COMPENSATION OF HOSPITAL-BASED SPECIALISTS AT SETON HOSPITAL, AUSTIN, TEXAS

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ABSTRACT

This thesis concerned the method of compensation of the Pathologist and the Radiologist at Seton Hospital, Austin, Texas. Prior to the Medicare Act, these physicians received a percentage of the income of their departments. Subsequently, they have billed all patients separately for the professional component of each examination. The impact of this change upon the doctors, the hospital, and a group of patients was studied.

The advantages and disadvantages of alternative methods were analysed with the conclusion that the present separate billing is the most equitable system for compensation of these physicians at this hospital at this time.

A compilation of the present patterns of relationships between hospitals and these types of specialists is included. A proposed contractual agreement to formally record the mutual responsibilities of the hospital and the specialists at Seton Hospital is presented.

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CHAPTER I

INTRODUCTION

When the history of medical social legislation in this country is written, the provisions for separate billing by hospital-based specialists in Public Law 89-97 will be credited with stimulating a dormant disagreement involving ethics and economics.

In 1964 the national elections finally paved the way for medical care as a social security benefit. Under the circumstances, and after many years of opposition, organized medicine supported the plan of Representative Wilbur Mills for an amendment to provide for physician services under a voluntary medical insurance plan (Part B). The proposal by Senator Paul Douglas to permit reimbursement under the hospitalization plan (Part A), where hospitals and specialists had arrangements for common billing, was not accepted. Upon its defeat, he commented that in this approach "the federal government interferes in existing and future practices of hospitals and the medical profession."[1] President Johnson noted as a defect of the bill "the method of payment of

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[1]"Medicare Report," Geriatrics, XXI (June, 1966), 60.

certain specialists," but was confident that these defects "can be quickly remedied."[2]

This is a study of a small, but important, part of the hospital-physician relationship. It is an analysis of the general problem, the situation at a specific hospital, and the alternative solutions at a local level for a problem which remains controversial at a national level.

Hospital Setting

Seton Hospital is a voluntary non-profit hospital. It is operated by the Sisters of Charity Order, whose Mother House is in St. Louis. Administrative policy is largely determined by a local board of sisters supported by a lay advisory board of fifteen civic leaders. The structure is centrally located in Austin, the state capital, a city of 211,000. The hospital is convenient to major population areas, metropolitan facilities, and the University of Texas. The original hospital, which had a bed capacity of 40, was opened in 1902. Since then, additions have increased the capacity to 140 plus 36 bassinets. Recently, some beds which were previously reserved for obstetrical patients have been used for general medical and surgical patients which has allowed increased utilization of total bed capacity. During the past year, occupancy has been approximately 90% of capacity, with occasional delays in elective admissions. Land has been obtained in the metropolitan

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[2] Ibid.

area, and plans are being developed for a new hospital to be occupied in about three years. This will be a 250-bed structure with capability for expansion to 500 beds.

Non-governmental medical facilities in the town consist of two private hospitals of 80 and 124 beds and a municipal hospital of 265 beds, 80% of which are used by private patients.[3]

There are approximately 300 physicians practicing in the Austin area. Of these, 104 are on the active staff of Seton Hospital and an additional 139 physicians have some type of staff privilege. There are nine other pathologists and 13 other radiologists practicing in the city.

The pathologist at Seton has been associated with the hospital for over 18 years. He initially worked on a salary basis to fill a vacancy created by the inability to renegotiate a contract with the previous pathologist. For some time after he started to work for this hospital, he sensed some animosity by certain members of his professional organization. This apparent attitude was reconciled after a period of time, and he has since enjoyed very satisfactory relationships with all professional groups. His relationships with the hospital have been good both from the business and ethical standpoint. He is currently the President of the County Medical Society.

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[3]American Hospital Association, Hospitals, XL, Part 2 (August 1, 1966), 207.

He has three partners in a private laboratory practice who bill individually for all services. Their partnership also serves a 124-bed hospital and partially serves an 80-bed hospital. His clinical and administrative activities at Seton Hospital are essentially a full-time job, and one of his associates is available when he is away at medical meetings or on vacation.

The hospital laboratory employs 15 full-time and 3 part-time technicians. A school for laboratory technicians is being planned and the pathologist will be responsible for this teaching program.

