



American Society of  
**Anesthesiologists**™

Residents In a Room  
Episode Number 10  
Episode Title – Getting Paid

Recorded January 2020

(SOUNDBITE OF MUSIC)

VOICE OVER:

This is Residents in a Room, an official podcast of the American Society of Anesthesiologists, where we go behind the scenes to explore the world from the point of view of anesthesiology residents.

You know, living like a resident for a few years even after you start making more money.

Everything we do, we undo later.

If you can't fund your practice, or profit from it in any way, then you're not even going to be able to provide that patient care.

RAJEEV, HOST:

Hi! I'm Rajeev Saxena, a CA2 at the University of Washington and I'll be your host for today's episode of Residents in a Room, the ASA's podcast by residents for residents. So, let go ahead and meet our fellow residents.

DANIEL:

Daniel Bingham, CA2, from the University of Arkansas.

TRISTAN:

Tristan Steinberger, CA2 from Las Vegas.

NEELAB:

Hi, I'm Nellab Yakuby, CA2 from New Orleans.

KANDICE:

I'm Kandice Olson, a CA2 from Baylor, Scott & White.

JORDAN:

Jordan Hill, CA3 from Iowa.

RAJEEV:

So in this episode, we're going to talk about everyone's favorite topic: money, money, money, money. So, let's start with, are you clear on how, uh, payment and reimbursement works?

TRISTAN:

I think it's ever changing. Anyway, I don't think anyone can be a hundred percent on that topic, but I definitely do not know as much as I'd like to know.

RAJEEV:

I don't think anyone really ever feels like an expert on this, but let's talk about what we do know, and about how anesthesiologists get paid.

DANIEL:

My knowledge is just barely scratching, you know, the basic, the bottom of the barrel, for the basics. But, from what I understand, you know, you get paid a, a base unit per procedure. So if you're, you know, doing a lap chole, then you get paid a certain number of base units for that, and you add on however much time you spent doing the case. So you get paid, you know, let's say seven base units for a lap chole, and then you get paid in 15-minute increments for your time. So if it was a 30-minute, lap chole, which never happens, then you would get two base units for time, that get you up to 9 base units. So, and, and then, I think it's, at that point you get, you have a conversion factor, whether you're getting paid from a private insurance company or from Medicare or Medicaid. I know that the ASA sends out a survey every year, kind of looking at what the average conversion factor is, and I think it's about \$70, uh, per unit. So you're looking at  $9 \times 70$  there for what you would get paid for that lap chole if you're going private insurance.

RAJEEV:

Daniel, you highlighted in a, a really clean kind of a summary of, of the basics. Are there other aspects to how we get paid that you think about or you know?

KANDICE:

Like with most questions that we're asked, the answer, kind of, it depends. And so, there's a lot of things that factor into how we get paid. You mentioned, like the conversion factors, the, the base units and the time units. But that varies geographically and also with the payers, so you can have the, um, CMS or even commercial contractors who are negotiating what that conversion factor is. Um, to back up a little bit, as far as base units, you know, it's determined by the surgical procedure. But it also, um, that value, is related to the complexity, you know, the pre-op evaluation and I think just learning different things that can add to the complexity of a, of a procedure that makes the base value go up or down, as well.

RAJEEV:

We talked about, you know, base units and time units, which is a really key distinction, right, for our field, as being very different than kind of billing per CPT codes. Um, what is, what are your understanding of how that translates to the number one question. You're going to get a job. How do you get paid? There are multiple ways to actually take home money. What is your understanding of the, the difference between how you bill, and sort of what you, as an individual, or a practice, you know, make?

KANDICE:

That depends as well. (Laughter) So it depends on kind of the practice you have set up and, and, you know, potentially, if you've negotiated in your contract to have a base salary, then, what you make is that. You know, you may have incentives for, um, value outside of that, if you make, or have more RVs or ... so it really depends on your contract, the, the practice that, um, you've joined.

