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The Hidden Cost of Convenience

Why Anesthesia Efficiency Starts with a Culture Problem, and How to Fix It

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Executive Summary

When healthcare executives evaluate the cost of an anesthesia program, the conversation almost always starts and ends with compensation: headcount, stipends, and contract terms. That conversation misses the larger driver of cost. Across a wide range of facility types and markets, the same pattern recurs: anesthesia staffing expands not because compensation is misaligned, but because the operational environment around anesthesia is inefficient.

This inefficiency is rarely the fault of the anesthesia department. It is the product of an institutional habit we call the accommodation imperative: the tendency of facilities to absorb operational friction rather than risk the perception of being difficult to work with. Unused block time, ad hoc procedural scheduling, inflated urgency designations, late first-case starts, and unmanaged after-hours add-ons all trace back to this same root cause.

This paper examines where these inefficiencies live, why they persist even when they are well understood, and what a coordinated, physician-inclusive approach to fixing them looks like in practice. It closes with a seven-part framework for building the data infrastructure, governance structures, and clinical partnerships required to make lasting change, along with the case for making the cost of inaction visible to the people who can act on it.

The Efficiency Gap No One Wants to Talk About

When healthcare executives look at the cost of their anesthesia program, the conversation almost always begins and ends in the same place: compensation. How many CRNAs and anesthesiologists are on the roster? What is the facility paying in stipends or subsidies? Is the group employed or contracted? These are fair questions, and while applicable, they represent only half of the financial picture.

The other half (often the larger half) is harder to see on a spreadsheet: the gap between how an anesthesia department is staffed and how it could be staffed if the clinical operations surrounding it were running as intended.

In assessing anesthesia programs across a wide range of facility types and markets, one pattern emerges with remarkable consistency. Meaningful cost reduction is less a function of renegotiating provider contracts and more a function of correcting the inefficiencies that drive excess staffing in the first place. In most cases, those inefficiencies are not the fault of the anesthesia department. They are the inherited consequence of a broader operational culture that has chosen accommodation over accountability (often for entirely understandable reasons).

Understanding why that culture exists and how to change it without fracturing the relationships that keep a facility functioning is one of the most important and underappreciated challenges in healthcare administration today.

The Scope of the Problem: Beyond the OR

It is tempting to frame anesthesia efficiency as an operating room problem. But modern anesthesia services extend well beyond the surgical suite. Providers are expected to staff interventional radiology, cardiac catheterization labs, cardiovascular ORs, labor and delivery, endoscopy suites, electrophysiology labs, and a growing number of other procedural areas, each with its own scheduling logic, clinical culture, and set of stakeholders.

This geographic and operational complexity creates a fundamental challenge: anesthesia staffing is, by design, a reactive function. A provider cannot be productive in a room that is not running. And whether a room runs, when it runs, and for how long is almost entirely outside the anesthesia department's control.

The providers themselves understand this well. Most anesthesiologists and CRNAs want to be productive. Idle time is professionally unsatisfying, and in models where compensation is tied to volume, it is financially costly to them as well. However, the operational rhythm of every other department that requires their presence determines their productivity ceiling.

When that rhythm is inefficient, disorganized, or driven by individual convenience rather than system-level planning, the result is predictable: anesthesia coverage expands to absorb the unpredictability, costs rise, and the root causes go unaddressed.

The Anatomy of Inefficiency: Where the Problems Actually Live

Operational inefficiencies in anesthesia-supported areas typically manifest in several recurring patterns.

1. **Block time that is held but not used.** Surgeons are allocated scheduled OR block time as both an operational tool and a professional courtesy. That block time is meaningful. It represents a commitment from the facility that a room, staff, and anesthesia coverage will be available. The problem arises when surgeons do not consistently fill their blocks and are reluctant to release unused time in advance. The fear is rational: many believe, with some justification, that releasing block time is a one-way door. Once given up, it may not come back, so blocks sit partially filled, or filled with cases that could have been scheduled more efficiently. Meanwhile, other surgeons who want time cannot get it, and anesthesia providers are committed to rooms running below capacity.

