What we do, what we call ourselves, and how we spell it

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Title: What we do, what we call ourselves and how we spell it.

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What's in a name

However you spell it, anaesthesia – or at least the administration of anaesthetic drugs – is not solely the preserve of anaesthetists. British Anaesthesia Associates, American Certified Registered Nurse Anesthetists (CRNAs) and an international spectrum of specialist nurses and technicians all provide sedation and anaesthesia with varying degrees of medical supervision and accountability. The accountability frameworks may differ but their practice is nevertheless lawful. Anaesthetic drugs (typically hypnotics) are prescribed by physicians in intensive care units and emergency departments (and less frequently elsewhere). Medically qualified specialist anaesthetists regard these alternate providers with a range of emotions reflecting their perceived status as valued colleagues or unwelcome competitors. One approach is to emphasise the value of specialist postgraduate training in anaesthesia and to reflect that with a special name. Thus, in 1902 American physician anaesthetists became anesthesiologists[1] and their counterparts in continental Europe and Ireland are now anaesthesiologists.

For decades, the American Society of Anesthesiologists (ASA) and the American Association of Nurse Anesthetists (AANA) have battled over supervision, independent practice and recently over names. A faction within AANA failed to change its name to the American Association of Nurse Anesthesiologists and recently the ASA intervened to prevent Certified Registered Nurse Anesthetists from describing themselves as Nurse Anesthesiologists and received a supportive opinion from the Supreme Court of New Hampshire.[2] At stake is the desire to distinguish medically qualified ('Physician') providers of anaesthesia from those without a medical degree. Increasingly, individuals trained as CRNAs may complete an

additional experiential programme and a project to earn the title Doctor of Nursing Practice thereby entitling them to the title Doctor.

Overlap of roles between clinical professions is normal. In the UK, nurses triage, diagnose, manage, prescribe and lead. None of these are the unique responsibility of doctors. The difference between doctors and nurses is therefore not defined by absolutes. Rather, it is a question of degree and the balance of activities. A doctor particularly deals with uncertainty – working towards a diagnosis for the undifferentiated sick patient then developing a treatment plan and supervising its execution. The equivalent in anaesthetic practice might be an acute, unexpected emergency during otherwise "plain sailing" anaesthesia.

The Covid-19 pandemic has demanded extraordinary flexibility from health workers and in turn their responses have been remarkable. Operating room anaesthetists have switched to intensive care, orthopaedic surgeons served in teams turning patients prone and undergraduate training has been adapted. [3-5] In Europe and in the USA, CRNAs adapted their anaesthesia skills to the ICU environment and and made valuable contributions to the ICU workforce.[6, 7] Overall capacity in intensive care is clearly inadequate and the workforce requires expansion.[8] The lead time for traditionally trained intensivists is enormous and the circumstances demand that other solutions at least be considered. The Competency-Based Training in Intensive Care Medicine in Europe (CoBaTrICE) program was established in 2003 to harmonise medical postgraduate curriculum standards.[9] It has subsequently provided important elements for training nurses as Advanced Critical Care Practitioners.[10]

In February 2021, Health Education England announced the development of a Core Capabilities Framework for four Medical Associate Professions: Anaesthesia Associates, Physician Associates, Surgical Care Practitioners and Advanced Critical Care Practitioners.[11]

The development of well defined (competency based) roles for non-medical providers with proper regulation by statutory bodies is therefore well underway and unlikely to be reversed.

If doctors are generally happy with their position vis-à-vis the nursing staff, why then such angst about nurse anesthesiologists or perhaps nurse anaesthetists in general? Misrepresentation ('passing off') of oneself as medically qualified and licensed when that is not the case is an offence in many countries including the UK and the USA. If the word anesthesiologist means physician anaesthetist then its use by a nurse is deceitful, a view shared by the Supreme Court of New Hampshire. However, there is more at stake. Automated systems, economics and competency based training of non-anaesthetists challenge assertions of physician anaesthetists' hegemony over names, roles and particular drugs or clinical procedures.

These broad challenges to professional identity also threaten traditional monopolies including provision of anaesthesia services in private practice. Profitable areas are at risk, especially the provision of propofol based procedural sedation where rapid growth of provision inflates cost without evidence of benefit.[12, 13] Indeed, physician anaesthetist (usually high dose) propofol sedation may actually be harmful[14] whilst sedation with lower doses by an autonomous device[5] or a protocol following nurse are demonstrably safe.[15, 16]

Do actions speak louder than words?

What to do? The traditional approach of briefing politicians, campaigning with the public and occasionally litigating is well developed. An alternative approach is to reconsider the physician anaesthetist's scope of practice. UK anaesthetists have long been the largest group of doctors working in intensive care and remain so as Intensive Care Medicine

develops its own training and professional identity. The extension of anaesthetists' scope to embrace pre-assessment and pre-habilitation as well as anaesthesia and care after surgery make Perioperative Medicine[17] a logical construct that is intelligible to patients and acceptable to surgeons and nurses. Arguably, the best way for physician anaesthetists to defend their status is by providing comprehensive care for difficult cases.

Does spelling matter?

England (for this pre-dates 'Great Britain' and 'United Kingdom') and America have been represented as 'Two nations divided by a common tongue', variously attributed to Oscar Wilde and George Bernard Shaw. This is certainly true for our specialty anaesthesia and its journals.

A digraph is the combination of two letters into one sound, a diphthong a single syllable word that contains two distinct vowel sounds, and a ligature is a character that combines two letters into one. In anaesthesia, 'ae' is a digraph that was historically represented by the ligature 'æ' or its capitalised form 'Æ'. Our digraph and its ligature are prominent in early descriptions of our clinicians and their practice

The journal Anesthesia and Analgesia began 1922 as 'Current researches in Anesthesia & Analgesia' on behalf of the National Anesthesia Research Society. In a clear statement of independence, our New World colleagues dumped the ligature. The British Journal of Anaesthesia followed on in 1923, proudly using the ligatured digraph in its lower case form 'æ' all delivered in an imposing Old English font, (approximately) thus British Journal of Anæsthesia, Figure 1.

