Private Practice in Anesthesia in the United States.

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As of December, 1980, the total number of anesthesiologists was 15,985, of which 11,338 (71%) were in private practice and the balance were in hospital based practice (residents and staff) or in research and administration.

Type of private practice:
The anesthesiologists in private practice work either in group or solo. The group practice, by definition by AMA, consists of three or more physicians working together, sharing the work load and the income agreed upon by the physicians in the group. Solo practice does not necessarily mean working alone, but, usually, they work together with other physicians, but, their incomes are separate and independent from others. They are paid for their each service rendered to their own patients.

Hospital privileges:
When an anesthesiologist wishes to work at a certain hospital where a position is available, his credentials have to be submitted to the hospital. The credential committee of the hospital will review the qualification of the applicant. If it is found satisfactory, the surgery committee will grant the applicant a probationary staff privilege for a certain period of time, usually, 6 months to one year. During this period, the new anesthesiologist will be proctored by one of the full time staff members. At the end of the probationary period, if everything is satisfactory, he will be granted a full time active status. Courtesy staff is not a full time member, but, he will be available when his service is required, usually as a consultant. He has no duties to attend regular hospital meetings or to serve as a member of various committees of the hospital. Locum tenens is a physician who is called in to cover some of the full time staff of the hospital during his temporary absence, such as vacation for a limited time.

Physician manpower:
In 1965, then president Johnson declared that there was a physician shortage. The U. S. medical schools responded by increasing both in numbers and in sizes. From mid 1960s to present 41 new medical schools were creat-
ed and its number is now 126. The number of medical students increased from 49,808 in 1973 to 65,497 in 1981 (31% increase). At the same time, immigration law was changed to accommodate foreign medical graduate (FMG) to practice medicine in the U.S. Between 1961 and 1976 more than 60,000 FMG immigrated to the U.S. and well over half of them received permanent visa and settled to practice medicine in the U.S. In 1980, however, the report of Graduate Medical Education National Advisory Committee (GMENAC), which was established in 1976 to advise the Secretary of Health and Human Services Department (HHS) on national health planning, revealed a miscalculation of an earlier report of physician shortage and now predict that there will be overall surplus of 70,000 physicians by 1990. The comparison of U.S. census population in 1970 and 1980 shows population increase by 11% (23,284,427) in 10 years. During the same period the number of physician increased by 40% (133,651). The physician/population ratio increased from 1/610 to 1/484. The number of anesthesiologists increased by 56% (5,759) during the same ten years period. GMENAC now recommends: 1) medical schools reduce their class size 2) no new medical schools be established 3) number of FMG entering the U.S. be severely restricted.

Cost of medical care:

The rise of medical cost is one of the biggest problems in the U.S. today. The total cost of medical cost paid out in 1981 in both private and government program was $287 billion which was 15% increase over the cost in 1980, whereas the general inflation rate was 11.4%. The federal government paid out $70 billion for health care for the elderly in the same period. The budget of HHS for 1983 is $274.2 billion, which is more than one third of the total national budget and it is larger than the total budget of any nation in the world except U.S. and Soviet Union. During the 12-month period from August, 1981 to July, 1982, the cost of physician service rose by 9.3%, which is comparable with other service index, but, higher than the inflation of general items (6.5%). The hospital room charge showed highest rise during the same period (16.7%). The average increase during the last 5 years shows the physician service rose the least per year (9.7%), whereas the hospital charge went up the highest, 13.0%/year.

The reasons for high cost of medical care:

At present, 11% of the U.S. population is 65 years of age and older and accounts for 26% of the patients in community hospital and one third of all health expenditures. People over 65 go to doctors approximately four
times as often as those under 65. By the year 2000, about 12% of the American population will be over 65 years of age and 25.1% of them—7.5 million—will be over 80. Inflation alone is responsible for 60% of the increase of the health care cost. 30% is attributable to increased demand per capital and 10% is due to population increase. Modern technologies, there has been an explosion of new technologies in recent years. A generation ago, CAT scanner, ultrasound, fetal monitor, arthroscopy, pacemaker laser beam, microsurgery did not exist. The advent and purchase of these technologies has enormously contributed to the quality of health care, but, with great cost. Over utilization; the high cost of medical care results not only from paying more for the same services, but, from consuming more and new health services. For example, in 1967, 650 people in the U.S. were on Kidney dialysis. In 1980, the number was 64,000. In 1981, the U.S. will pay out $1.5 billion for dialysis. By 1990, this is expected to reach $6 billion. Government regulations; in New York State, a study indicated that hospitals were spending 25% of their budget to meet local, State and federal regulations. Each registered nurse spent the equivalent of one day a week on regulatory matters. In addition, $38.86 of each patient's daily bill was generated to fulfill regulatory requirements.

Malpractice crisis:

In last ten years, malpractice insurance premium increased by ten folds. The litigious nature of our society, which contributes to the increase in the premium, has provoked the practice of defensive medicine. Many doctors order tests and other procedures they might not deem essential just to protect themselves if something should go wrong. It is estimated that 30 to 40% of all the diagnostic procedures ordered by the physicians are attributable to the practice of defensive medicine. The premium for anesthesiologists is about $12,000.