The radiologist at Seton has been associated with the hospital for over 12 years. He has a private partnership with two other certified radiologists who provide service to another 80-bed hospital in Austin and a small hospital in a town 100 miles away. As Chairman of the Committee on Ethics of the State Radiology Society, he was aware of the strong stand on separate billing by the American College of Radiology; but he did not feel that any pressure had been exerted on any specific individual by these organizations.

The x-ray department has one secretary, four registered technicians, and a school of x-ray technology consisting of approximately ten students in a two-year program of on-the-job instruction. In addition to his teaching activities and private practice, the radiologist has administrative responsibility for the radiology department.

Over the past year there has been significant change in the

administration of the hospital. In addition to a new administrator, Seton Hospital has added to its staff an assistant administrator, a comptroller, an assistant administrator for personnel and, most recently, a public relations secretary. A perception of this experienced and competent administrative and professional staff, who are willing to work together in a cooperative spirit, is essential to a logical study of this problem.

Conditions Which Prompted this Study

Prior to July 1, 1966, the pathologist and the radiologist were compensated by the hospital with a percentage of the net or gross income of their respective departments. Subsequent to that date, upon the recommendations of their professional groups and encouraged by the principles of "Reimbursement Under Medicare for Services of Hospital-Based Physicians," these doctors have billed patients directly and separately for the professional portion of laboratory and x-ray services. The hospital has included the cost of the technical portion of the examinations with the hospital bill.

CHAPTER II

THE PROBLEM

Statement of the Problem

The problem is to determine the most equitable system for compensating the radiologist and pathologist at Seton Hospital, Austin, Texas.

Factors Bearing on the Problem

The primary concerns of both the specialist and the hospital are quality of care and that which is best for the patient.

It is essential that an effective hospital feature quality laboratory and radiology facilities, and these require the services of or supervision by a pathologist and a radiologist. Although these individuals are specialists in every sense of the word, the peculiar nature of their services in the past has caused them to be treated differently from other doctors. For the most part, their responsibility has not involved the usual personal doctor-patient relationship.[1]

The radiology and pathology groups have attempted to erase their identification as hospital ancilliary services. They have received support from other professional groups who felt the medicare

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[1] "M. D.'s and Hospitals," Pennsylvania Medicine, LXIX (September, 1966), 83.

act would give additional control of the hospitals to the government. They hoped that unity of standards would delay similar control over professional groups.[2]

Hospitals, in general, are limited in fulfilling their obligation in providing these specialty services by a shortage of specialists. There is a net gain to the field of radiology of only 250 specialists per year, although the United States will require 15,000 more by 1975. Of the 1,950 training positions open in radiology today, 20% are unfilled. A similar shortage of pathologists is predicted.[3]

From a federal taxation standpoint, the Internal Revenue Service will not permit a hospital to retain a charitable, non-profit status if a portion of the facility is leased to the specialists for their profit.[4] The Texas State Law concerning the "corporate practice of medicine" does not permit a salary agreement between the hospital as an administrative body and the physician.[5]

There is much evidence that the principle factor determining hospital-specialist relationships is probably not the method of agreement, but the actual amount of money that the specialist

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[2]Harold G. Robinson, "Radiology Leader Cites Crises in Field," Medical News, I, No. 17 (April 24, 1967), 9.

[3]"Pathologist in a Changing Socio-economic Order," Bulletin of College of American Pathologists, XV (May, 1960), 67.

[4]U. S., Federal Income Tax Code, Sec. 501 (c), par. 3.

[5]Texas, Civil Statutes, Annotated (Vernon, 1966), Sec. 4498.12.

receives. The earning period of the average specialist does not begin until he is 34 years of age. Since he has only 24.7 productive income years, the problems of compensation are not created solely by selfishness of the individual.[6] In general, compensation of radiologists and pathologists has been adequate. (Appendix A.)

The American Medical Association recommends separate billing as the preferred method of compensating these hospital-based specialists, and the College of American Pathologists and American College of Radiology have taken an even stronger stand in opposing salary or percentage agreements. In 1966 the American Medical Association issued a resolution:

> Resolved that since separate billing by the physician for his professional services is a preferred ethical practice, it shall be deemed unethical for a physician to displace a hospital-based physician who is attempting to practice separate billing.[7]

Although this resolution was not implemented for legal reasons, the attitude persists.

Literature Review

The literature on the subject of separate billing by hospital-based specialists is voluminous. The source of each contribution, however, characterizes its nature and its conclusions.