RAJEEV:

Kandice, your point is really valid. It, it really does depend on the practice and there's many ways to do that. So I tend to think about it in terms of, um, kind of extremes. So on one extreme is kind of the hunter model, which is what people call, you know, eat what you kill, for better for worse, or it's essentially, you know, the units that you bring in. The revenue that you generate from that is, is the salary you make. That still depends on your pair mix. It's still you know, your charges are not the same as your revenues, right,

and so that may vary. But in general it's like a pure productivity model, um, and then, you know, there's blended units, where you take the whole group's revenue divided by all of the total units, and it's a, kind of a blended unit. And so some, you know, we've been talking about incentives and behavior. Right? You can imagine how the incentives may be a little bit different if, if it's purely what you do is what you make. Right? And so a blended unit maybe moves away from that a little bit, um, to sort of a dollar per hour or like, you know, kind of model, vs. a pure salary. And so, I guess there's a lot of nuances here, um, to think about.

JORDAN:

One really important thing that, you know, a lot of us probably are wondering is, do they pay you for that extra A-line you put in, or for that extra epidural you put in, um, because if they're not paying you for it, then you're going to do it. So I think a lot of us wonder, how can we do what's best for the patient, but still do it, or bill it in a way that we can still be compensated for it?

RAJEEV:

You know, I think you kind of hit the elephant in the room, right, which is while we are all physicians, and we went in to do the best for patients, we are still humans. Right? And we're influenced by incentives. And so, I mean, there's a lot of data to support what you just said. If you don't make money from an A-line, lo and behold, your practice may not do as many A-lines. It's, it's kind of a little bit of a scary thought, but, but, but it is true. Um, so, you know, I guess I'm going around in our group here. I mean, when you hear about these different ways in which you get paid, how do you evaluate practices? Like how important is it to you how you get paid?

TRISTAN:

I think it depends, what you want? What, what's your lifestyle, what your personal goals are. Um, if you want to make more money, with private practice, you can pick up extra hours. If you wanted more a scheduled lifestyle, you can be in a larger group and take less call. You can do academics, you can go to the VA, where the hours are probably the best. I think it's the hard question to answer just because it depends on the individual.

JORDAN:

Yeah, uh, I think as I think about this whole transition of money, it just seems almost mind-boggling confusing in terms of, I do something for a patient, and the number of steps that has to occur in order for someone to then put a charge through, and then the steps that have to occur for then someone to pay, and that money make it back to me, is really convoluted.

But I think the take home point for me, when I look at all of this, is just that a lot of it is not in our control, and so because of that, I think it's extra important, like Tristan was just saying, to know what you're looking for in a practice and being very vigilant about understanding how your practice works, or how the practice you're interested in works. Uh, like was mentioned earlier, the conversion factors can change based on geography, and whether it's government or private practice, private insurance, can change that also. So again, I can, being residents in medicine, we love big picture sort of concepts that we can apply to every situation. And I think it's just more of a situation where when you're looking for a job and you're looking at those practices you really need to dig down and figure out what it is you're looking at and how they're making their revenue and distributing it.

RAJEEV:

Jordan, you went right into my next question, which is how do you actually find out, find this information out? Where do you guys go to when you're trying to find out about how a practice reimburses their physicians?

TRISTAN:

To figure out that, you have to talk to people in the group. I mean, it's going to be hard to figure out how the group pays, or, I've heard from multiple sources if you want to know how it works, when you interview, when you, you go over and talk to the partners, you talk to people there. How, what's the group, what's the practice like? What's call like? What's the payment like? You have the time, so there's really, the way to do that is to talk to them.

JORDAN:

I think too, and this goes a little bit more big picture, but in addition to talking with the practice that you're interested in terms of how they distribute their revenue, I think it's also important that we're all paying attention to the bigger landscape including the sort of bills that happen that can go through that can change how, um, that revenue is generated. And understanding how the big picture changes affect our specialty

individually. Those changes are then going to affect each practice in sort of a unique way because those conversion factors can be different and that ratio of government to private insurance can be different. So understanding how these big picture changes to healthcare affect us as a specialty, and then affect practices individually, I think is one of the big challenges. But it's just another reason that we need to be paying attention to what's going on, uh, in the big picture.

