

Health Care and the Anesthesiologist: Influence and Factors*

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When one asks me today what are the special factors that influence the health care delivery of anesthesiologists, I am compelled to say that they are almost identical with those factors which influence the delivery of health care for all physicians.

The first and major influence is the role of government. Probably the most beneficial impact of government activity in the past decade has been the advent of Medicare in June of 1966. This is an excellent program which has truly provided marked beneficial results for the elderly. It has brought more talented medical care to the aged at a minimum of cost and, up to now, at a reasonable reimbursement level. On the other hand, the Medicaid or Title 19 activity which was added to the Medicare legislation at the last moment has proven itself to be a colossal fraud. This was simply overpromising and underfunding. In many areas of the country, institutions and health care providers are underfunded to the extent that billing for services is not worthwhile. Hence, this large poor segment of the population is left with no better health care delivery than it had before the inception of the Medicaid proposition.

Attendant to the Medicare legislation was the establishment in each major health care institution of a utilization review committee which would study the effectiveness of medical care delivery of its practitioners. This was geared to increase productivity of overcrowded hospital facilities. In many areas this has proved extremely effective. Hospitalization periods have been reduced, many unnecessary costs have been limited, and hospital beds are more readily available so that there is a more efficient turnover of

acute care patients. In this regard, one of the challenging problems affecting government and health professions in general is the accuracy of predicted demographic projections for the immediate and remote future. At present, our country of over 200,000,000 people has 11,000 anesthesiologists and some 15,000 nurse anesthetists delivering anesthesia care for some 15,000,000 major surgical procedures performed in this nation each year. Initial projections before the concern with population growth were that we should have a total population of some 275,000,000 people by 1985. With the recent changes in birth rate, it is projected that we shall not have such a population abundance until closer to the year 2000. This problem ties in very directly with the utilization efficiency of the numbers of anesthetists, both anesthesiologists and nurse anesthetists, that we now have in ratio to population and our concerns for projecting our adequate future supply. In both of these areas, manpower has been increasing adequately over the past decade. One thought has been to supply physicians' assistants in this area. There are several schools where physicians' assistants in anesthesia and job identification of anesthesiologists' functions are being developed. I cannot conceive that this is a universal need, for the physicians and nurse anesthetists are presently doing a most adequate job and have a depth and scope of information which leads to a more adequate judgment so necessary for quality patient care in the operating amphitheater. In a study of ten hospitals conducted by the American Society of Anesthesiologists in 1969 and repeated in 1970 with almost identical results, the surgical anesthesia committee of this society found that the operating room efficiency in terms of operating rooms utilized per man hour of anesthesiologists and anesthetists available and per eight-hour working day was somewhat below 50%. Efficiency seemed to increase

* Presented at the 25th Annual Stoneburner Lecture Series, February 25, 1972, at the Medical College of Virginia, Richmond.

with the increase in hospital size, and where a teaching setting was involved. In such institutions the mode curve ran as high as 55 to 60%. It stands to reason, therefore, that with our present numbers we can simply double our efficiency and effective delivery of health care by a more careful scheduling of operative procedures. The anesthesiologist has extended his arm outside of the operating room, particularly in intensive care, emergency care, and coronary care facilities. It is here that his special talents have proved so successful. It is here also that the immediate continued attention of the anesthesiologist is not necessary in the same degree or in the same manner as it is necessary in the operating room. It is here, therefore, that I believe a physician's assistant in anesthesiology will be a very effective mechanism for improvement of anesthesia care in general. Studies in the effective utilization of operating rooms and demographic projections of manpower within the speciality are presently being continued under the auspices of the American Society of Anesthesiologists.

"Peer review" is something everyone seems to be talking about. There does not seem to be a consensus of application with the exception that everyone understands it is a quality analysis of the effectiveness of the health professional, both in terms of the capacity of his professional competence and his socio-economic delivery. Needless to say, any regulation of the quality of the professional activity of physicians and other professionals can only be effectively established by those professionals themselves. No lay government bureaucrat can expect to succeed in this area. They have neither the knowledge nor the know-how.

