

Not the Last Word: Paying Surgeons More Might Cost Less

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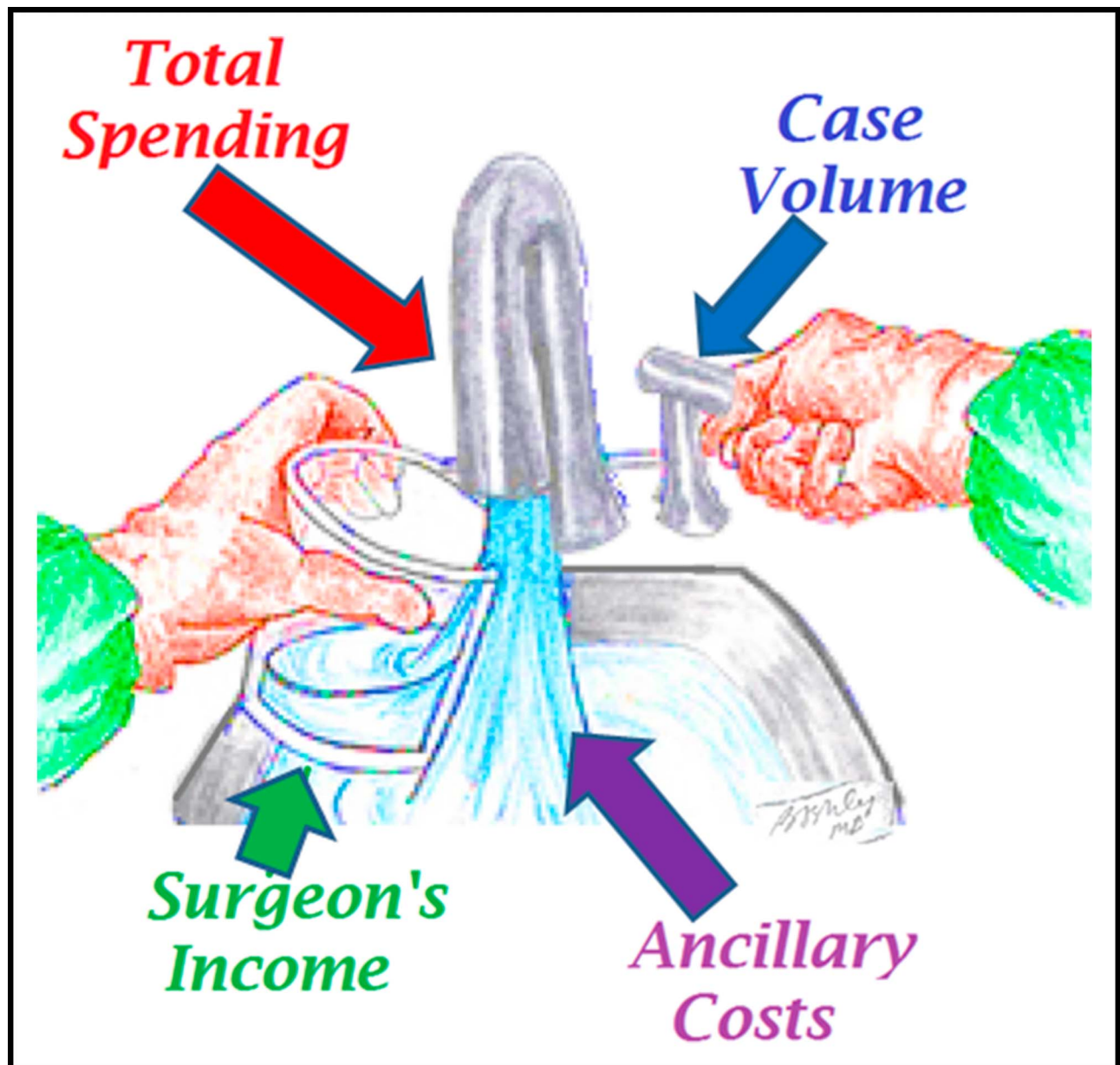


