do not operate continuously throughout the week. For example, a pulmonary service may request anesthesia support for two bronchoscopy rooms operating five days per week. However, pulmonologists performing bronchoscopies often also maintain outpatient clinics, cover other hospitals, or rotate through other clinical responsibilities. As a result, procedural demand fluctuates.



**Franklin Dexter, MD, PhD, FASA**  
University of Iowa

The operational question for anesthesia leadership becomes: How much anesthesia staffing capacity should be planned so that pulmonologists can schedule bronchoscopy procedures within a target patient access interval (i.e., within two weeks)?

This differs from traditional operating room efficiency problems because the primary objective is to provide proceduralists with access to anesthesia care within a defined number of days, rather than maximizing room utilization.

To identify relevant literature on scheduling and staffing for anesthesia services outside the operating room, searches were conducted in Scopus on March 3, 2026. The primary search focused on scheduling terminology appearing in article titles:

TITLE(appointment\* OR schedul\* OR staffing OR  
allocat\*)

AND

TITLE-ABS(anesthe\* OR anaesthe\*)

AND

(  
TITLE-ABS(bronchoscop\* OR "non-OR" OR  
"nonOR" OR "satellite")

OR

TITLE-ABS(outside AND "operating room\*")

)

This search yielded 13 articles, of which three addressed scheduling or capacity planning for anesthesia services outside operating rooms [1-3]. The third article was about induction rooms [3], highlighting that "non-OR anesthesia" translates poorly to other languages or means different things in different countries. The search was then expanded to include the term "nonoperating", which appears in the title of some NORA publications:

TITLE(appointment\* OR schedul\* OR staffing OR  
allocat\*)

AND

TITLE-ABS(anesthe\* OR anaesthe\*)

AND

(  
TITLE-ABS(bronchoscop\* OR "non-OR" OR  
"nonOR" OR "nonoperating" OR  
"satellite")

OR

TITLE-ABS(outside AND "operating room\*")

)

This search added two review articles discussing operational considerations for NORA services [4,5]. Finally, because some studies focus on reducing patient wait times or delays, an additional search was performed, including terms related to access and waiting:

TITLE-ABS(appointment\* OR schedul\* OR  
staffing OR allocat\*)

AND

TITLE-ABS("wait time\*" OR "waiting time\*" OR  
"time to procedure" OR backlog OR  
(access\* W/3 patient\*))

AND

TITLE-ABS(anesthe\* OR anaesthe\*)

AND

(  
TITLE-ABS(bronchoscop\* OR "non-OR" OR  
"nonOR" OR "nonoperating" OR  
"satellite")

OR

TITLE-ABS(outside AND "operating room\*")

)

This search identified two additional studies addressing delays in NORA services [6,7].

Dexter et al. reviewed staffing and case scheduling for anesthesia services outside the operating room [1]. They described planning anesthesia staffing to ensure proceduralists have open access to anesthesia time within a desired number of days [1]. (We include an example of these steps and Excel file, below.) The anesthesia department implements a service guarantee of no more than a two-week wait [1,2,8]. Sufficient full-day block time is allocated to each specialty to accommodate most of its non-OR cases [8]. When a specialty that is allocated non-OR time has filled that time, any other cases are scheduled into open, unblocked, first-come, first-served time so that the case is performed within two weeks, and usually within one week [9]. Cases of those specialties without allocated time are also scheduled into the open time [9]. The hours of allocated and open time are adjusted 2-3 times per year using 12 two-week periods of data [10]. Calculation of the overall staffing for non-OR locations is based on the normal distributions, followed by rounding up to the nearest whole day [9]. A related study showed its implementation, with clerks and nurses from other departments then scheduling cases into the allocated time using an enterprise-wide scheduling system [2].

Warner and Martin reviewed scheduling challenges in geographically dispersed NORA services and discussed operational issues, including service consolidation and block scheduling [4]. The methodology reviewed for planning capacity is that of the preceding articles [1,2,8-10]. Navidi and Kiai discussed scheduling in gastrointestinal endoscopy suites, but not the mathematics of calculating capacity to meet access guarantees [5].

Two additional studies focused on reducing delays on the day of the procedure rather than on ensuring access within a defined number of days. Qiu et al. reported process improvements in scheduling NORA cardiac anesthesia cases for transesophageal echocardiography, reducing procedural delays and case cancellations due to scheduling conflicts [6]. This service represents a relatively low caseload NORA environment in which procedures can be scheduled using a shared clinic calendar rather than dedicated anesthesia capacity [6]. Similarly, Mueller et al. examined diagnostic imaging procedures performed under anesthesia during nights and weekends [7]. They showed that rational case sequencing requires knowing how long each case can safely wait before being started without increasing patient risk [7]. In these settings, imaging results may lead to immediate surgical or medical therapy, so capacity planning must ensure that urgent diagnostic procedures can be performed promptly when needed [7].

The studies collectively highlight an important distinction between two types of scheduling problems in NORA services. The operational objective must be defined before selecting the analytic approach to staffing, staff scheduling, and case scheduling [8,9]. Reducing delays between cases or improving workflow within procedural areas can enhance operational efficiency and patient satisfaction [2,6,7], but do not address the broader question of how much anesthesia capacity must be available to meet patient demand [1,2,8-10].

To illustrate this process [1,2,8-10], the accompanying Excel workbook can be used to model procedural demand and estimate the amount of anesthesia capacity needed to meet specified patient access goals (<https://bit.ly/AACD NonOR>). Enter your service-specific data into the 'Input' worksheet. Select cells and "clear contents" from the bottom unused. The formulas in the 'Analyses' worksheet calculate the anesthesia capacity required to provide proceduralists access to anesthesia time within a specified number of days. The worksheets are protected to keep structure, but without password. Expand the formula bar to see the dynamic array equations. By adjusting inputs, departments can evaluate different staffing scenarios for services such as bronchoscopy suites. Currently the 'Analyses' worksheet is based on 7.75 hour blocks, but these can be revised to whatever duration, recognizing that these are the hours into which cases are scheduled (i.e., staff scheduling should be planned for at least 45 minutes more). Analyses allow anesthesia departments to move beyond anecdotal scheduling decisions toward data-driven planning of non-operating room anesthesia services.

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## 2026 AACD Perioperative Leadership Summit

March 27-29, 2026

Austin, TX

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