Professional organization spokesmen have decried the medicare

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[6]John G. Steinle, "Medical Specialist-Hospital Relationships," Hospital Topics, XXXVI (June, 1958), 42.

[7]Wesley W. Hall, "Letter from Chairman of the Board to Members of the House of Delegates," Journal of the American Medical Association, CXCVII (September 5, 1966), 137.

bill in general and particularily resist any expansion of its benefits or intervention of any official agency in the doctor-patient relationship. As an extension of this attitude, the specialty groups officially endorse arrangements by which the doctors are completely independent contractors in the delivery of medical service.

At the other extreme are spokesmen for consumer oriented groups. These represent labor-management organizations, Blue Cross groups and, in some cases, social security agencies. They are interested in using every legislative and administrative tool available to deliver the maximum medical service at the lowest price.

In the middle of these two extremes are groups who realize that past patterns of activity, as well as new requirements for providing medical care, must be blended over a period of time in a manner that is acceptable to the hospitals, the doctors, the patients, and the third party representatives of the patients.

The attitudes of these spokesmen are well characterized by the position of the American Hospital Association which states:

> It is the right and responsibility of both hospitals and physicians to develop on the basis of local conditions and needs any terms of service that are fair to patients and that are designed to provide high-quality care, and that any contractual arrangement is satisfactory providing it does not entail exploitation of the patient, the hospital, or the physician.[8]

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[8]American Hospital Association, Relationships: Hospitals and Hospital-based Specialists (Chicago: American Hospital Association, 1966), p. 1.

Almost thirty years ago the American Hospital Association and the major radiology societies agreed on the following statement:

> The American Hospital Association and Radiological Inter-Society Committee view with disapproval the proposal that the actual cost of films and associated overhead be separated from the professional charges of the radiologist or that the responsibility for this department be divorced from the hospital. While in many instances this would be a financial relief to the hospitals, it would probably result in frequent omission of the radiological consultation with a specialist in radiology, would mean less efficient radiological services with potential legal complications, and would tend to create difficulties with national and other organizations requiring supervision of the radiological work by a competent radiologist.[9]

In 1950 the American College of Radiology, as a sole spokesman of the radiologists, withdrew approval of this statement. As a later step towards "emancipation," this group, with the strong support of the American Medical Association, overcame the opposition of the American Hospital Association and other groups and persuaded the House Ways and Means Committee, and finally the entire House of Representatives, to place reimbursement of radiologists (and three other groups) in Part B of Medicare.[10]

Eight principles were announced in January, 1966, to implement the medicare law. Principle Three held that physicians would be reimbursed under medicare's voluntary plan (Part B) only if they rendered an identifiable, direct service to a given patient.

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[9] Ibid., p. 26.

[10] "Why Radiologists Want to Bill Separately," Your Radiologist, IX (Spring, 1966), 8.

Services benefiting medicare patients in general, such as a physician's administrative duties in a hospital, would be reimbursed under Part A, the basic hospital insurance plan.[11]

Hospitals are required to provide pathology and radiology services. They have usually billed the patients for these services, provided the equipment, and contracted (on a percentage of the net or gross income of the department or a salary basis) with the specialist to provide the professional and administrative management of the department. Administrators claimed that, by virtue of this relationship, they had reason to maintain control over these services. Much of the work in a hospital pathology department is handled by technicians, often with automated equipment. To medicare officials these services were clearly hospital rather than medical and, therefore, Part A services.

Upon additional review, the College of American Pathologists noted:

> The statute provides that part A benefits covered medical and other health services "other than physicians' services unless furnished by a resident or intern of a hospital." Congress decided that part A funds simply would not be used to pay for the professional services of physicians. Principle Three is an indirect attempt to win the same battle which HEW lost in Congress, that is, the Douglas amendment.[12]

Subsequently, Medicare officials provided that the hospital

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[11]George E. Reed, "Eight Principles of Reimbursement of Hospital-based Physicians," Hospital Progress, XLVII (February, 1966), 6.

[12]"Medicare Report," Geriatrics, XXI (June, 1966), 72.

and the pathologist could, by mutual agreement, elect to use an appropriate uniform percentage of each pathology service in determining the amount of the pathologist's charges to be reimbursed under Part B. They required that the total amount allocated to Part B by the percentage method would be the same as would result from evaluating separately each service rendered.

