Anesthesiology
1998; 89:1597

Rural Realities

To the Editor:—Dr. Orkin's editorial view on rural realities[1] adds one more contribution to his long list of epidemiology studies on anesthesia practice. However, the editorial commentary on the distribution of anesthesia personnel in rural areas did not reflect reality in a number of points. Although we applaud Dr. Orkin's attempt to identify the factors influencing the numbers of anesthesiologists and nurses anesthetists who work in underserviced area, the author admits that the data were obtained from an annual survey conducted by the American Hospital Association and answered by hospital administrators.

We relocated to the Florida panhandle in 1989 and have lived in Walton County, which has about 31,000 inhabitants. Because of our interest in rural hospital services and management, we are also well informed of the anesthesia-related situations and the hospitals' statistics for other adjacent rural counties, such as Washington, Holmes, Gulf, Franklin, and Jackson, which have one hospital each with a small bed capacity (table 1).

The ratio of anesthesiologists to 100,000 population in northwest Florida is erroneous, as far as the shaded areas shown in Dr. Orkin's figure 1 are concerned. There is one anesthesiologist in Walton County and one nurse anesthetist; other hospitals have one nurse anesthetist each covering between 20–40 cases per month, except for in Franklin County, which has four CRNAs providing anesthesia coverage for about 90 cases per month. Dr. Orkin's map is an incorrect representation of anesthesiologists per 100,000 population in this part of the country. By incorporating two non-rural counties such as Okaloosa County with 14 anesthesiologists and Bay County with 9 anesthesiologists, all the adjacent rural counties shown in figure 1 appear to have 7 anesthesiologists per 100,000, when in fact there are only 2.

We have been aware of anesthesiologists wanting to practice in these hospitals; however, administrators have not only been uninterested, but at times they have been openly hostile. The reason is economics because even with only 30–40 cases per month, by employing a CRNA for about 60,000–70,000 dollars per year, they actually profit more by billing for the medications, supplies, equipment and for the professional fee. Therefore, hospitals are not eager to have anesthesiologists.

Finally, case reviews and analysis of pre- and postoperative complications and deaths are seldom conducted in a proper manner, making quality assurance a family affair. Deaths and complications are not discussed and go unreported, and because litigation is scarce in this location, the AHA statistics do not reflect reality as far as morbidity is concerned. The reports describing no anesthesia-related deaths in these hospitals is a myth because there are powerful reasons to cover them up.

Nevertheless, anesthesiologists should consider going into rural areas not expecting a certain number of cases set up for them, nor a guaranteed income, but with the mission to join the community and build practice as any other specialist would do based on professionalism, availability, and competence. Incorporation of Pain Management, for example, could help to establish their own base of patients for whom they will be providing medical care and making treatment decisions. Hopefully then, emancipation from "consultant only" stigma may elevate the spirits of some anesthesiologists.

J. Antonio Aldrete, M.D.
Professor
Department of Anesthesiology
University of South Florida
Tampa, Florida
Valentina T. Aldrete, D.D.S., M.S.H.A.
Chief Executive Officer
Sunshine Medical Center
Destin, Florida

Reference

1. Orkin FK: Rural realities. ANESTHESIOLOGY, 1998, 88:568–71

(Accepted for publication July 9, 1998.)

Anesthesiology
1998; 89:1597–8

In Reply:—I am pleased that the Drs. Aldrete share the interest in and concern for the adequacy of anesthesia care in the rural United States expressed in my editorial.[1] They note an apparent discrepancy between their assessment of the availability of anesthesiologists in their Florida panhandle region and that depicted in figure 1. That illustration is a map of the geographic distribution of anesthesiologists across the United States, which was developed from the data and "viewer" software in the CD-ROM accompanying *The Dartmouth Atlas of Health Care 1998.*[2] Although not involved in that mapping project, I can offer some reasons for the discrepancy, as well as comment on the Aldretes' other unrelated concerns.

The Aldretes' assessment of anesthesiologists' availability in their region relates presumably to the current situation (*i.e.*, 1998), whereas the *Atlas* is based on the latest available national data (1996) collected in the American Medical Association and American Osteopathic Association surveys, unique data sources used widely for public and private physician workforce analyses. In contrast to the Aldretes' tabulations of hospital-associated personnel, these data sources also include physicians working in non-hospital settings (*e.g.*, hospital-independent, freestanding surgery center; pain management office practice). More important, the Aldretes' assessment relates to their region's seven rural (and nine total) *counties,* whereas an early finding of the *Atlas* project