One of the most recent influences in health care delivery that is affecting the government, the patients, and the anesthesiologists as well as physicians in general is the mounting cost of malpractice. When I started in medical practice some twenty-odd-years ago, my premiums for \$100,000-\$300,000 malpractice coverage were \$102.00 per year. Today, in New York, a policy with \$2,000,000-\$6,000,000 coverage, which is necessary because of the frequency and increasing fees of malpractice defense, is \$6,000 per year. This has been one of the most troublesome areas in rising costs of medical delivery by professionals. The professional cannot be expected to absorb all of this expense, and a great deal of it has been passed on to the patient as evidenced by increasing fees. Malpractice coverage

costs have also increased health costs in general by creating the need for more expensive laboratory tests and by limiting a certain professional therapeutic activity to very costly methods where there is a high degree of safety. At present, there is a presidential commission studying this problem. All we can say is that we urge their haste before malpractice premiums raise the rate of health care delivery beyond any reasonable expectation.

There has been a recent surge toward prepaid clinic development. This is taking several different directions. Basically we are talking of that which is known as health maintenance organizations. These may be institutional and they may be individual. The Department of Health, Education, and Welfare over the past year has been actively involved in the development and planning of such HMO's on a pilot basis. Needless to say, of the eleven functioning at this time all are in serious financial straits, with one exception, and a much more extensive review of this HMO problem and projection of financial operation must be undertaken before any reliable results might be expected.

The second major influencing factor in health care delivery in the United States is the activity of the American Medical Association. I think it is important to say that there has been a great swing in the philosophy of activity within this organization, particularly regarding scientific and educational opportunities. This has been all for the good. The most interesting of the changes is in the fact that as of July of this year, the specialty organizations within medicine will take over most of the responsibility for scientific programming at annual and clinical meetings of the AMA.

There also has been an extension of the lines of communication within the AMA between the medical specialties and the officers, trustees and delegates. The first of these has been the development of the Section Councils which will be chosen for the most part by the parent specialty organizations. It is these Section Councils that will augment, authorize, and be responsible for the scientific activities presented as educational efforts of the AMA. The second line of communication has been the development of the Interspecialty Committee of the AMA's Board of Trustees so that specialties now have direct representation and voice channeled to the trustees of the organization. This provides for a rapid, informed dialogue between both organizations involved and the specialties at large.

Another important change in the American Medical Association has been the activity of its Council on Education. The Council has been instrumental in implementing the thinking published in the Millis Report. As you all know, internships are being phased out. There is an attempt to shorten the medical curriculum. In this regard, the AMA, the American Hospital Association, The American Association of Medical Colleges, The American Medical Specialty Boards, and the Council of Medical Specialties Societies are in the process of agreeing on a projected development of liaison committees for undergraduate and postgraduate medical education. There is no doubt that their thinking will eventually extend to Continuing Education and to Allied Health Professionals with the development of liaison committees in each of these groups together with representation from each of the parent organizing groups. Overseeing all of this will be a coordinating council which will have representation from each of the liaison committees and will be responsible as a single voice for medicine to the United States Commissioner of Education. This will probably prove to be one of the most effective links American medicine has ever had for a productive coordinated delivery. Of course, it is important at this time to realize that the early locking-in of a young medical specialist, whether he be in one of the surgical, medical, or family practice specialties, may influence the ability of future graduates in medicine and postgraduate training in their ability to pass present medical examinations. They may not easily swing from one medical

specialty to another with the same freedom of license to practice medicine. Consequently, there are many areas now where it is thought that an M.D. degree might eventually have to be modified so that it would specify a particular parameter of activity such as a medical specialty. Hence, in the future one might see M.D. (Anesthesiology) or M.D. (Surgery). This will also probably call for a complete change in licensing examinations on a nationwide basis unless there is a very adequate and broad depth of medical information funded to a young medical graduate with a foreshortened curriculum who is locked into a particular specialty early in his medical existence.

The third major influence on health care delivery of anesthesiology is the American Society of Anesthesiologists. This is a national federation of twenty-four component societies. It is extremely effective organizationally as a unifying force for education, for combined efforts, and for the production of standards within the specialty. The ASA is also a very effective liaison organization with the other specialties of medicine and with government where it speaks with one voice. It has just adopted a requirement for Continuing Education for continued membership.

In summary, then, let us say that there are many factors influencing health care delivery of anesthesia in the United States. The people of this country expect improved delivery of medical care. The medical profession stands ready to do its part. And it expects the government to assume its liability. Simply stated, that means adequate funding.