Over the years the orientation of these specialties has changed from a role of research and a minor diagnostic service. Today they have assumed a major part in patient care activity. With this emerging role has come a desire to get out from under what they consider the "domination" of hospital administrators.[13]

At the present time, an amendment to the basic law is being considered. It would create a Part C fund which would provide reimbursement for specialty diagnostic services to hospitals without the present deductable amount. Outpatient services would remain covered by Part B. The pathology group favors the proposal since it would replace the controversial principle which requires a physician's service to be performed in person in order to be reimbursed under Part B. The radiologists oppose the measure because they feel it would destroy the similarity of treatment of radiologists and other physicians. The Part C proposal is rejected by the American Medical Association, which opposes any extension of

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[13]Ibid., p. 78.

medicare. It suggests restructuring the entire Part B program into a voluntary health insurance plan with subsidy only of the needy.

Criteria and Standards

An agreement between the hospital and the specialist should clearly state the administrative and professional relationships and responsibilities. The specialist's practice should be, from a standpoint of medical judgement, as independent as that of other staff members. Similarily, it should be subject to review by the medical staff organization.

Considering his training and experience and the level of compensation prevailing in the locality for physicians of comparable qualifications, the physician specialist is entitled to fair remuneration for his services.[14]

The California Medical Association has published some guidelines which appear to be suitable for evaluation of alternative agreements:

1. Regardless of the type of contractual arrangement there shall be no additional charge or cost to the patient or third party on an over-all basis if there is a change in the contract.

2. The professional component charge should be no greater than similar charges made by equally qualified radiologists in comparable hospitals in the area.

3. Within limitations herein set forth the hospital component of the charge will be established by the hospital in accordance with the Guiding Principles for Hospitals adopted by the California Hospital Association.

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[14]American Hospital Association, op. cit., p. 2.

4. In the event there is question as to the fairness of the professional fee or fees established by the specialists, then such matter shall be referred to the Executive Committee of the Medical Staff for final determination. If said Executive Committee does not have a radiologist or pathologist upon it, then the specialist shall have the right to appoint a radiologist or pathologist of his choice to sit on said committee solely for the purpose of this determination.[15]

Research Methodology

The alternative methods of compensation were determined by a review of the current literature. The attitudes, opinions, and frequency of use of these various methods on a national level were ascertained. The local setting was studied by interviews in Austin during 29-31 January and 1-12 May 1967. Interviews were held with the administrator, assistant administrator, comptroller, personnel director, medical records librarian, business office manager, insurance office manager, the pathologist, and the radiologist.

In order to determine the fiscal impact upon the hospital, the gross income, operating expenses, and the net income of the hospital from the departments of radiology and pathology were determined for comparable nine-month periods before and after the initiation of separate billing. The resultant figures were correlated with work performed by the two departments during these periods.

The impact of separate billing procedures upon the doctors was determined during several interviews.

The impact of separate billing upon the patients was

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[15]Samuel J. Tibbitts, "Relations Between Hospital-Based Specialists and Hospitals," Hospital Forum, IX (June, 1966), 18.

determined by a telephone survey of the attitudes of thirty-one patients who had been discharged from the hospital in the previous months. These were selected from consecutive charts which had been set aside by the medical librarian for medical audit. Routinely, every fifth chart is reviewed by the audit committee. For this study only patients who had both x-ray and laboratory examinations were interviewed; patients with malignancies and terminal illnesses were not contacted.

CHAPTER III

DISCUSSION

The American Hospital Association has suggested several types of arrangements for compensation of hospital-based specialists. There are basically five methods of payment for these physicians' services: salary, lease, percentage of the gross department income, percentage of the net department income, and separate billing by the physician. The latter three methods have been used for or are being used at Seton Hospital. A review of the frequency of use of these various methods is included in Appendix B.

There are many possible combinations of these arrangements between the specialist and the hospital. The physician, as a member of the hospital staff, and the hospital must determine the relative merits or deficiencies of each method to establish what is best for them, the hospital, and the patients they serve.[1]

Salary

The Principles of Medical Ethics of the American Medical Association, published in 1957, provides that:

> A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and

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[1]American Hospital Association, Relationships: Hospitals and Hospital-Based Specialists (Chicago: American Hospital Association, 1966), p. 20.

> complete exercise of his judgment and skill or tend to cause deterioration of the quality of medical care.[2]

No exception can be taken to the avowed intent of this principle. The prevention of exploitation of a professional person and the maintenance of the profession's dignity are fundamental to any profession.