RAJEEV:

I think that's a really important point, I mean, I think is very well articulated in our group here. I mean, you have to start by understanding the basics of time units and base units and conversion factors, and pair mix. Not even the specific numbers, but just how that works. And you do have to talk to people in the group. As you can understand, part of the reason it is so convoluted is because this is very valuable information, right? No private practice want to tell a resident and have that resident tell every single person in their program what their blended unit cost is. Right? There's a certain level of trust required here, because if you do that, you're potentially jeopardizing the reputation of the people in that practice who are in competition with alternative employers for you. So it's just something to think about, when you think about the larger system, is us as residents, we kind of want to know all the information. But by nature, it really has, has to probably happen at an individual level with, with understanding the people, and then on top of that you have the broader system sort of changes, too.

I know some of us here in this group, you know, are likely to go into academia and a large number of our listeners around the country are going to go into academic medicine. So, one thing I've heard people, you know, say sometimes as I don't want to deal with all this business stuff. I just want to avoid it. And sometimes they'll say, I want to go into academic medicine. So, I have a question. Do you think this is important for people going into academia to know about, you know, in terms of how you get paid or do you think this is really kind of more of an issue for the private practice world?

DANIEL:

I think in general, most people probably see it more importantly for private practice, but I, I think it can be really important in, in academia. I mean if you're not, if you don't understand how the system works, then you're not really able to advocate for your department and your specialty in the healthcare system or the hospital as a whole.

TRISTAN:

Yeah, I think it's important, even if you're in academics, cuz you'll just make your organization more efficient if you're aware of billing, and where, where you could be more efficient.

RAJEEV:

Well, I think it's also interesting because we in this group are around the country, right? And you hear the easiest number is, what's your salary? Right? That's the easiest number to grasp on, upon. It's not ... it's not conversion ratio, it's not dollar per hour. It's what's your take home pay? Even though that number may not reflect things like benefits or flexibility and things like that. And so, I personally think, you know, you actually, by understanding what your academic institution, how they pay staff, it actually tells you a lot about the incentives and the culture, and you also know how to evaluate jobs outside of academia by, by having that comparison. So, I, I agree, Tristan, I think that it is really important. Um, at what point do you guys think it is important to start asking these questions in your residency?

TRISTAN:

As early as possible, just get more exposure. I do agree that as a CA1, I would just focus on anesthesia. As you become more confident, you look for more opportunities and in the non-clinical aspects. But, I think ultimately have to be solid clinically first.

JORDAN:

Yeah, I think especially, uh, as you're getting to the point where you're going to be interviewing with practices, and especially if you're looking at private practices, I think if you can go to an interview and talk intelligently about how they generate their revenue and understand when they lay down sort of how that revenue is, uh, distributed through the practice. Just from the standpoint of being able to get an offer from that practice, I think they're going to see you as someone is going to be an asset to them, uh, versus if you go in and they start talking to you about, uh, these specifics and it looks like the first time you've ever heard these terms thrown across. You know, that's not going to be in your best interest, so I think, uh like you were saying, clinical expertise is the priority, but hopefully by the time you're getting to your CA3 year, and you're looking at applying to

practices, you're going to be in a spot where you can talk intelligently about some of these concepts.

RAJEEV:

And I think one other thing about that is, understanding how practices make money actually tells you a lot about different types of opportunities there. For example, you know, a lot of us have an interest in, um maybe broader medicine whether it be entrepreneurship, or starting a practice, or maybe running a department one day, um, in all sorts of different settings. And you know, if you go into a place where everyone is paid purely on production, there are places like this that have rotating CEOs, or rotating, you know directors because it's not viewed as necessarily value-added and so it's sort of like, we share the burden evenly. And then there may be other places where those opportunities are coveted and compensated for, built, built into the structure of, of how physicians get paid in either may be a blended unit for non-clinical time. Um, so I think it very much, you know in research it's very straightforward. What is your grants, and how is your time paid for? But in some of these broader areas, it's not quite so crystal clear.

You know, there's a lot of talk, now broader in, in the field of anesthesia, but largely, even in medicine, right, about the move from fee-for-service to, um, value-based care or pay-for-performance. That's sort of the systems of I want, I want to hear kind of what is your understanding of, kind of pay-for performance, or value-based care?

TRISTAN:

When I think of pay-for-performance, I think of the fee-for-service model. Whatever you do is what you make, and so I think that was shown to be, it's not very effective. It's ends up fostering lot of greed and I think it's developed what we have now is the accountable care, the bundled payments, were it's more value-based. So, you work as a team, and you try to cut costs and the costs you save, if you can keep for the group, and you just do it evenly amongst the group. And I think that's been, that's a more promising model, and so a model worth working for.

