Published in Anesthesiology News
May 2010

ARE YOU HEADED TO THE ANESTHESIA FACTORY?

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Shortly after 4 a.m. one day last December, I pulled out of my driveway. It was pitch black and raining.

But from the moment I merged onto US 101 heading south into Los Angeles to give a Grand Rounds presentation, there were other cars on the road. By 5:30, as I approached the major arteries of the L.A. freeway system, the road was crowded.

I began to play the imagination game: Where was everyone going?

Some, I suppose, were headed to manufacturing jobs that start at 6 or 7 a.m. The same drive in, day after day. The same start, middle and end of work. The same drive home.

That morning, as I gave my lecture, I commented on my imaginings to the audience, medical residents and attending staff. I posed these questions:

“I know that you are highly educated. I know that you are highly trained and experienced. But are you going each day to a factory, too, just a factory of a different kind? Do you have the same factory worker mentality—the mentality that what you do can be done by many others in much the same way, the mentality of ‘I’ll work for what they give me’? Sure, the reward you receive is quantitatively different, but is the situation qualitatively the same?”

On another level, is your anesthesiology group simply a unit of production within the larger factory of the hospital? Does the group view itself simply as a service provider, delivering the same commodity as any other anesthesiology group in your community? Does it believe that other groups are competent potential competitors for the provision of services at your hospital? Has your workload risen while collections failed to keep pace, creating a “workload–reimbursement gap” (a term I’ve trademarked)? And has the group determined that it must accept the increasing gap, and the hospital’s unwillingness to stem it by way of sufficient stipend support—simply another way of working “for what they give me”?

To break free, either at the individual or the group level, requires both a change in mentality and strategic action.

A Medical Degree Is a Terrible Thing To Waste

Life has few guarantees, but this much is certain: If you believe that you provide a commodity service, your future has little upside. Grab a lunch pail and head to the factory. Form a union and protect against someone else doing your job for less. That’s the problem with commodities: Sellers are relegated to competing on the basis of price, and someone will always do it for less because price is the easiest basis on which to compete.

To be fair, part of this commodity-think mentality is fostered by the high level of collegiality within the medical profession, an otherwise very positive attribute. However, recognition and honor of a colleague's similar training and skills does not necessarily equate to the belief that the two of you, or your respective anesthesiology groups, deliver the same value to customers: facilities, surgeons and patients. The failure to focus on that value package distinguishes the commodity group from the strategic group.

Even more troubling, are we approaching a point at which commodity status might largely remove many anesthesia groups from the hospital-based equation because of a convergence of thinking, technologies and business models?

As anyone who deals with hospital management on a regular basis will attest, administrators often take the position that anesthesiology services are a commodity to be obtained at the lowest possible cost, akin to laundry, maintenance and meals. Administrators often threaten to replace a group with another that is more compliant to their wishes. They issue requests for proposal, seeking to obtain the services of whatever group can provide coverage at the lowest cost.

Government-financed programs, such as Medicare, ultimately lead to cost cutting, which leads program bureaucrats to consider alternative means of obtaining services, including considering the use of alternative—read, nonphysician—providers. The impact of these programs has a two-pronged multiplying effect: Historically, private insurers have attempted to link, when beneficial to them, to government program rates and payment policies. And, once alternative providers are permitted to practice at a facility, the scope of their activity will be hard to contain.

Technology is converging on the same point, too, and promises to bring dramatic changes to the practice of anesthesiology, not all for the good.

The entrants in this race include better pharmaceuticals that avert the need for surgical interventions, robotic surgery and even nanorobotic surgery, which may one day dispense with the need for what is traditionally described as surgery altogether.

A January 2009 news piece in the *Sydney Morning Herald* reported that Australian scientists have developed a motor smaller than the width of three human hairs. The motor powers a spiral tail that propels the structure through liquid in the manner of bacterial flagella, and represents a significant step toward the creation of a “surgical submarine” à la the sci-fi movie, “Fantastic Voyage.”

Each of these developments foretells a reduction in the intensity of needed anesthesia care. But there’s a potential double-whammy: At the same time that surgical technology advances, so has the technology of anesthesia delivery. The result is that hospitals and insurers now believe that lesser-trained paraprofessionals are substitutes for physician-delivered anesthesia. Who will be the human interface: anesthesiologists or paraprofessionals?

Cost-cutting efforts only serve to make nurse anesthetists more attractive when the sole basis of comparison is pricing.

Unfortunately, to quote the futurist Rolf Jensen, the technology-rich information society in which we have lived is coming to an end, replaced by a society in which feelings replace facts and in which imagination replaces information. Just who tells the better story—nurse anesthetists or anesthesiologists—might mean who wins the economic battle.

Strategic Action

Although a change in mindset is required to remove yourself, and your group, from commodity-level thinking, so is action. You must perform an honest assessment of your present situation and develop a model of your ideal future. Note that this strategic process differs completely from making incremental plans based on your present reality. You need to break the mold completely and create a new one.

In order to have a chance to compete, your ideal future must include the creation of an experience monopoly, a standard of service and interaction that no one else can duplicate—would-be competitors might not even understand what is being done—and that, therefore, makes your group the only logical choice for the relationship.

There are many aspects to creating this level of service. It's not simply the delivery of high-quality patient care. That's expected; it's only a small, but important part of the overall picture.

More important is the manner in which your group's providers interact with their patients, with surgeons, with hospital administration. Instead of wasting time debating who the customer is, realize that all of those groups are customers and that identifying which one comes first is a question of context.

Also understand that to successfully create an experience monopoly, almost all of your group's functions, from administrative internal tasks to dealings with hospital management, must be aligned. Too often, anesthesiologists mistakenly believe that these interactions are separate, when the reality is that they all are related.

For example, the overall relationship with a referring physician affects the care provided to a particular patient. What can be done to create a relationship with that surgeon that takes your group from commodity status to that of a monopoly? At the very least, this process includes fostering both a personal and a professional relationship with the surgeon and his or her office, proactively making the experience of working with your group a delight. Realize that these relationships are largely emotional: The way you communicate and conduct yourself, and the way your group, as a whole, demonstrates the importance of the relationship, builds support. What efforts are made to train your group's physicians on the way to interact with surgeons? What responses are your office staff, or those of the billing service, trained to give in response to inquiries from surgeons' offices? What promotional activities has your group directed to surgeons individually and collectively, either directly or through the medical staff?

It also means that the group must find ways to monitor, measure and demonstrate the value that it is creating. For example, can you track the immediacy of responses to requests? Have you surveyed patients' level of satisfaction with your services? Have you publicized your activities in support of referring surgeons?

And as the relationship between the group and the hospital and its administrators impacts the ability of the group to deliver that level of service, the group must develop and implement efforts to cement that relationship as well. Have you taken steps to develop a process to deal with issues before they light up on the chief executive's radar? Do you have a process of turning potential problems into demonstrations of your group's management skills? Has your group become so integral to the operation of the hospital's operating rooms that replacing you would endanger the operational ability of the institution?

After all, the creation of an experience monopoly means that your group has removed itself from competition—it no longer provides a commodity service—and has become the only group considered by

its customers. That means a dramatically increased willingness on the part of the hospital to consider its relationship with you more than just a contract, and to provide the necessary level of stipend support.

The time to get started is now (OK, it was really yesterday). And yes, change is uncomfortable. But to quote Gen. Eric Shinseki, secretary of the Department of Veterans Affairs, “If you don’t like change, you’re going to like irrelevance even less.”

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