Fig. 1 Paying surgeons less has been associated with increased overall spending [1]. Surgeons determine who is indicated for surgery, and thus control their patient volume. The evidence suggests that surgeons will aim for a specific target income [4] and will adjust their volume to reach that target [3]. Nonetheless, in the case of total joint arthroplasty, for example, more than 90% of the spending associated with each patient is not directed to the surgeon [2]. Thus, any “savings” created by a lower per-patient fee is dwarfed by the increase in spending on greater ancillary costs, including hospital facility fees, anesthesia, therapy, and others. Perhaps, then, paying surgeons more, and thereby decreasing pressure to maintain a target income, might likewise help contain overall spending growth. Created by Drs. Bernstein and Ashley (CC BY 4.0).

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From the Column Editor,
This column was inspired by an interview with Dr. Robert Burton (<https://www.econtalk.org/robert-burton-on-being-certain/>) [6]. Dr. Burton said that after a long career of writing books and articles he had “become convinced that further exposition...is unlikely to convince anybody of anything ...”. He suggested that maybe one’s point could be better made with a short story, for example. In that spirit, after 7-plus years of conventional column-writing, I will try to make my small point (namely, that unrelenting reductions in surgeons’ fees may have a paradoxical, money-spilling effect) with a single illustration I devised and brought to life by Blair S. Ashley MD. Yes, I am cheating a bit, adding not only this comment, but a figure legend

A note from the Editor-in-Chief: We are pleased to present to readers of Clinical Orthopaedics and Related Research® the next Not the Last Word. The goal of this section is to explore timely and controversial issues that affect how orthopaedic surgery is taught, learned, and practiced. We welcome reader feedback on all of our columns and articles; please send your comments to etc@clinorthop.org.

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and four citations; I am as new to this as the readers are.

— Joseph Bernstein MD

Robert A. Burton MD

Author, *On Being Certain: Believing You Are Right Even When You’re Not*

While playing doctor, two 9-year-olds dreamed up a science class project to compare open management versus Band-Aid treatment of knee scrapes. They calculated that a USD 100 grant from their science teacher would cover research costs and generate enough leftover money for them to buy toy stethoscopes and scalpels with which they could expand their fledgling practices.

After consulting with his wife and financial advisor, their teacher, with school-wide fanfare, ceremoniously tapped his meager savings account to fund the project.

Unexpected problems soon reared their expensive heads. Unable to agree on the best way to analyze the statistics, the two were forced to hire a math-savvy 4th grader to settle the difference. They also bickered over the best subjective scoring system. Was feeling better the same as being better? Was itching relevant? Cosmetic satisfaction? To clarify end point ambiguities, they hired a neighbor who was majoring in psych at the local junior college. And, to create an attractive brochure to entice

potential patients, they rented a color printer from the woman next door, who, as luck would have it, had an attorney husband willing to provide a cut-rate review of the consent and information-release forms.

With the logistics seemingly covered, they were ready to begin the study. “Let’s get our Band-Aids and set up shop,” the girl said to her research colleague.

“What Band-Aids?” the boy asked.

“You didn’t buy the Band-Aids first?” the girl said with disbelief.

“I was waiting until we paid all the other bills,” the boy said, near tears.

The girl, always resourceful, remained determined. “Let’s just buy the Band-Aids with our own piggy bank savings.” Mimicking her father’s response when solicited for charitable donations, she hooked her thumbs in her belt and said, “It’s least we can do.”

“Yes, we should be grateful for being able to afford giving to those in need,” the boy chimed in. “But does that mean that we’ll never be able to buy stethoscopes?”

“Being a doctor is a calling that often involves sacrifices,” the girl replied.

“So, how long are we going to carry on this losing project?” the boy asked.

“Until some new kid doctors move onto the block,” the girl said. “Then we can hire ourselves out to them as consultants. Instead of buying Band-Aids with our savings, let’s print up high gloss color fliers highlighting the many advantages of starting a medical practice in the neighborhood.”