JORDAN:

Yeah, and I think it's, you know, I think it's a model that may provide us as anesthesiologists with a unique opportunity in terms of what we can bring to the table, especially when we start talking about the bigger picture of adding value to a patient's uh, perioperative stay and perioperative experience. As a specialty as we're kind of expanding out of the OR, we're starting to expand more in the pre-operative area, the

post-operative area, even into these, uh, transitional pain clinic type settings. This, in a lot of ways provides at least the opportunity for us to say, hey these things that don't necessarily have clear reimbursement advantages, at least under the current system, may turn out to be an important value added to the system, once it's taken into account the sort of value-based reimbursement. So, it's hard to predict what changes will be for, uh, our benefit or not, but potentially could be a good opportunity.

RAJEEV:

Yeah, I mean I'm hearing, in the group, there are lots of opportunities and in many respects the system is changing because the old system had a lot of perverse incentives, and I'm curious to know, do you see any challenges in sort of this changing reimbursement model? You know, what, what are things that you may be worried about when you think about how, you know, the reimbursement models are moving away from fee-for-service?

TRISTAN:

I guess one problem, so when you try to integrate horizontally and vertically amongst departments, it's hard to figure out who's in charge. And so it can lead to a lot of unnecessary bureaucracy. You don't know whose, whose decision's what. Um, who's supposed to take responsibility for certain patient or at a certain time. And I think you'll need a lot more organization and discipline amongst different departments to be successful with such a larger, a mo, a payment model incorporates a larger group of physicians.

JORDAN:

Yeah, I think, too, anytime you sort of change the stage, you can sometimes inadvertently make a path for market disruptors that may not be in our best interest. Um, kike I said an opportunity to expand our practice and our value perioperatively may conversely be seen as an opportunity to cut costs with intraoperative care, whether that's, uh, stretching us to more of a supervision model, um, things like that. It's, it's hard to predict but definitely when we're looking at these kind of changes, it'll be on us to make sure we're evaluating how things are changing and providing our systems with good value to show that, uh, we are the answer for the system, uh, as it changes.

RAJEEV:

I think to that point, you know, there's been a lot of talk in our field and certainly at conferences in terms of MIPS and you know, merit-based incentive payments and how you actually demonstrate that you're achieving quality in very, very specific metrics. One of the concerns I have is the amount of data that you have to demonstrate to meet these measures and you know, we've all seen the value of checklists, but we've also seen kind of potentially checklists uh, over, overload. Right? Um, you know, there are times when you have many checklists that people are just going through the motions. And so there's a potential I think for some, um, different perverse incentives to just achieve whatever metrics garner, um, reimbursement, as opposed to a fundamental unified, sort of quality improvement, you know, structure.

KANDICE:

You know hearing you all talk about these things makes me realize just the, the larger forces that kind of are in control of you know, some of these things or that play a role in, in all of these things and it just makes me want to emphasize the importance of one being knowledgeable, and two, doing something about, about it. Like if you are concerned, you know those things that you addressed, um, of sharing it with someone that may be able to make the change, you know being involved in advocacy, or sharing with people just kind of what you see and how you think might be a solution, so it's very important.

RAJEEV:

I think if there's one theme that's come out of here is, the old way of practicing medicine, putting your head down and just practicing medicine, no longer exists. For better, for worse, we do live in a system, and a lot of these changes, um, are going to affect us. And they already are affecting us in residency whether we see it or not, but they certainly will be much more tangible once we're out in practice.

I'm curious to know, are there specific things about payment that you wish you understood better? I know Kandice, you've kind of mentioned the importance in general of exploring these topics. I think for all of us there are definitely growth opportunities or weak spots. Um, I'm curious amongst us, you know, are there areas about payment that you want to delve deeper into or you wish you understood better?

NELLAB:

Personally, I, I wish I had a better understanding of, um, insurance compensation and, uh, exactly what goes into that process. I have a very limited knowledge of that, um, so far, so.