Figure 1 near here

The BJA's proclivity for medieval typography persisted until January 1954 when the journal moved from quarterly to bimonthly publication and celebrated with a new format and the quiet abandonment of the ligature.

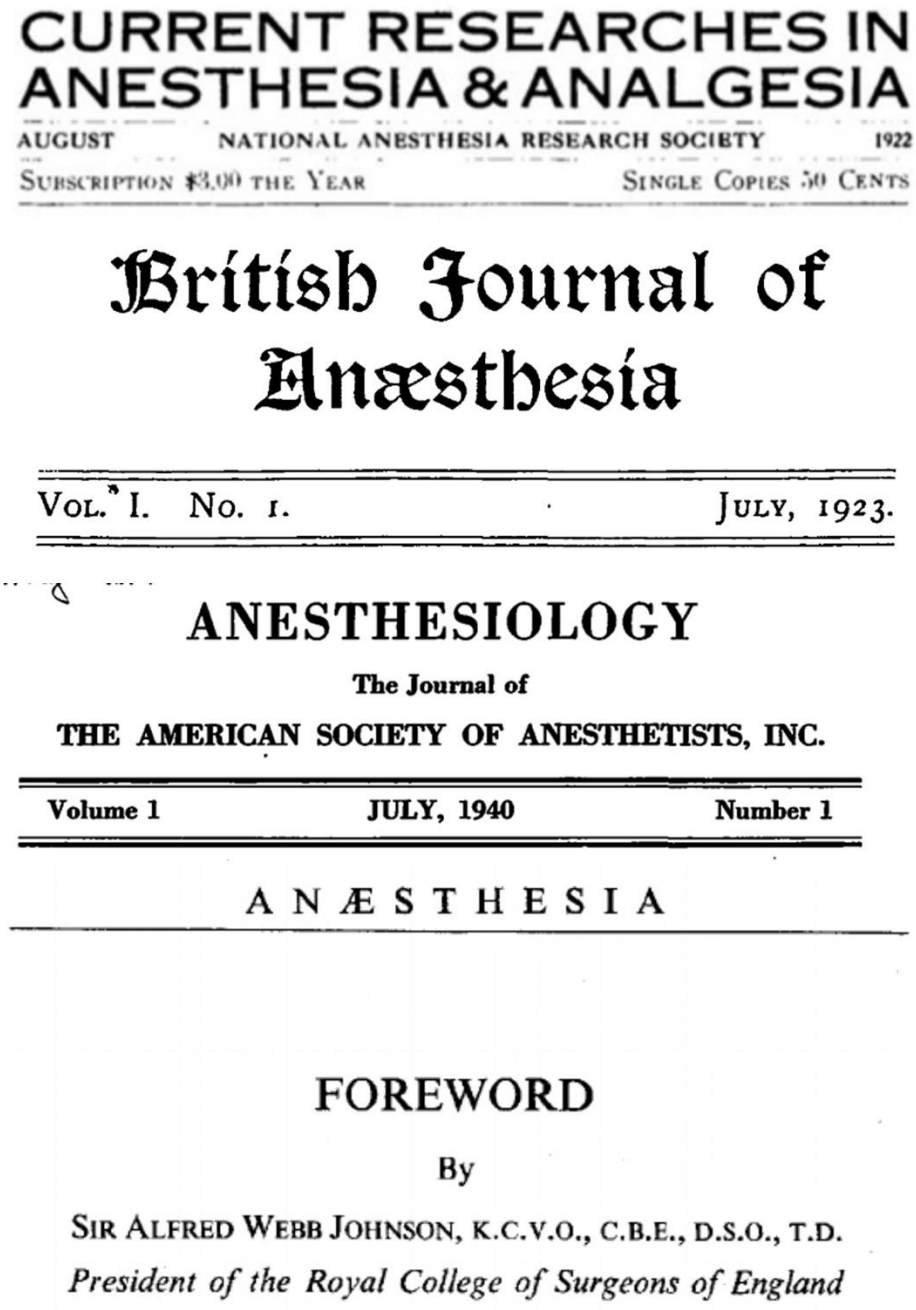
Special words have their uses, even if their annexation to territorial campaigns feels petty. Anaesthesiologist (or anesthesiologist) as a sobriquet for physician anaesthetists has a useful precision leading to its adoption by professional bodies outside the USA when seeking to emphasise their medical credentials. Thus the College of Anaesthetists of Ireland became the College of Anaesthesiologists of Ireland. In contrast the European Society of Anaesthesiology changed to the European Society of Anaesthesiology and Intensive Care (ESAIC) to emphasise its members' scope of practice rather than their underpinning degrees.

Looking ahead

Physician anaesthetists have everything to gain and nothing to lose by extending their scope of practice. The professional appreciation of our colleagues in surgery and in nursing is best earned by providing outstanding service to patients. Straightforward elements of anaesthetic practice may be safely provided by appropriately trained and supported non-medical practitioners. Exemplary performance of simple procedural sedation of healthy patients for brief diagnostic procedures arguably underpins excellence[18] but doesn't, on its own, justify the title 'Consultant' or 'Specialist'.

Spelling probably doesn't matter and the ligatured digraph belongs in the history books.

Figure Legends.



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FOREWORD

By

SIR ALFRED WEBB JOHNSON, K.C.V.O., C.B.E., D.S.O., T.D.

President of the Royal College of Surgeons of England

Figure 1. Title pages of four English language anaesthesia journals.

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