± 4.3% for PA and 9.4% ± 5.5% for the IVC diameter, 
(11.5% ± 3.0% for PA and 6.3% ± 3.3% for the IVC
diameter, n = 16). The results of our preliminary study
suggest that the respiratory-dependent variation of PA
measured by a pulse oximeter may be a reliable and
early predictor of hypovolemia.3

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Pulse oximetry plethysmographic waveform during

Anesthesiology: the misunderstood occupation!

To the Editor:

Previous studies done across the globe reveal that
patients have numerous misconceptions regarding the
anesthesiologist’s role.1–4 The purpose of this study was
to assess Canadian patients’ knowledge of the role
of anesthesiologists, anesthesia and their concerns
regarding general anesthesia.

After approval from the Institutional Research
Ethics Board, patients waiting for preadmission anes-	hesia consultation were asked to participate in a sur-
vey at a tertiary hospital. Eight-nine patients were
asked to participate, 86 agreed. Thirty-nine percent
had obtained postsecondary education, 69% had ≥
two anesthetics and 69% were ≥ age 55. Eighty per-
cent recognized anesthesiologists as physicians (Table)
compared to 65% in Britain1 and 67% in Spain.2
However, despite the increased recognition of anes-	hesiologists as physicians, the majority (38%) described the primary role of anesthesiologists as assis-
tants to surgeons, 36% as physicians and 22% as tech-
nical experts. In Japan, more than half of participating
patients believed that the only responsibilities anesthe-
siologists had were to put patients to sleep and pro-
vide pain relief.3

Approximately one third stated that the anesthesi-
ologist was the main person in charge of resuscitating
a patient in the operating room while one third chose
cardiologists. Only 11% knew anesthesiologists made
decisions for blood transfusions. Only 4% indicated a
preference for their attending anesthesiologist. More
than half recognized iv injection as the technique used
to induce unconsciousness and many incorrectly per-
ceived iv injection as the primary technique to main-
tain unconsciousness. Twenty to 30% were concerned
about awakening in the middle of the procedure, pro-
longed awakening time, negative reactions to drugs
and overdoses.

When asked who or what would be responsible in
the event that a patient did not wake up after the
surgery, one third associated this complication with
the anesthesiologist despite the lack of understanding
of his/her role. Drugs and surgeons were also thought to be responsible.

More patients who obtained postsecondary education
correctly identified the anesthesiologist’s role and
responsibilities (Table A, available as Additional Material
at www.cja-jca.org). More patients < age 55 had con-
cerns regarding awakening in the middle of the proce-
dure (41% vs 20%, P = 0.04) and negative reactions to
drugs (41% vs 15%, \( P = 0.01 \)) compared to patients \( \geq \) age 55. Previous experience with anesthetics did not affect their knowledge about anesthesia.

In summary, the majority of patients acknowledged anesthesiologists as physicians; yet, most patients thought anesthesiologists were assistants to surgeons and did not identify them to be the principle person responsible for resuscitation or blood transfusions in the operating room. Improved communication with, and education of, patients may help correct misconceptions about anesthesiologists in the future.

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Ankle block success rate: a prospective analysis of 1,000 patients

To the Editor:
There have been few published studies investigating ankle block success.\(^1\) We therefore conducted a prospec-