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Will Medically Consulting Anesthesiologists Supersede Medically Supervising Anesthesiologists And Replace Medically Directing Anesthesiologists?

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My opinion

I am deciding to not wait for my early/normal/late and forced/unforced retirement to ask theÂ question [1] which may healÂ anesthesiology, the Fisher King. The healing question "Whom does the Grail serve?" [2] has been and will always be wide open to interpretations depending onÂ who, why,Â when and where. For me as a young full-time anesthesiologist in the United States, that Grail is the science and art of anesthesia and analgesia and the time to ask the healing question is right now whenÂ wartime approach to pandemic is meddling with physician exceptionalismÂ [3] and non-physicians'Â delimited scopeÂ of practice [4].

- Does theÂ GrailÂ serve patients who look upÂ to good outcomes for themselves?
- Does the Grail serve payers who look up toÂ cost-effective outcomes among patients?
- Does the Grail serve providers who look up toÂ livelihood-supporting reimbursements for patient care?
- Does the Grail serve regulators who look up to socioeconomically viableÂ healthcare deliveredÂ by payers and providers?

Being an anesthesiologist myself who may have conflict of interestÂ while seekingÂ answer to the healingÂ question,Â I willÂ just pose questions asÂ pertainingÂ to current and future medically directing anesthesiologists.

- HasÂ the evolved Grail become mature enough to allow non-physiciansÂ safely flying soloÂ without theÂ oversight byÂ anesthesiologists who have superiorly famed degrees, longer training durationsÂ and higher student loans-debts?
- Has the matured Grail equalized the anesthesia providers in terms of minimum basicÂ skillsÂ demonstratedÂ by them to safely and cost-effectively provide anesthesia care for supermajority of diagnostic and therapeutic surgeries and interventional procedures?
- Has the safe-skilled GrailÂ limitedÂ the need for extra-pair of hands to some occasions, extra-set of eyes toÂ few occasions and extra-mindÂ toÂ fewer occasions?
- Has the futuristic Grail been looking up to the evolution of medically directing anesthesiologists into medically supervising anesthesiologists to eventually medically consulting anesthesiologists?
- Has the visionary Grail envisioned humans or artificialÂ intelligence as medically consulting anesthesiologistsÂ toÂ provide elective or emergent 24x7 consultations via on-siteÂ presenceÂ and/orÂ audiovisual support remotely [5]?
- Has the collaborative Grail been planning toÂ coalesce anesthesia providersâ€™ workforce by shedding redundantÂ trainingÂ period in theÂ specialty as well asÂ redundant personnel presence during the procedures so that theÂ shortagesÂ within the subgroups of anesthesia providers turn into overallÂ surplusÂ of anesthesia providers once equalized within a unified workforce [6]?
- Has theÂ equalizer GrailÂ foretold the need to downsizeÂ and thenÂ eventually abort anesthesiology training programs to allowÂ medical students' pursuit for alternative futures in the medicine rather thanÂ being born into a war-torn specialtyÂ whichÂ may never see the peacetimeÂ whenÂ despite unpredictable future, new soldiersÂ have celebratoryÂ recruitmentÂ every year?
- Has the realistic Grail ever wondered whether the downsized or aborted anesthesiology training programs will have ripple effect on medical schools' enrollment and their tuitions in the United States unless the major loss may beÂ limited to the debt-free international medical graduates whoseÂ opportunitiesÂ to pursue graduate medical educationÂ in the United StatesÂ may get restricted because their future recruitment opportunities within the unified anesthesia providers' workforce may become extremely limited?

The million-dollar questions are:

- DidÂ systems-based practice of safer medicineÂ dampenÂ the charm of being aÂ savior physician orÂ being an enterprising anesthesiologist?
- Did protocols-based safely diagnosing and treating patientsÂ delimitÂ physicians' humanityÂ to just comfortingÂ the managed patients?
- Did teams-based workplaceÂ deem physicians overqualifiedÂ per theirÂ medical degreesÂ butÂ under-qualifiedÂ per theirÂ leadership skills?
- Did web-based socialized knowledge neutralizeÂ exceptionalism enjoyed byÂ those matriculatingÂ to graduateÂ with prestigious degrees?
- Did loans-based tuitions envisageÂ that providers' bubbleÂ [7] is toÂ unnecessary procedures as litigators' bubbleÂ [8] is toÂ unnecessary litigations?

Going forward, the futuristic existential questionsÂ are:

- Will anesthesiology consultancy model be vibrant enough to meet elective and emergent needs of equalized and unified anesthesia providers' workforce personally delivering anesthesiaÂ in the procedure roomsÂ by beingÂ dynamically attuned to their first attempt success rates for invasive anesthesia procedures, call-for-help rates for extra-hands/eyes/mind,Â and anesthesia event ratesÂ with corresponding patient outcome rates?
- Will anesthesiology consultancy model createÂ comfortable livelihood for full-time in-person medically consulting anesthesiologists unless they will have to supplement theirÂ earningsÂ as part-timeÂ anesthesia providers personally delivering anesthesia in the procedure rooms and/or by expanding their reach of anesthesiology consultancyÂ to provide remote peri-anesthesia supportÂ for anesthesia providersÂ via privacy-compliant audiovisual gadgets and robots?
- Will anesthesiology consultancyÂ model limit the liability of medically consulting anesthesiologists only as pertaining toÂ their elective and emergent in-person or remote consultations?
- Will anesthesiology consultancy model create better revenue/reimbursement per medical consultation for medically consulting anesthesiologists than current revenue/reimbursement per medical supervision or direction?
- Will anesthesiology consultancy model eventually drive up the number of anesthetic procedures toÂ sustain the equalized salaries of surplusÂ anesthesia providersÂ available in the unifiedÂ workforce to personally deliver anesthesia in the procedure rooms unless, toÂ accommodate paid work opportunities for all within the ballooned workforce, anesthesia providers voluntarily or mandatorily decide toÂ uniformly limit theirÂ work-weekÂ to 40-hours thus allowing them more quality time for self and with family despiteÂ their smaller paychecksÂ bringing them down from top 5% to top 10% in the United States [9]?
- Will anesthesiology consultancy model turn out to be an intentional self-harmÂ event to heal anesthesiology, the Fisher King, byÂ endorsing a well-informed and educated decision aboutÂ managed contraception of anesthesiology asÂ a medicalÂ specialty [10-11]?

Essentially, I am envisioning while fearing the fear itself that, in due course of time when sustainable future metamorphoses from delusional present,Â (a) some medically directing anesthesiologistsÂ mayÂ evolve intoÂ medically consultingÂ anesthesiologists, (b) some medically directing anesthesiologistsÂ mayÂ teach full-time as academic anesthesiologistsÂ if anesthesia providers want to learn from them, (c) some medically directing anesthesiologists mayÂ explore as full-time research anesthesiologists if the society expects them to innovate, (d) some medically directing anesthesiologists may retire, (e) some medically directing anesthesiologists mayÂ emigrate from the specialty and/or the locality to greener pastures, and (f) some medically directing anesthesiologistsÂ may move back into theÂ procedure rooms to personally deliver anesthesia. Only time will tell whether modern artists will continue to be nurtured by modern technological societies just like ancient artists had been nurtured by ancient hunter-gatherer societies because without nurturing ancient artists who were allowed and expected to neither hunt nor gather [12], ancient hunter-gatherer societies would not have evolved into modern technological societies due to the escalated evolution of humanity as wired in the culture [13] by the non-hunting non-gathering visionaries.

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