HEALTH AFFAIRS BLOG

Building Something Worth Building For All Patients

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Editor's Note: *Today, Rep. Michael Burgess (R-TX) kicks off a series of posts on Jon Gabel's article "Where Do I Send Thee? Does Physician-Ownership Affect Referral Patterns To Ambulatory Surgical Centers?," published March 18 on the* Health Affairs *Web site. The series will also feature posts from Jerry Cromwell and Chris Cassel.* To paraphrase the great American architect, Frank Lloyd Wright: no man should write about building who has not himself built something worth building. As

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CONTENT

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a physician who helped build an ambulatory surgery center (ASC), I conform to Mr. Wright's formula and am glad to pen some thoughts about my personal experiences with the facility. Let me begin by stipulating that I am neither a statistician, an economist, nor an academic. I have, however, practiced twenty-five years' worth of medicine. My experience is far-ranging: from a multispecialty practice, to a solo practice, and then in a single-specialty group. It was as a part of this single-specialty group I helped organize and start an ASC in my Texas hometown. And now, by virtue of the fact that I have been elected to Congress, one could argue that I've become an expert in almost anything. Therefore, I am grateful to have the opportunity to provide some alternative insights into the conclusions outlined in the piece by Jon Gabel and colleagues titled "Where Do I Send Thee? Does Physician-Ownership Affect Referral Patterns to Ambulatory Surgery Centers?" While the overall piece is thoughtful, I take issue with some of the conclusions. First and foremost, it is unfair to assume that self-pay patients fall into one of two categories: those seeking cosmetic surgery or those who are wealthy. There are also those who lack health insurance. Like other patients, the uninsured require and request surgery as well. In my own practice of obstetrics and gynecology, it was in dealing with patients who lacked health insurance where the payment disparity among

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different facilities became most apparent. Many times I encountered patients who desired operations, such as tubal ligation, but lacked health insurance. If they chose to pay for this operation, our local hospital would ask them to pay up front between $8,000 and $12,000. If, however, they were to make the same inquiry at an outpatient surgical center, they would find the total facility fee to be in the range of $1,000. My own modest fee for this procedure was in the neighborhood of $400, which would be unchanged whether the surgery was performed in a hospital facility or an ASC. In response to these facts, I would simply ask the rhetorical question: in which scenario was I more likely to be paid my fee? That in which the patient had paid $1,000 for the facility or a figure about ten times as high? Invariably the patient's finances would be depleted by the hospital charge, and the physician's fee would often go unpaid. Thus, if a patient with no insurance presented to my practice for an elective procedure, my likelihood of receiving compensation might, in fact, be increased if the patient were referred to an ASC, regardless of ownership.

Ownership encourages quality. Payment disparities are certainly a challenge. But, there are many other health care concerns today, including the issues of quality of care and payment for performance. One of the most controversial and complex subjects is physician-ownership of medical facilities, as

evidenced by Gabel and colleagues' discussion. There is an old axiom that says no one ever checks the water in the battery of a rental car. There is a lot to be said for pride of ownership in any facility, including one's own office or one's ASC. **The relative efficiency of ASCs.** Paperwork and policy are also problems when it comes to modern-day health care. In my own twenty-five years of clinical practice, I had multiple struggles with hospital administration. Indeed, sometimes the conventional wisdom was that my local hospital behaved like an absentee landlord. I recall very vividly a five-year effort to get filtered drinking water for my hospitalized patients. It is not a battle I would like to relive at any point in the future. Additionally, timing and schedules are critical parts of any medical practice. I was fortunate to have a robust roster of patients. So I began scheduling minor procedures on a day that I typically took out of the office. If I were to do four procedures at my local hospital, turnover time after each case would approach one hour. As a consequence, I could complete those four extra cases each week, but it would consume a large amount of time. If, however, those four cases were performed in an ASC, turnover time was much shorter. It allowed me to place the patient safely in the recovery room, speak with her family, and dictate a procedure note before it was time to start the next case. This meant that those four cases

could be accomplished by mid-morning and I could be off about other pursuits. Turnover time was reduced because the correct incentives were in place to make the facility run smoothly and safely. **The need for better data on physician owners of ASCs.** While I disagree with several of Gabel and colleagues' assertions, I do concur with their statements about the difficulty in interpretation of data because of the lack of public information about physician owners of ambulatory surgery centers. In fact, without this relevant data, any conclusion drawn becomes suspect -- relying on broad generalities, or merely reinforcing preconceived notions. It is frequently hard to correct for observer bias. Additionally, the statements on the difference between Medicaid and Blue Cross Blue Shield -- in other words, those ranging from the lowest to the highest payer -- were somewhat confusing. As a clinician, why would I want to invest more of my most valuable commodity (time) to treat a patient for which my reimbursement is lowest? In the interest of precious time, it seems that the incentive for treating the Medicaid patient would be tilted toward the ASCs, so that it could be done more efficiently. Whenever I am confronted with a set of medical choices, my first default question is always, "Is it safe?" Secondly, I might consider, "What is the least complicated option for me and my patient?" And third, "What are the clinical as well as the

business outcomes?" Thus, if I found myself recommending a procedure for a patient, and it could be safely performed in a surgery center, regardless of the amount of available compensation, the ease of scheduling and the rapidity of performance would tend to influence me toward the outpatient facility. There also might be a case to be made in terms of differentiation by specialties. Generalists such as gynecologists or general surgeons will typically have a broad mix of patients. Their diagnoses might reveal a different pattern than those among physicians who were more narrowly focused within a more well-defined specialty. **Differing attitudes toward the provision of health care.** Finally, within the discussion section for this piece, perhaps the focus should not be on why the lowest reimbursement patients (Medicaid) were referred least often to an ASC. Instead, we should determine why Medicaid is the lowest payer. We should also explore what this says about those who want to expand the government's role in paying for health care. The paper talks about 11 a.m. on a Sunday morning. The statement is made that this might be the most segregated hour of the week. I am not certain about the source of that data, but I do wonder if there is a mindset of a segment of the population who believe that they should pay nothing for medical care versus those who search for an affordable option when hospital costs have increased to

a level would preclude their use. The fact remains that both hospitals and ASCs are necessary for providing good, efficient, and cost-effective care in modern medicine. Physicians are more inherently aware of this fact than any other profession. Therefore, it is not surprising that they would want to provide these types of facilities or partner with their hospitals to provide these types of facilities, to provide the best possible care for their patients in an efficient and cost-effective manner. After all, it is patient care that really matters at the end of the day, and this begins and ends with doctors.