The American Medical Association's Judicial Council has reiterated its previous position:

> The Council has repeatedly stated that the acceptance of a salary by a physician does not in itself constitute unethical conduct. If, in a given situation, a physician disposes of his professional services under terms which permit exploitation, his conduct is unethical. . . . Solutions of controversies relating to financial arrangements can best be effected at the local level.[3]

The position of The College of American Pathologists is that a salary is acceptable on ethical grounds only in the following circumstances: in government institutions (local, state, or federal) where private paying patients are not ordinarily accepted; in large private clinics or physician groups wherein all physicians are similarly remunerated on a salary basis; and in institutions where the salary is received for departmental, administrative, educational, or research activities.[4]

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[2]American Medical Association, "Principles of Medical Ethics," Journal of the American Medical Association, CLXVII (June 7, 1958), 31.

[3]Ibid., p. 37.

[4]College of American Pathologists, Manual of Physician and Hospital Relations, A Manual Prepared by the Hospital and Institutional Relations Committee (Chicago: College of American Pathologists, 1966), p. 14.

A salary arrangement has the advantage of providing a guaranteed income to the physician and attracting a specialist to a particular locality. Perquisites, including annual vacation, sick benefits, insurance and retirement program, liability insurance, and attendance at medical meetings may be provided. An affluent physician may be attracted to a salary from a charitable institution, since 20% of such salary, and the personal income tax to be paid on it, may be deferred as a retirement benefit.[5]

The hospital has exerted a great impact in the improvement of medical care. Contractual arrangements with physicians apparently weld the medical care team into a more cohesive unit. Esprit de corps in a hospital staff requires at least a small core of doctors who identify themselves wholly or largely with the institution.[6]

According to a 1967 national survey by the American Hospital Association, 24.3% of pathologists and 14.5% of radiologists are on a salary. This is slightly less than a year earlier.[7] A similar survey in 1958 revealed 26% and 11%, respectively, compensated by salary.[8]

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[5]Stephen F. Donahue, "Deferred Income As a Tool for Negotiating with Specialists," Hospital Topics, XLIV (June, 1966), 83.

[6]Milton I. Roemer, "Growth of Salaried Physicians," Hospital Progress, XLV (September, 1964), 79.

[7]The Week--for Hospitals, III, No. 16 (April 21, 1967), 1.

[8]Seymour E. Harris, The Economics of American Medicine (New York: Macmillan Co., 1964), p. 126.

Government agencies, trustees of labor-management benefit plans, Blue Cross intermediaries, Blue Cross plans, and private insurance companies have all become more interested in the economical delivery of medical service. As these groups provide more and more money to hospitals--money that they administer but do not create--they feel a right and an obligation to insist on standards of delivery of medical care. Their consumer-oriented point of view has stimulated them to raise their voices in favor of what they insist is the most economical method, that is, employment of these specialists by the hospital on a salary or percentage basis.[9] Instances are reported of busy salaried specialists performing services which would be valued at $100,000 to $500,000 a year if charged at prevailing fee schedules. One may presume that these patients were actually being charged prevailing fee schedules and that the excess of the specialist's earnings over his income was applied to other areas of the hospital.

This is the "exploitation" that the professional societies oppose. Traditionally, the laboratory and the x-ray departments have been considered sources of revenue to support non-revenue producing areas; and until accounting procedures are developed and used which properly allocate indirect and direct costs, administrators will not know the true cost of performing these diagnostic

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[9]Ruth Brecher and Edward Brecher, How to Get the Most out of Medical and Hospital Plans (Englewood Cliffs, N. J.: Prentice-Hall, 1963), p. 45.

procedures. These improved accounting procedures will be necessary for the hospitals to be appropriately reimbursed by government agencies and insurance carriers.

Wilcox has pointed out the regional legal problems of a salary agreement:

> Nonprofit hospitals enjoy an affirmative authority from the legislature (New York State) to employ physicians to practice medicine and thus legislative immunity from the corporate practice rule. Similar views have been expressed by the attorneys general of Connecticut and North Carolina. A decision of the Supreme Court of Texas adopted much the same position, but its authority has been shaken by later cases and the status of salaried practice in the nonprofit hospitals of that state is seriously in doubt.[10]

At the present time, the pathologist at Seton Hall receives a salary for his administrative activities. Additional use of this method would not simplify the need for identifying the professional component of each examination. Although there may be some personal advantage to this method, interpretation of the state law and standards of ethics by the medical professional organizations makes its additional use inadvisable.

