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## THE HEALTH CARE CON-VERGENCE

BY: MARK F. WEISS, J.D.

The long con: a meticulously planned, long-term confidence scam designed to obtain a large return from the “mark.” It is the opposite of the short con, designed to instantly fleece the mark of the money or property on his person.

Nobel Prize winner Niels Bohr commented that prediction is very difficult, especially about the future. What did he know? After all, they’re handing out Nobel Prizes to almost anyone these days, apparently for what they might do in the future.

Certainly, some things are easier to predict—for example, the very different role of physicians in the health care system of the future.

I’ve always believed that we don’t have a health care system—we have a health care *market*. Or, at least, we had one. As words matter in persuasion, propaganda and politics, the public at large—and many within the market itself—became sold on the “system” approach. Voila! There was a “system” to fix. Of course, the fix was in: Obamacare.

So just how will physicians fit within the system? A prominent role in return for the American Medical Association's support of Obamacare? Maybe not.

Consider these trends that appear to be converging on your medical degree.

### **The Struggle Over Money and Control**

As Obamacare has promised more care for less money, the battle for control of limited health care dollars and of the delivery system itself is intensifying. Obtaining the power to allocate funding and delivery means that those in control of allocation will have the ability to shift funding, and cost savings, to themselves or their favored participants.

Accountable care organizations (ACOs; see "Accountable to Whom? ACOs and the Battle Over Private Practice," *Pain Medicine News* August 2010) are an example of this struggle over money and control. Although not specifically defined, these hospital-plus-provider organizations are to act as funnels for federal health care dollars. Picture every case as being subject to a super global fee: X dollars to be paid for all related services, both facility and physician sides. With the hospital in charge of allocating your fee, how fairly will it act? Of course, this begs the question of whether it should be acting at all.

### **The Shift to the Lowest-Cost Alternative**

With fewer health care dollars per patient to spend, those doing the allocating will be tempted to select the provider who offers the service at the lowest price. There will be a predisposition toward acceptance

of substitute classes of providers. There also will be the adoption of lower standards as to what constitutes an acceptable substitute service.

For example, let's look at the current state of the "nurse versus physician" debate. Nurses, and the hospitals that hire them, seek to greatly expand their roles. They see existing limitations placed on the scope of nursing practice as anachronistic and view a health care future that is largely led by nurses.

The battle is on for public perception, but nurses consistently come in first in the annual Gallup Poll on the public's opinion on professional honesty and ethical standards. Even the English language has the odds stacked in favor of nurses. (I wrote this short story to demonstrate: "Sally *nursed* the escaped convict back to health. Afraid he'd be identified, the convict *doctored* Sally's drink.")

Looking even deeper at the nursing issue, consider the certified registered nurse anesthetist (CRNA) versus anesthesiologist war for more clues.

Political and economic pressures have forced regulatory change; 15 states have opted out of Medicare's CRNA supervision rule, and the Centers for Medicare & Medicaid Services (CMS) guidelines already permit CRNAs to administer labor epidurals for the purpose of analgesia without physician supervision.

Earlier this year, the Lewin Group released a study funded by the CRNAs' national organization, the American Association of Nurse Anesthetists (AANA), concluding that CRNAs acting independently provide anesthesia services at the lowest cost, with no difference in the level of care. In August 2010, another AANA-funded study was published in the journal *Health Affairs*, concluding that there are no differences between patient outcomes when anesthesia services are provided by CRNAs, anesthesiologists or CRNAs supervised by physicians. The study's recommendation? That CMS allow

CRNAs in every state to work without the supervision of a surgeon or anesthesiologist. Hospital administrators are already more willing than ever to accept CRNA-delivered anesthesia from their contracted providers.

### **Doctorates for All**

Just as it has become in pharmacy and physical therapy, the new gold standard in registered nurse education is a doctoral program awarding a PhD, DrNP or similar degree. Of course, nurses with doctorates want recognition of their new status: “Hello Mr. Smith, I’m Dr. Jones.” No, not exactly.

There are fewer dollars to go around, and let’s assume nurses and other paraprofessionals can deliver the same service (or, at least, a level of service benchmarked to the mediocrity of “national health care”). If those paraprofessionals are “doctors,” can we then expect a major reboot of the system in which MDs are removed from the flowchart? Or are they relegated to a less prominent role of technician, not of front-line provider with control over patient care, and importantly, over the flow of patients to and through the system?

À la *“Invasion of the Body Snatchers,”* once nurses are “doctors,” the transition will be complete.

### **No Magic Pill**

There’s no magic pill to resolve this dilemma. On the political front, there’s the ballot box. On the medical society front, there’s tremendous PR work to be done to convince the public of the deceptive substitution of providers.

And, on the levels that can more easily be impacted by your personal involvement, there's the fight, at the medical staff level, to protect patients by making certain that physicians control medical care and that paraprofessionals are supervised by the appropriate physician specialist in implementing that physician's orders. On the medical group level, it's avoiding establishing business practices that foster acceptance on the part of your patients and referring physicians of employed or subcontracted paraprofessionals as *substitutes* for physicians. Physician extenders are one thing; physician executioners are quite another.

Whether by plan or coincidence, the substitution of paraprofessionals for physicians is a major element of the long con of national health care. As they say in the confidence game, if you don't know who the mark is, it's you.

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Mark F. Weiss is an attorney who specializes in the business and legal issues affecting anesthesia and other physician groups. He holds an appointment as clinical assistant professor of anesthesiology at USC's Keck School of Medicine and practices with the Advisory Law Group, a firm with offices in Los Angeles and Santa Barbara, Calif. He can be reached by email at [markweiss@advisorylawgroup.com](mailto:markweiss@advisorylawgroup.com) and by phone at 800-488-8014.

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