The girl smiled to herself as though uncovering a great truth. She turned to her friend and said, “Anyone can be a doctor. Administration and paperwork, that’s where the real money is.”

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It is said that “a picture is worth a thousand words.” In this specific situation, although the “picture” commentary provided by Dr. Bernstein is worthy of a thousand words (and much more) I’ll limit my response to 500.

Let me first compliment Dr. Bernstein on his decision to utilize a graphic to illustrate an important point. *CORR* has taken a page from *The New Yorker*, by using images—even cartoons—to deliver strong messages for readers to consider. Although some may conclude that this enhances the name and reputation of *CORR*, I believe it does at least as much for *The New Yorker*.

Dr. Bernstein’s graphic suggests that reducing surgeon fees for performing procedures will not decrease the overall cost of care because it will result in an increase in the number of procedures performed. The foundation for his conclusion derives from evidence suggesting that surgeons aim for a specific target income and will adjust their volume to reach that target—a phenomenon referred to as “physician income homeostasis” [2]. Although there may be evidence to support this conclusion, it is a situation in which the presence of “evidence” does not make it right.

The basic premise is that if an orthopaedic surgeon’s compensation is reduced 20%, the orthopaedic surgeon will perform 20% more procedures to maintain the same income. This will require him or her to identify 20% more patients to operate on. This can only occur through two mechanisms. The first is for orthopaedic surgeons to increase the volume of patients evaluated and to

identify patients who may choose to undergo a procedure based upon their current operative indications; and the second is for orthopaedic surgeons to “expand” their indications for the procedure so they operate on patients whom they may not have operated on before.

Of course, there is no surgeon who would admit to consciously pursuing the second option. Most would pursue the first option if it were possible to increase the volume of patients evaluated. However, this often is impossible; many surgeons already are maxed out in terms of the volume of patients already being evaluated, the local patient demographics, and the number of orthopaedic surgeons within a specific geographic area.

I have no doubt that, faced with declining revenue, surgeons will work harder to increase volume and revenue. However, I have concerns that this situation may lead to “indication creep” in spite of the best of intentions. This would not be good for patients, health-care, or our specialty. Nonetheless, there is evidence that factors other than “indications” impact the volume of operative procedures performed including population density, patient income and the number of orthopedic surgeons in a specific geographic area [7].

Dr. Bernstein’s additional point is that “paying surgeons more and thereby decreasing the pressure to maintain the target income” might help contain overall spending growth. In other words, it may result in surgeons performing fewer procedures. I believe this is not a “healthy” approach. It implies that surgeons might evaluate fewer patients and thereby offer fewer patients surgery. In reality, surgeons would more than likely continue to see the same number of patients or more—we are a driven group—and continue to perform the same number

of procedures, maybe even more. There is an end point at which the number of patients evaluated cannot be increased but most surgeons never feel they reach that point.

There is another impact of reducing surgeons’ fees. Although orthopaedic surgeons are considered to be well-compensated within the spectrum of physician compensation [5], in fact their compensation varies, sometimes widely, particularly for joint arthroplasty surgeons with Medicare-dominated practices. In a study my group performed [8] that modeled a busy, self-employed orthopaedic surgeon specializing in joint arthroplasty (3000 patient visits annually, 300 joint replacement surgeries, two-thirds knees, one-third hips, and 15% revisions) the impact of declining Centers for Medicare & Medicaid Services reimbursement and increasing practice expenses resulted in decreasing physician salary levels that would become unsustainable and potentially drive orthopedic surgeons away from this subspecialty area. If reducing surgeon fees resulted in an insufficient number of surgeons to perform the procedures our patients need, the goals of decreasing the cost of health care would certainly be accomplished—much to the detriment of our patients.

It is quite clear Dr. Bernstein’s “picture” raises many issues; it’s certainly worth far more than a thousand words. Most important, it should make us all think carefully about the ongoing changes in surgeon reimbursement and how “penny wise and pound foolish” our leaders often can be.

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