Anthony Messina (AM): 0:10 So, from my point of view, it's very disheartening.

Michael Wang (MW): 0:16 But, it's very heartening that you have the views that you have.

Michael Avidan (MA): 0:20 Well, I mean, one could argue that you say it's heartening because of your unique biases and perspectives.

AM: 0:27 Yeah.

MA: 0:28 And I'm not arguing, I'm saying…

AM: 0:29 I know you're not.

MA: 0:30 I'm just saying that different people would have different perspectives …

MW: 0:32 Views, yeah.

MA: 0:33 different views, yeah. If somebody else would say that if…and I'm not arguing this, because I just want to be clear on one thing. All of this evidence about light anesthesia and delirium, this is very preliminary stuff. It's not as if we have…you know people are adopting these iron clad positions, as if this is now firmly established…

AM: 0:55 Correct.

MA: 0:56 and it's by no means firmly established. But if it were, let's say it were firmly established, that giving deep anesthesia was resulting in increased 30-day mortality. If that were established, then you would have a different scenario, and then you'd need to enter in it to a different contract with patients, to say "Look, you know we're in a difficult bind over here. We want to ensure that you're unconscious for your surgery, but there is strong evidence emerging that the more anesthesia we give you, the more likely you are to be dead 30 days or one year after the surgery." We're not there, but if we were there, then it changes the calculus, and it changes the conversation.

AM: 1:41 But I would say this, in response to that. We need to start introducing surgeons into the dialogue, because ---one…I asked one of the experts, he commented robotic surgery, absolutely no movement, and I said okay. What's the justification for the robotic surgery? He said infection. I can imagine how long it took the surgeons to figure that infection was decreased in robotic surgery. The point being that, let's say we get to the point, the issue comes into the vast majority of surgeries use quality of life surgery. It's important to give appropriate informed consent to patients, in terms of what…but, if we start using light techniques again, and across the board paralysis, then the patients need to be exposed to maybe a more open discussion of the need for that particular surgery. Especially if it's end of life surgery, in terms of quality or middle-aged people having completely unnecessary, but quality of life enhancing surgery. The anesthesia part of it is always…it tends to be damped down.

MA: 2:49 I agree with you, and there are all sorts of reasons for that including power dynamics and…

MW: 2:55 Precisely.

MA: 2:56 they're all true…

MW: 2:56 Yeah.

MA: 2:57 all true.

AM: 02:58 Can you just amplify the power of dynamics?

MA: 3:01 Well, I mean, I think the power of dynamics in relation to surgery are that, like it or not, the surgeons wield more power in the perioperative setting, than other members of the team, and they're more involved in deciding with the patient's whether or not the patients have the surgery in the first place. It's very unusual that an anesthetist or anesthesiologist will have a major impact on that. You know, usually the decision is already made one way or the other by then, and you know, for an anesthetist to talk to a patient on the morning of surgery about you know, this is…you know…have you thought about the quality of life implications? Is this really…you know, what's the evidence behind this kind of surgery? It…that's politically very tricky, and you know…

MW: 3:52 Michael, you've practiced in London…

MA: 3:55 Yes, I have.

MW: 3:56 as well as in the United States.

MA :3:57 I have.

MW: 3:58 Have you practiced in South Africa as well?

MA: 3:59 I've practiced in three continents, absolutely.

MW: 4:01 Yeah.

MA: 4:02 (unsure what was said) practiced in…

MW: 4:03 Do you notice…is there any variation in the…this dynamic in the operating room?

MA: 4:09 There is, you know, I think certainly in United States, the politics is perhaps more skewed towards the surgeon in the power dynamic, than in South Africa or the UK. I think there's also a difference in, for example, the NHS and private practice. I would often see in NHS, where if an anesthetist worked with the same surgeon in private practice, she or he would be pretty reluctant to gain say that surgeon in the NHS practice, because they're reluctant to lose their private practice.

MW: 4:48 Of course.

MA: 4:49 So, there are other interesting power dynamics in the NHS…

MW: 4:52 Yes.

MA: 4:53 that I noticed. So, I would actually say, that in the other hand…so, you see the other extreme in the NHS. In the NHS, your anesthetist who's doing private work, is entirely and completely beholden onto that particular surgeon, and if you piss that surgeon off, you lose your private list.

MW: 5:14 Yeah, yeah.

MA: 5:15 You know, so you don't get into it with that surgeon.

MW: 5:17 But not all anesthesiology…not all anesthetists in the United Kingdom are working with the same surgeon.

MA: 5:26 Not all, but many times that is the case…

MW: 5:28 May happen.

MA: 5:29 that is many times the case. And you know in the United States, where I work…it should you know, the surgeons have some power, whatever, and that is the case. But, you know, they don't…they don't have power over me, they're not going to hire or fire me. And I can you know…I often get into debates with them, and it's fine, and you know they respect me, and…I don't think it's as…and I'm not sure what it's like in private practice in the United States. I don't have a good insight into that.

AM: 5:59 I can tell you, I can tell you. So…

MW: 6:01 I'm a bit worried about the…

AM: 6:02 Alright, two minutes. We'll wrap it up.

MW: 6:04 getting back to the program.

AM: 6:05 When I was in a group that did their own cases, no nurse anesthetists, build good relationships with the surgeons. A lot of flexibility for dialogue. Supervising? Very not, not optimal relationship, but you're not doing the case, and the United States is mainly supervised. Final point to you, yes, I agree the day of surgery anesthesia shouldn't be talking about that. What I mean is a dialogue with surgeons about the model. About surgeons and anesthesiologists agreeing about taking into account the anesthetic issues and how necessary is their surgery.

MA: 6:39 Well yes, but the problem is, you know the way that surgery works in many countries at the moment with fee for service, is that surgeons, and hospital, and anesthesiologists are incentivized to do cases. So, the incentive come do the bloody work you know, not, not figure out ways to do what's necessarily best for the patient. There are bizarre incentives in our society, that don't always necessarily work in the patient's best interests, and you know, we justify it to ourselves and we say "Oh, we are doing what's best for the patient," but we're often not doing what's best for the patient. And, you know if advocacy is complicated in an environment with specific financial incentives.

MW: 7:30 Right.

MW: 7:31 That was fabulous.

Manuscript transcribed by Vanessa Soto; reviewed by MAW & AM; emailed to Dr Avidan on 11/21/17;