2. **Ad hoc and last-minute requests from procedural areas.** Procedural departments outside the main OR (cardiac catheterization labs being a particularly common example) frequently request anesthesia coverage on an as-needed, same-day basis rather than through structured advance scheduling. From the proceduralist's perspective, this is simply how the work flows: cases are identified, and coverage is arranged. From the perspective of anesthesia operations, however, it creates constant disruption. A provider pulled to cover an unplanned cath procedure may leave a room short-staffed elsewhere, or require the department to carry a cushion of unassigned coverage “just in case,” which is simply institutionalized inefficiency wearing a clinical uniform.

3. **Case urgency inflation.** The designation of a surgical case as urgent or emergent carries real operational weight. It authorizes the case to move ahead of others, occupy resources after normal operating hours, and, in some facilities, bypass standard scheduling review. This designation is, of course, clinically necessary in genuine emergencies. It becomes operationally corrosive when applied to urgent cases, primarily because a surgeon is already at the hospital and would prefer not to return tomorrow. The distinction between a case that must happen now and a case that is being made to happen now is not always drawn clearly, and facilities rarely have the governance infrastructure to challenge it.

4 **Resistance to first-case on-time starts.** Few operational metrics are as consistently tracked and as consistently underachieved as first-case on-time starts. The reasons for late starts are numerous: patients not ready, consent not completed, equipment not in the room, and attending not yet arrived. Responsibility is distributed across many parties. What matters operationally is that a late first case does not just affect the first case. It compresses every subsequent case in that room, shifts add-ons later, extends the operating day, and, in doing so, extends the period of anesthesia coverage required. A surgical suite that chronically starts late does not save money by starting late. It spends more.

5 **Schedule compression and after-hours add-ons.** Perhaps the most direct driver of anesthesia overtime cost is the pattern of squeezing cases into the end of the scheduled operating day. A surgeon who has a late-afternoon opening in their schedule, or who has a patient they want to fit in before the weekend, may add a case to a board that is already running long. This is not inherently unreasonable. Case cancellations create real gaps that add-ons fill productively. The problem is when add-on requests are systematically accepted without regard to the operational consequences: extended staffing hours, overtime costs, staff fatigue, and the diminishing returns of late-day clinical performance.

The Accommodation Imperative: Why Facilities Accept What They Should Not

Any experienced healthcare administrator reading the above will recognize these patterns immediately. They will also recognize, with some resignation, that they have been present at the conversations where these very issues were raised and at the decisions that followed, which more often than not defaulted to accommodation.

This is not a failure of awareness. It is a predictable response to a genuinely difficult structural tension.

Surgeons, cardiologists, and proceduralists are not merely hospital employees. In many markets, they are independent community physicians who have chosen to bring their patients and their cases to a particular facility. That relationship is valuable and, in some cases, essential to the facility's financial viability. It is also inherently asymmetric. The surgeon can, in most markets, take cases elsewhere. The hospital cannot easily replace the volume.

This dynamic creates what might be called an accommodation imperative: the institutional tendency to absorb operational costs and inefficiencies rather than risk the perception that the facility is difficult to work with, unresponsive to physician needs, or less convenient than the competitor across town. The calculus is understandable. What is less often acknowledged is that it is also incomplete.

The true cost of accommodation (the additional anesthesia FTEs required to cover unpredictable requests, the overtime incurred by schedule overruns, the opportunity cost of block time held but not productively used) rarely appears on the same ledger as the revenue from the surgeon relationships being protected. If it did, the balance sheet might look different.

Reframing the Conversation: Efficiency as a Shared Value

The most effective path toward sustainable improvement does not begin with a policy memo or a utilization report. It begins with a reframe.

Framing efficiency initiatives as a cost-cutting exercise aimed at physicians is both counterproductive and, in most cases, inaccurate. What operational efficiency in the perioperative environment represents is an improvement in the conditions under which everyone works: surgeons, anesthesia providers, nurses, and patients alike.

A surgeon who reliably gets a first-case on-time start, whose add-on requests are processed through a predictable workflow, and whose block time is managed transparently, is not being constrained. They are being served. The physician who must wait because a prior case ran long due to a late start earlier in the day, or who cannot get block time because another surgeon is holding it without using it, is experiencing the downstream effects of inefficiency just as directly as the facility is.

Framed this way, the conversation shifts from “the hospital needs you to do things differently,” which activates resistance, to “here is how we can make the OR a better place for everyone to work,” which invites engagement.