DANIEL:

For me, it goes back to what I touched on earlier. I think just knowing, um, how to get reimbursed while still providing the most, um, appropriate care for your patient. You know, if your patient needs a post-op block for pain, you know, how, how do you provide that for them while, while still getting reimbursed for it, and, and not being a detriment, you know, I guess, financially to your institution.

JORDAN:

I know that we talked a lot about the base units and the time and the conversion factor. I know one area that interests me that I still am a little fuzzy on, is sort of the ancillary services and how they get reimbursed, and understanding how to balance those with the cost of those ancillary services. Um, and, and just in general, I wish I knew better about how these decisions are made and what we can do to try to influence the decision to be more accurate to the value that these services provide.

RAJEEV:

And I think, to give us all a little bit of credit, I think these are hard questions, you know trying to understand how insurance companies, um, establish contracts and where they reimburse and at what rates is incredibly challenging, I think not just for us, but for people have been in the field for 20 plus years, and it, it drives a lot of behavior, too. I mean, I feel like I've learned a lot from people out in practice who are talking about mergers, or consolidating power to have leverage with insurance companies. Right? And so it does affect us, but it's hard. Um, so I want to know you, how do you think we can get mentorship here? How, how do we start to tackle these questions?

This is in some respects kind of different from other topics in that it's very specific. Right? I mean, a lot of what we're talking about is very specific and yet we have a lot of looming questions. And so how do, you know if, if you don't know the answer, where do you turn? How do you get mentorship on understanding payments and reimbursements and financial questions?

DANIEL:

And I, I think it's tough in academic medicine because most academic institutions have a separate billing, coding, reimbursement department. So it's not something that is handled by the physician.

TRISTAN:

Yeah, I agree, I mean, I'm in private practice and it's still not that relevant to me because I'm not doing billing. And so, if it's not a problem of mine, it's really outside of my focus, so I think as residents be aware, like going to this conference, just sitting and learning and listening. But only until you're actually involved in it and you have the problems of billing and coding, then you'll, you'll seek somebody who knows, who can guide you.

NELLAB:

I think it would be interesting, I'm not sure if some residency programs offer this already, um, if perhaps during your CA3 year, you could have a rotation or service where you rotate, um, at a private practice, and kind of understand, get more insight into the billing and coding aspect of it because as you mentioned earlier, it is a little different when, in residency, when it is an academic program, there's a completely separate department and we're kind of blinded from that whole process.

JORDAN:

So, uh, I know for me I, uh, one of the things I struggle with, is I'm not very good at charting and because of that I've had some mistakes I've made that have been brought to my attention by the billing department. And actually, that has been a great experience for me, going in and talking with the billing department at my institution, because they know a lot. And they have a lot of answers and I know for me talking with them, has been really illuminating in terms of understanding how this all works. So I know we met with one of our billing department folks and went through the acute pain billing process and it was really illuminating and frankly things that I'm not even sure, uh, our attendings knew, and all that detail, but they're people out there that know the answers they might just not be physicians.

NELLAB:

Maybe if we all start charting wrong, we can learn from that.

(Laughter)

RAJEEV:

I, I think, Jordan, that's a really excellent point. I, I went to a conference a couple of years ago about quality improvement, and the most popular poster was one about the pre-anesthesia clinic and what codes you could bill for, for services that you already do. If you think about that, it's not even like how can we get better? How can we expand? It's just how can we bill for things that we already do? And that, that was the most popular one. Right, because this issue of transparency and how you actually get the data is really hard. So I'm curious to know, I mean, that's a really, really valuable experience. I mean, do you think that's translatable? I mean, it's I think about, for the rest of us here. Do you think you could go to your billing department? What type of reactions might you get if you wanted to learn more about this?

DANIEL:

I probably have to figure out where it is first.

(Laughter)

KANDICE:

For the most part, people are pretty open to sharing what they know. You know, it's something that they do every day and if someone shows interest then, you know, just carve out time and make time so that they can teach someone else, usually open to that. It's worth a shot. It's better than not trying.

