Analysis of awareness and attitude among practicing anesthesiologists- a statewide survey

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Introduction

The doctors are group of top meritorious students of the state every year. They choose medicine for many reasons, mainly because they can live without depending on other persons or companies and they can practice till they like. Many of them do postgraduate diploma or degree which makes them specialists and their quality of work and professional life changes into a better one. But majority of those doctors taking anesthesiology as their post graduation tend to avoid General Practice assuming that they have specialized in giving anesthesia, cannot avoid emergency calls, cannot do that simple general practice and went behind the screen. In this process, majority hid themselves from the public and became dependent on surgeon for their survival. As there is a tendency to be dependent, they lost self assessing skill and the right to decide their professional fee and hence quality of life. **We wanted to analyze how much the anesthesiologists of Tamil Nadu State are aware of this loss and how many want to break the tradition and want to lead a quality life.**

Materials and methods:

We sent a questionnaire covering various aspects of anesthesia practice with printed primary answering options and possible secondary responses that could justify the selection of primary answer. We tried to reach as many as possible. Postgraduates were not able to perceive this and did not actively participate.

We received back 55% of the sent forms. Failure to receive feedback from the remaining 45% could be due to following reasons.

Some could have been busy with cases and some might have been reluctant as they already have their own OP with or without own hospital. Some felt that questionnaire was complex, confusing and lacking good format. Some would not have been be willing to participate. The questionnaire might not have reached many in spite of our efforts.

Observations from the feedback were as follow:

Q1.How long a anesthesiologist can take annual vacation ? 13% opted to go out only when their main surgeon is out of station, 54% opted 3 days of anesthesiologist's priority, 27% opted 5 days and 6% opted for 7days and any country.

Q2.How an anesthesiologist can plan to be at home without elective cases? 18% said, anesthesiologist cannot decide, 27% opted for half day in all Sundays, 46% opted one Sunday in a month and 9% opted for all Sundays.

Q3.Can an anesthesiologist restrict elective cases after 10 pm? (excluding caesarean, appx, bleeding injuries, perforation, etc)

96% opined that we can attempt, because sleep deficit is neither paid well when compared to total budget and surgeon fee nor recognized by the surgeons and patients. Sleep deficit has ended in mortality either due to accident, myocardial infarction or both together. But Majority said, it is up to the individual anesthesiologist to decide when to restrict i.e. from day 1, 5 yrs, 10 yrs, 15 yrs, etc.

There was also a response that we should support the surgical team as they are also running short of time.

4.Regarding PAC, 99.4 % favored a statewide common file system, having three components, one about anesthesia techniques and risks involved, second questionnaire about patient's health and third, the anesthesia chart.

Can we insist PAC before admission (except those who cannot walk / fractures/ pregnancy) whether patient accepts surgery and comes for admission or not and whether same anesthesiologist or some other will anesthetize.

There were varied responses. Majority felt it will be ideal as we interact with the patient directly and collect the fee so that there is no room for manipulation by somebody, but it may take years to make it realistic. We have just started to think about it.

5. Whether Anesthesiologist can start General Practice and restrict availability of anesthesia service?

None has opted for the response NO (surgeons will get angry and may not call, have to serve surgeons till last breath), and UNQUALIFIED (he does not have medical knowledge sufficient enough to practice). Few responses added that a specialist should not have General OP.

8% opted NOT NECESSARY (no significant income, others may capture, also responses like-chose anesthesia because I don't like sitting in op, govt. service pushes to avoid OP, etc).

92% opted that anesthesiologist can practice, 1.6% already have their own OP and some own hospital (anesthesiologist is best physician the society needs as he knows many surgical and non surgical illness in various fields- but he is avoiding OP, when MBBS can become hospital owner, why not anesthesiologist?).

6. Majority of Anesthesiologists in various districts join together and put efforts regarding anesthesiologist fee. What is going on?

62.5% consider that they are fighting for decent fee, 37% feel they are fighting for freedom which means anesthesiologist will decide his fee and 0.5% feel that anesthesiologists have not realized their worthiness and still in the process of pleading for a hike of Rs. 300-1000.

7. Shall anesthesiologist ask his fee? 99.8 % said yes and 0.2% had dual response.

8. How to arrive at the correct fee for a case in a given city as each city differs in paying capacity?

None of the responders selected the option of get whatever is offered. Probably those anesthesiologists willing to receive whatever is offered have not participated.

16% wanted 25-30% of surgeon fee (less friction with surgeons, match the paying capacity of the patient).

Others (84%) said that it should be independent variable based on skill, duration and risk involved (not all surgeons weigh the anesthesiologist's component and give worthy fee- especially for high risk cases, may hike other components and keep surgeon fee more or less same, anesthesiologist is unaware of many components of the total budget).

One senior anesthesiologist has sent information that this disparity was present even in the period of 1840s (Crawford Long where he was the surgeon as well as anesthesiologist and anesthesia charge was low when compared to surgeon fee- 25cents and 2 dollars).

Among them, 57.5% wanted a decent fee to be decided by the city ISA, 25% wanted the fee to be fixed by the individual anesthesiologist for each case, of course based on the reference fee format by that city ISA

1.5% felt that anesthesia fee in a given city should be arrived only by equating fee of surgeons for simple ordinary procedures in that city. Only then the anesthesiologist will realize how much really his anesthesia is worth.

Discussion:

Old trend of allowing surgeons and nursing home owners to decide anesthesia fee is going out. Majority of anesthesiologists started recapturing their lost right to decide the fee (most of the professionals have that). New concept of arriving at anesthesia charges for a given city by equating with surgical skills is proposed and yet to get a shape.

It is up to the individual anesthesiologist to lead a quality of life i.e. restricting elective case after 10 pm, insisting on PAC before admission, planning rest period and annual vacation. It is up to the anesthesiologist to decide whether to do only anesthesia practice accepting all disadvantages and be dependent or to start General practice, pain clinic, intensive care, etc and make anesthesia practice as a part of professional life.

The energy spent for the growth of surgeons and nursing home owners can be diverted to uplift his own life and growth either by motivating other anesthesiologists to realize their worthiness or by learning ECHO, SCAN, Nasal endoscopy, Pain management, bronchoscopy, etc and setting a mini health centre, COPD clinic, Pain clinic, etc which might turn into your own hospital. We should aim for independent professional and quality life without bothering about other anesthesiologists who are hesitant to assess their skills and their importance in the surgical teamwork.

Summary:

A significant change has appeared in the quality of life of the practicing anesthesiologists in Tamil Nadu. They are realizing the loss in their quality of life, remuneration and also the cumulative loss over ten or more years not only in the wealth but also in the health. It is just beginning and we are here to see the rise of anesthesiologists in the forthcoming years.