The reasons for high cost of malpractice insurance:

Oversupply of lawyers; there are too many lawyers in the country today. 25% of them are unable to find jobs as lawyer and engage in work not related to law. Their competitions are very high and everybody is looking for a case. Contingency fee system; the lawyers for malpractice litigation work on contingency fee system. The lawyer receives fee only when the case was won out of the award, usually 40-60%. This system makes it easy for anybody to sue doctors. Excessive amount of award; it has been a trend in recent years for the court to award huge amount of money to malpractice cases, usually millions. A record breaking settlement occurred in California not long ago at Stanford University Hospital, where a newborn baby suffered a period of hypoxia after delivery resulting permanent brain damage. The case was settled out of court for a total
amount of maximum $122 million if she lives to the life expectancy of normal person. Too many settlements; It has been a tendency for the insurance companies, doctors and hospitals to settle the case out of the court rather than going through years of agony and expenses of law suit. This tendency of settlement has encouraged lawyers to file the suit and get the easy money. Naturally, the number of law suit increased and the premium skyrocketed. This problem has been recognized and the recent trend is not to settle the case but to fight at the court if it is a defendable case.

Health insurance:
The basic system of health insurance in the U. S. is that, for elective cases, 80% of the cost deemed reasonable by the insurance company is paid after certain amount of deductible, usually $100-$500. The insurance company pays either to patient or directly to the doctor or hospital (provider) depending on the arrangement made. The patient is still liable for the balance of the cost and he must pay directly to the doctor or the hospital. There is no limit in the amount that doctors or hospitals can charge to the patient. However it has to be within an acceptable range in that particular community. As for emergency cases, there is no deductibles and the insurance pays 100% which is considered to be reasonable by the insurance company. There are insurance systems run by federal, state and private. People over 65 years of age are covered automatically by Medicare which is run by federal government. State government runs Medicaid which covers indigent with no age limit. There are numerous private companies throughout the country, some are financially stable and others are facing difficulties.

Health Maintenance Organization (H. M. O.):
Recently, a new type of health insurance had emerged in an effort to reduce rising cost of health insurance. This is called, in general term, Health Maintenance Organization (H. M. O.). This is a prepaid health insurance system. The enrollee pays in advance as monthly premium and when medical care is needed, there will be no extra cost to him. However, the patient has to use a panel physician and hospital that has signed contract with H. M. O.. In other word there is no freedom of selecting the doctors and hospitals.

There are three types of services available:
A) Individual practice association (IPA):
These are the physicians in solo practice who signed contract with H. M. O. and agree to accept the fee set by the H. M. O. as full payment.
B) Group model:
A medical group signs contract and reimbursed at a fixed amount per capital whether a patient received medical care or not.
C) Staff model:
Some H. M. O. owns and operates its own hospital. The physicians are employee of the
The cost of H.M.O. premium is about one half of that of regular insurance ($125 vs $250). H.M.O. is rapidly expanding throughout the country especially among employees of big corporations and now estimated that about 25% of the population in the U.S. are enrolled in some form of H.M.O. However, the drawbacks of this system can be very serious, but, not quite understood by most of the enrollees. The Organization makes profit by giving less medical care to the patient. There are usually a long waiting list for elective surgeries. The employed physicians have incentives not to give adequate care because their bonus is based on the profit hospital makes. Nevertheless, the government encourages this type of insurance because of its low cost and avoidance of overtreatment.

The future of private practice:
Private practice means a contract between physician and his patient which obligates the physician to deliver quality medical care and the patient to pay for such care. No other party should stand between them. This system, free from control by insurance companies and government, traditionally allowed patient a free choice of both physician and hospital. The physician has freedom to deliver to the patient the best of medical care at the most economical price. If the cost of medical care continued to rise beyond general inflation rate, it will come to the point where neither patient nor insurance can pay any longer. Then, the government will eventually take over the health care system with severe restrictions on the freedom of medical practice including fee schedule and choice of treatment and the private practice of medicine will perish. Recently in California, a new legislation had passed which gives private insurance companies the right to create their own complete health organizations by contracting with doctors and hospitals. These doctors and hospitals, once signed the contract, will agree to accept the fee schedule made by the companies. The companies will dictate the policy making and health care delivery. The doctors and hospitals will be assured to have referral of patients by the companies. In California, recently, nurse anesthetists tried to press the legislators to pass the bill which would have allowed them to practice anesthesia independently without physician supervision. Although it failed this time, there is a definite movement for the nurse anesthetists to become independent. The hospital would be willing to employ them because their lower salaries than physician anesthesiologists and the insurance companies would accept them because it will be more profitable. Those problems will add to the pressures of competition already imposed on the private practitioner by physician oversupply, recession, falling number of patients and H.M.O.

We must, therefore, maintain certain principles to preserve private practice in the
future:
1) Contain the spiraling cost of health care 2) encourage the government to stay out of the medical care system 3) oppose systems that lock in a group of patients to a hospital or a list of physicians 4) oppose the insurance companies to take control of practice of medicine 5) do not allow the nurse anesthetists to become independent practitioners.

The private practice of medicine will survive if we can return to a status where no third party interferes between patient and physician, and the patient has a fiscal responsibilities and physician has a duty to maintain high quality of medicine and give the best of the medical care at the most economical price.

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