RAJEEV:

But I think to your point, Kandice, too, if you have somebody who has some influence also behind your back to support you in this, it may also help. I know at the University of Washington, I mean, no matter what my experiences are if I just knocked on the billing department, I don't think they would actually welcome it with open arms. But, if I got, you know, somebody who is a little bit more senior to me, that's a mentor who could, who has some influence, who asked the same question, you know, we could as a team, you know, what kind of start to extrapolate and make data based decisions. So I think that also goes into mentorship and, um, you know the data is there and if you ask for it, you may be able to get it.

JORDAN:

Going back to the way you were saying about that poster in terms of showing what we're already doing, sometimes I feel like our specialty is so unique in that everything we do, we undo later. In the sense that when we get a patient the expectation is when we're done with them, they look exactly the same as when we got them. And so that being the case, it takes a little extra effort to show what value we're adding and what we're doing and why that's important. And to that end, uh, our folks in the billing department are sort of advocates on our behalf saying, no they did this and they did that, and this is how they should be compensated because that was an important value added to this patient experience, even though at the end of the day, there's not going to be something concrete for the patient to show. Hey, anesthesia did this because ideally, they won't have anything to show, it will be like we weren't there.

RAJEEV:

Well, I have an existential question about this. Some of our listeners around the country may be wondering why a group of doctors are here talking about money. Isn't that your job to just go take care of patients? So, question to the group, I mean how important is it as a physician to understand these money questions, and does it influence, for good or for bad, your clinical decision-making?

TRISTAN:

If you don't know what's going on, you can be taken advantage of. So I think regardless, you have to know what's going on, why every, whatever practice you're in, you have to know the billing part, the coding, or else someone's going to take advantage of you.

NELLAB:

I think in order to be able to provide for patients, you need to have an actual functioning practice, um that's able to run and stay afloat. And part of that, is understanding, um, the financial aspect of it. If you can't fund your practice, or, um, profit from it in any way to allow it to sustain, then you're not even going to be able to provide that patient care.

JORDAN:

I think sometimes, too, when we have these discussions, it can sound, if we're not careful, like we're trying to make the cost of healthcare higher. And the way I see it is rather than that, it's just a matter of trying to make sure that whatever healthcare dollars we're spending as a nation gets distributed to the places that have the most value. And in order to do that, you have to, through billing, show what kind of value you're adding to

the system. But, I, I do think that in the end, we're just trying to make sure that we have the resources that we need to effectively care for our patient. And in order to do that we have to be able to show that we have value and get the revenue we need through the billing.

RAJEEV:

I think those are all really good points. I, I would also say, I think it is our responsibility to actually change some of the culture of medicine in this space because I think for a long time this entire topic of payment, reimbursement, money has been just viewed as a necessary evil, and something that's deprioritized, and has, all of us who have gone through the medical system realize that it actually is very fundamental. For better, for worse, it does influence behaviors. And so if you're not seeing it for what it is, you're actually not putting the focus on value for your patients. Right? You're kind of putting your head down and just proceeding. Um, so yeah, I mean, I think that it is, is the way to think about it in terms of value. How do you, you know, allocate resources effectively, or, you know, how do you improve patient care broadly, and how do you do it in a sustainable way? Like you were saying, Nellab, in terms of, of practice that actually works is, is a really important takeaway.

So there's a lot of talk in the broader healthcare system in terms of the patient experience, or rather the consumer experience. Right? That maybe healthcare is not so different from every other industry and we have consumers, and it's the reason you know, people want to go to Walgreens, right, to get their medical care. It's fast. It's convenient. It's easy. It's why Amazon or Google will save the day. Right? There's this tendency towards moving in that direction. So the question I have is, when you look at anesthesiology as a field, how important is it to promote your value and services and what challenges do we face?

DANIEL:

The challenge that we face is that a lot of times people don't really know us, you know, we're expected to bring them back in the same condition that they arrived in, and they meet us for 5 minutes beforehand, they are asleep through the surgery, they go to the recovery room, they wake up and we're gone. You know, they, they don't really equate us with being their doctor, their physician, cuz we don't have any relationship with them.

JORDAN:

Yeah, and I think to that point, since it's hard for them to see the value we've added, it just highlights the importance of sort of the customer service aspect. In some ways really, the only value that the patient will see, if things go well, will be how did we treat them preoperatively? How, were we kind? Did we help them feel less anxious? Did we follow up with them after surgery? In some ways those things that we think about as being sort of ancillary to what we really do are the only things that are patients really experience, and just highlights the importance that we do a good job with those.