Lease

A lease or contractual concession arrangement is considered the most desirable by the College of American Pathologists. In this arrangement the specialist has an independent contractor relationship with the hospital. He is an active member of the medical staff,

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[10]Alanson W. Wilcox, "Non-profit Hospitals and the Corporate Practice of Medicine," Readings in Hospital Law (Chicago: American Hospital Association, 1966), p. 51.

has the entire responsibility for providing all phases of his medical specialty, and must personally answer for its quality.[11] The hospital may depend upon a constant source of income as a return on its investment in the involved property. The patient would receive a bill for specialty service separate from the hospital bill, but he would not receive separate bills for the technical and professional portions of the x-ray or laboratory examination.

Reimbursement under medicare is simplified under this method since Principle Six says:

> Where a hospital-based physician himself bears some or all of the costs of operation of a hospital department and bills his patients directly, rather than through the hospital, the reasonable charges for his services recognized under Part B will reflect the costs so borne by him. Where all of the costs are to be borne by the physician, charges heretofore established for such services by agreement between the physician and the hospital may be acceptable (under Part B), but they will require either upward or downward adjustment if the hospital has been bearing a cost significantly greater or less than its share of the proceeds of such charges.[12]

Under these provisions, if the hospital has been receiving more than the cost of the technical portions of the examination, the total reimbursement under Part B will be less to the benefit of the patient.

The American Hospital Association views a leasing arrangement as the least desirable of the alternatives.[13] In many areas there

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[11]College of American Pathologists, op. cit., p. 6.

[12]George E. Reed, "Eight Principles of Reimbursement of Hospital-based Physicians," Hospital Progress, XLII (February, 1966), 6-7.

[13]American Hospital Association, op. cit., p. 24.

are legal prohititions preventing such arrangements in government owned hospitals (county, district, or municipal). In many states a nonprofit hospital may risk loss of all or part of its tax exemption if it leases facilities to a physician for the latter's profit. Under such an arrangement, Seton Hospital would probably lose its status as a charitable institution.[14] The College of American Pathologists has proposed a "Mutual Working Agreement," which may be legally distinguished from a lease only because it does not require the conveyance of an interest in real estate.[15]

With either of these arrangements the administration loses considerable control over a segmented departmental area. This loss of uniform management standards may present problems of different personnel policies and salary scales for ancilliary personnel within the same building. Although administrative authority may be delegated, legally the responsibility for professional acts within this department remains with the governing authority of the hospital. The only control over activities within the leased department is what the leaseholder agrees to accept through the medical staff.

The hospital would have little control over development or expansion of the leased facility to meet growing requirements of the community or the medical staff. The hospital directors would be

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[14]U. S. Internal Revenue Service, Federal Income Tax Code, Sec. 501 (c) (3).

[15]College of American Pathologists, op. cit., p. 7.

limited in soliciting donations for creation or expansion of leased facilities. Since the leaseholder would have a considerable investment in the department, replacement of a specialist would be complicated. For the same reason a young specialist would find it necessary to join an existing group rather than start out on his own.

The biggest argument against a lease arrangement is that an artificial administrative barrier is created which might interfere with the communication and co-ordination with other activities whose sole excuse for existence is patient care.

Percentage of the Gross

This method provides for compensating the specialist with a percentage of the gross charges of the laboratory or x-ray department less deductions for bad debts, charity, and other normal charges. The hospital owns all of the equipment and furnishes all of the supplies. The hospital hires all personnel with the approval of the department chief. The head of the department is responsible to the hospital administrator in administrative matters and to the chief of the medical staff in professional matters.

In this arrangement the department chief has little incentive to keep overhead costs down, and he has little control over the amount of charity work he contributes. These possibilities do not mean that the quality of work will be low or the quantity of work or costs will be high; it does mean that the hospital does not have

direct control over its own costs.[16]

This method does not ordinarily provide for identification of the examination as a medical service; and, without adequate cost accounting, it may inadvertently lead to the division of fees. This method is often misunderstood by other physicians and the general public as fee splitting.[17]

Prior to July 1, 1967, the radiologist received 35% of the gross billing, less charity, of the department. His relations with the hospital, both from the administrative and economic standpoint, had been satisfactory. He did feel that there was a lack of true knowledge of the department operating expenses, but did not feel that he was exploited.