This reframe is not merely rhetorical. It reflects a genuine alignment of interests that, when surfaced and made explicit, can serve as the foundation for durable change.

A Framework for Meaningful, Lasting Change

Change of this kind does not happen through a single initiative. It requires a coordinated approach that addresses clinical culture, data infrastructure, governance structures, and individual relationships simultaneously. What follows is a framework for pursuing that change in a way that is both ambitious and realistic.

1. Build a Data-Driven Foundation First

No conversation about operational efficiency is credible without credible data. Before approaching any stakeholder group with recommendations for change, invest in building a clear, defensible, and transparent picture of current performance.

This means developing a detailed utilization analysis by service line, room, time of day, and day of week. It means calculating block utilization rates not just at the aggregate level but at the surgeon level and doing so in a way that makes the data shareable without being punitive in tone. It means tracking first-case on-time start rates, case length variance, turnover times, and after-hours activity with sufficient granularity to support a meaningful conversation.

When data is accurate, current, and presented without an agenda, it transforms the nature of the conversation. A surgeon who is told “your block utilization has been below the release threshold for the past two quarters” has a different response than a surgeon who is told, “we need you to give up some of your time.” The former is a data observation; the latter is a negotiation. Start with the data.

2. Engage the Medical Staff as Partners, Not Subjects

The physicians and proceduralists whose behavior drives many of the inefficiencies described above are not, in most cases, acting in bad faith. They are acting rationally within a system that has historically rewarded accommodation and rarely made the costs of that accommodation visible to them.

The most effective engagement strategy is one that brings medical staff leaders into the problem-solving process early and positions them as architects of the solution rather than recipients of a policy dictated by administration. A surgical quality or operations committee with genuine physician representation, one that has access to the utilization data described above and is charged with developing recommendations, is far more likely to produce durable behavioral change than a mandate issued from the C-suite.

This approach requires patience. It also requires that hospital leadership be willing to share data that may be uncomfortable to share and to accept that physicians who are engaged as genuine partners will sometimes push back on proposals they do not agree with. That is not a problem to be managed. It is a feature of authentic collaboration.

3. Redesign Block Time Governance with Transparency and Reciprocity

Block time is the most contentious operational issue in most OR environments, for good reason. It represents both operational efficiency and professional status. Surgeons who have held block time for years experience proposed changes as a loss, even when those changes are objectively reasonable.

The most constructive approach is to establish block time governance as a transparent, consistently applied, and prospectively communicated system, one in which the rules are the same for everyone and the data driving decisions is accessible to all parties.

A well-designed block management policy should include clear utilization thresholds with defined consequences, a structured release timeline that gives surgeons a reasonable window to fill or release time without permanent forfeiture, a mechanism for surgeons who release time in good faith to reclaim equivalent future access, and a process for requesting temporary adjustments during low-volume periods such as vacations or conferences.

Critically, the policy should include a sunset provision: released time not used within a defined window returns to open scheduling rather than to permanent reallocation. This directly addresses the fear that releasing time means losing it forever, a fear that is often unspoken but is almost always driving resistance.

4. Create Formal Scheduling Protocols for Procedural Areas

For procedural areas outside the main OR that rely on ad hoc anesthesia requests, such as cardiac catheterization labs and interventional radiology, the development of formal advance-scheduling protocols is both operationally necessary and, when framed correctly, a benefit to the proceduralists themselves.

A scheduling protocol that requires anesthesia requests to be submitted with a defined lead time (typically 24 to 48 hours for elective cases) and that provides proceduralists with reliable confirmation of coverage availability is not a restriction. It is a service. It eliminates the uncertainty of last-minute arrangements, reduces the risk of cancellation due to coverage unavailability, and allows the anesthesia department to plan staffing rationally rather than reactively.

Implementation of these protocols is most effective when the proceduralist teams are involved in designing the workflow: what information is required, what the confirmation turnaround looks like, and what the escalation path is for genuine urgent cases. When proceduralists have built the system, they are far more likely to use it consistently.

5. Establish a Perioperative Leadership Structure with Real Authority

One of the most consistent structural deficiencies in facilities with persistent operational inefficiency is the absence of a governance body with the standing and the authority to make and enforce operational decisions across all perioperative areas.