TRISTAN:

I think it's hard to have leverage as anesthesia particularly because we don't have our own patient base. So you're, a lot of times at the mercy of his surgeon, or a GI doctor who, uh, has the patients. So it's difficult to leverage, um, ourselves.

NELLAB:

I think, um, something that's also important is our own portrayal of ourselves. I think it's very easy to get mixed up in this sea of CRNAs, or AAs, or, um, especially when everyone is wearing the same scrubs at least in my hospital, I've, it's really hard to distinguish the differences. And so one of the things we can do, which I, I know my institution doesn't do at the moment, but we're trying to make it a thing, is to start wearing our white coats more. And kind of demonstrate that we're actually, we are physicians, and that there is a difference between an anesthesiologist, um, and a nurse anesthetist, um, and I think we can demonstrate our own value by just showing that we are actually doctors. And perhaps having people in the operating room refer to us as doctor, you know, so-and-so, instead of by my first name, which I admit that I've just become accustomed to because that's the way it goes, but nobody refers to the surgeon by their first name.

RAJEEV:

Yeah, I think we have a unique challenge in our field and I think it's also perpetuated because of some stereotypes, right? We've all seen that the, uh, anesthesiologist who plays Sudoku in the operating room, and kind of ruins the reputation for everyone else. Um, I, I think in my practice now as a resident, some of the points Nellab you said, I mean, I do introduce myself as Dr. Saxena and I try to make it a point to say anesthesia is four things, is analgesia, amnesia, muscle relaxation, loss of consciousness, in a, in a more clear way, and that my job is to actually do these things on the entire case. That is a very unnatural state for the patient and I'm supporting your blood pressure, and I'm breathing for you, and I'm doing all of these active things to keep you safe. So not to

scare them, but to reiterate in those few minutes, like what are we actually doing for them? And it, we do I think have a responsibility to carry our field with that sort of reputation and demonstrate our value.

So, just to close, we talked a lot about finance and systems, but at the end of the day, we each are individuals and we will have our own, one day hopefully, a salary bigger than our resident salary. So, any advice for other residents, in terms of how to manage your personal finance? Or how to apply some of these techniques in your own life?

KANDICE:

A good place to start is just kind of drawing out your own budget. You know, where you're at, where you want to be, kind of what goals you personally have, and I feel like you know, writing things down and re-evaluating can go a long ways. I've had advice of, you know, living like a resident for a few years even after you start making more money. And that way, you kind of have a better financial health. There's multiple other aspects we can touch on his first debt management or investing, and insurance you know, disability and those kinds of things. Um, but I think the best place to start is just getting and idea of where you're at and where you want to go.

JORDAN:

Yeah, I would just echo what Kandice said, we may not have the money now, but we have the resources and we should make the time to make the plan now, so that when we get that paycheck that we're all dreaming of, we don't give in to what will no doubt be our first thought which is to buy a new car or do something like that. Uh, if we make the plan now while we're living like residents, it's going to be a lot easier than trying to play catch-up later in our careers when we were having to cut back because we haven't prepared.

NELLAB:

I think it's important to start early. A lot of medical schools offer, um, free services in your fourth year with, uh, like a financial loan officer. Um, session, just one session can help, kind of help you, you know understand how repayment works. Um, and so, I think the earlier on, understanding that can help you later on the future.

DANIEL:

Yeah, you know just kind of piggybacking off of that, compound interest is your friend. So, even if it doesn't seem like you're saving much now, uh, every little bit is, is gonna multiply.

RAJEEV:

Awesome. So I've learned a lot, and hope you have learned a lot, too, and this is I think a really nice avenue for us to share ideas. We talked a lot in terms of how an anesthesiologist gets paid, how practices make money, what are the setups for practices, how do you think about the larger legislative and kind of bigger systems, and how they affect your microsystems and local systems? And then we also kind of talked about personal finance and how to apply these in our personal life. So I think we, we covered a lot. It's been a pleasure to be your host. I am Rajeev. This has been Residence in a Room, the ASA podcast, by residents for residents. I'd like to thank our colleagues and have a good night. Tuning out.

(OUTRO/MUSIC)

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