

Contributing to the Medical Community: Is There a Place for Loyalty?

By Adam Dorin, MD

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While medical societies fight uphill battles to preserve the 'scope of practice' integrity of a medical license, and political action committees (PACs) work to stem the overwhelming tides of legislative and regulatory initiatives that decrease reimbursement, it may seem that all we can do as doctors is struggle against overwhelming odds to survive. I would argue that there is much we can do as physicians to contribute to each other (and the health systems within which we operate) to yield invaluable dividends.

The positive role that physicians play in our neighborhoods is unmistakable. Free clinics, volunteer physicals, and sideline assistance for public school athletics are only a small fraction of the good deeds we manage to make time for outside of our busy practices. That we are generous to the general public is undeniable; are we also giving to our colleagues and hospitals? Should we regard loyalty and supporting our local hospitals as an important part of our professional ethics?

I write for a medical magazine and have recently been collating the various requests I've received from other anesthesiologists to write a piece about the role of 'office-based' anesthesiologists who also work in formal, multi-specialty ambulatory surgery centers and hospitals. Some of these individuals, like Dr. Marc Koch and associates in New York, have received national attention, been featured in major newspapers, and received the highest honors my specialty has to offer for their high clinical and ethical standards. These individuals have helped establish the foundation of office-based anesthesia in a way that strengthens — not weakens — the essential link between physician-owned, freestanding facilities and traditional, hospital-based medicine. Others (and the reason for the chorus of concern) have managed to eke out niches and practice patterns that exploit both fellow physicians as well as hospitals. The real-life samples sent to me about mobile anesthesiologists are illustrated below. I think the reader may find some bells that ring true to his own observations.

Dr. S. provides services to two surgeons in their respective practices across town and also covers selective cases in the hospital. The office work is mostly cash-pay and higher-paying insurance cases. While Dr. S. personally attends to these cases, his junior associates cover less attractive inpatients. Dr. S., as an independent contractor, is an undeniable asset to his two surgeon colleagues, who do not need to hire a full-time physician employee or partner and are still able to capture facility fees for their work. Offsetting these attributes of Dr. S., however, is a rather wide ripple effect of negative consequences. Dr. S. is misusing the resources of an open medical staff (and the absence of restrictive, exclusive contracts) to effectively manipulate the hospital operating room schedule around 'his' personal daily planner. Not only is Dr. S. exploiting the goodwill of his own partners, but he is making it unreasonably easy for selective surgeons to implement an insurance-location selection model that dictates where a given patient will have surgery. A model that is disproportionately unfavorable to the hospital system.

Dr. S., who still receives a sizable percentage of his income from his hospital work, benefits from junior associates who manage the hospital schedule to suit their senior partner's varying routine but are themselves denied access to the better-paying cases. These junior associates are left to toil in a hospital that teeters on the brink of financial ruin because of a depletion of adequately paying customers.

This is a scenario that could beg the question: Is there a place in the hospital board room where serious consideration should be given to exclusive contracts for hospital-based physicians? Better yet, one could ask if there is a place in the practice of medicine for the ethic of loyalty and/or decency in the way physicians treat one another?

One physician wrote me a note that ended with the following question: "At what point do our professional, self-protective instincts cross from reasonable and prudent to selfish and self-destructive?"

Said another way, while we as physicians struggle to make ends meet in our daily practices, maybe we would be better served to find as many ways as possible to achieve collective success. In the end, we need each other, and our hospital systems, far more than we need that extra dollar, which ultimately comes at someone else's expense.