A well-constituted perioperative leadership team is typically tri-led by a physician champion (ideally a surgeon with operational credibility), a senior nursing leader (the OR director or perioperative nursing executive), and an experienced perioperative administrator. This kind of team provides several critical functions that no individual department can provide on its own. It creates a neutral forum in which competing priorities can be surfaced and reconciled. It provides a mechanism for translating data findings into actionable policy. And it provides the institutional backing required to enforce standards consistently, even when individual stakeholders push back.

The physician co-leader role is particularly important. Policies that are perceived as administratively imposed will encounter resistance that policies presented as physician-endorsed will not. A surgeon who is willing to stand up in a medical staff meeting and say, “We developed this block release policy together, and I think it's the right thing for our patients and our OR,” is worth more than any number of administrative memos on the same subject.

Nursing leadership matters just as much and is often the most underutilized lever in perioperative reform. OR nurses, charge nurses, and nursing directors are the people who actually execute the operational rhythm of the surgical day. They see the late starts, the unprepared patients, the add-ons that should have been scheduled, and the turnover delays in real time, and they almost always have a clear-eyed view of which dysfunctions are systemic and which are episodic. A perioperative governance structure that treats nursing leadership as a full partner rather than an implementer of decisions made elsewhere will yield better data, design more workable policies, and achieve far greater compliance during execution. Bringing nursing leadership into the diagnostic phase, not just the rollout phase, is one of the highest-yield decisions a facility can make.

6. Address the Urgent/Emergent Classification Problem with Clinical Transparency

The misapplication of urgent and emergent case designations is a sensitive issue because it touches on clinical judgment, and no administrative body wants to appear to second-guess a surgeon's assessment of a patient's acuity.

The most defensible approach is to work with medical staff leadership to develop agreed-upon, specialty-specific criteria for urgent and emergent case designation, documented in a transparent, consistently applied manner. This is not about creating bureaucratic barriers to necessary care. It is about creating clarity that protects the process from abuse while ensuring that genuinely urgent cases move without obstacle.

Periodic review of urgent/emergent case patterns, ideally presented as aggregate data rather than individual case audits, can surface trends that warrant conversation without singling out individual providers in a way that generates defensiveness.

7. Make the Cost of Inefficiency Visible to Decision-Makers

Ultimately, sustained improvement in perioperative efficiency requires that hospital leadership understand the financial dimensions of the current state. That means not just department heads but board members and senior executives.

Translating operational inefficiency into dollar terms is not always straightforward, but it is possible, and it is persuasive. Several costs are calculable: the marginal anesthesia FTE required to cover unpredictable demand, the overtime attributable to schedule overruns in the last two hours of the operating day, and the value of block time that was held but not filled. When these figures are presented clearly, alongside a credible improvement trajectory, they have a way of changing the terms of the conversation.

When senior leadership understands that the accommodation imperative has a price and that the price is being paid in real dollars, the organizational will to support meaningful change tends to increase accordingly. This includes the willingness to have difficult conversations with valued physician partners.

A More Productive System for Everyone

The inefficiencies that drive excess anesthesia costs are not mysterious. They are the predictable result of a clinical culture in which individual convenience has, over time, been allowed to take precedence over collective efficiency. This is not the product of negligence or malice but of the understandable desire to protect relationships that are genuinely important to the facility's success.

Because these causes are structural and cultural rather than technical, they are addressable. Not easily or quickly, but sustainably, provided the effort is approached with the right combination of data rigor, clinical partnership, transparent governance, and strategic patience.

The goal is not a system in which surgeons and proceduralists feel managed or constrained. It is a system in which OR time is more predictable, more fully utilized, and more professionally satisfying for everyone who works in it, including the surgeons themselves. Anesthesia providers can be more productive, facilities can reduce unnecessary staffing costs, and patients can benefit from a perioperative environment that runs with purpose and efficiency.

That outcome is achievable. But it requires being honest about what is standing in the way and being committed to the work of changing it.

About Acuvance Coker

Acuvance Coker delivers end-to-end strategic, operational, financial, technological, and compliance expertise to hospitals and health systems navigating complexity, growth, or transformation. With more than 35 years of focused healthcare experience, Acuvance Coker brings senior-level engagement and clinical, financial, and operational depth to every client relationship.

To learn how Acuvance Coker helps organizations reduce anesthesia costs, improve perioperative efficiency, and build lasting operational alignment, connect with our team.

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