Although this system in this hospital had been generally satisfactory for several years, it did not meet with the recommendations of the American College of Radiologists or the personal desires of the specialist.

Percentage of the Net

By this arrangement the specialist receives a predetermined percentage of the income of the department after all costs of operation are deducted. This may be calculated on a sliding scale

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[16]Walter J. McNerney, Hospital and Medical Economics, Vol. II (2 vols.; Chicago: Hospital Research and Educational Trust, 1962), 1247.

[17]American College of Pathologists, op. cit., p. 29.

with a guaranteed minimum. The physician has a personal interest in the economical operation of the service and it is a method which was used by approximately 30% of hospital pathologists (see Appendix B). In addition to the disadvantages listed for a percentage of the gross method, the percentage of net method requires sophisticated accounting practices and procedures.[18]

Prior to July 1, 1966, the pathologist received 40% of the income of the department after deduction for charity, bad debts, salary of department employees, and other department operating expenses. It was not a true net figure as (1) the hospital purchased all capital equipment and did not compute depreciation or indirect costs of operation, and (2) accounting was on a cash, not an accrual, basis.

The pathologist felt that there were regional differences in hospital-specialist relations and that these were better than average in Texas and particularly good in Austin. As a member of the College of American Pathologists, he felt some obligation to follow their recommendations. He also felt a desire for increased participation in the doctor-patient relationship. His income had been satisfactory, and the pathologist did not expect an increased income from separate billing although he did anticipate more clerical work.

Relations between the pathologist and the hospital had been

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[18]American Hospital Association, op. cit., p. 21.

satisfactory. He would have liked more authority in some personnel decisions, but he did approve all hiring.

Over the years, the administrative and professional work load of the laboratory had increased considerably. The pathologist provided quality control from his private office. Although this method had been mutually satisfactory to the physician and to the hospital, it did not meet the recommendations of the College of American Pathologists.

Separate Billing

The separate billing method, by which the specialist submits his bill to the patient for the professional portion of the examination, meets the ethical standards of all professional organizations. Slightly less acceptable to these professional societies, is the submission of the bill to a third party (medicare intermediary or insurance company). And least acceptable is the inclusion of these charges in the hospital bill even if they are identified as a separate service. The medicare bill requires identification of the professional portion of the examination for reimbursement from Part B funds; but the hospital, as well as the specialist, may bill professional charges under Part B. The federal government is not concerned with the disposition of the proceeds of such billing between the hospital and the specialist.[19] These same requirements will probably apply to patients eligible under Title XIX of the

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[19]American Hospital Association, op. cit., p. 28.

Medicare Act. Since such a large group of patients will have a published fee schedule separating the professional and technical aspects of the examinations, it is argued that all patients should be billed in a similar manner.[20]

Present Blue Cross plans will not reimburse separately for the professional service, but will pay the hospital for this component as part of the total charge for the examination. The patient who has Blue Cross, but not Blue Shield, will not have as much coverage as he would under any other system of billing. New Blue Cross contracts may be written, however, providing for the professional component of these examinations to be paid to the physician.

The physician is responsible for establishing a method of obtaining necessary patient data for billing purposes. The actual billing is best done by his clerical help away from the hospital. If the physician hires clerks to work in the hospital, personnel problems might arise. He is still responsible to the hospital administrator in administrative matters and to the director of medical education in teaching activities, and he may receive a separate stipend for these services. There is little doubt that this method would require more administrative problems for the doctors and some inconvenience to the patients. To the extent that

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[20]"Why Radiologists Want to Bill Separately," Your Radiologist, IX (Spring, 1966), 13.

the doctors' income is increased, revenue to the hospital must be decreased, assuming that the total bill remains the same.

One of the frequent arguments against separate billing is the inconvenience to the patient of paying segmented amounts for what to him is a single service. Even if the physician takes an assignment for his fee and the patient has already paid his annual deductible amount for Part B, the patient is still responsible for 20% of the professional portion of the examination. He still has the same responsibility to pay a percentage to his primary physician and other consulting specialists as well as a separate payment to the hospital for those benefits not reimbursable under Part A. In any event, in the future it is predicted that all of these transactions between a patient's debtors (bank, insurance company, Medicare intermediary) and his creditors (physician, hospital, and ancilliary medical services) will be by computer.

> Money, which is now a thing, a slip of paper passing from hand to hand, from bank to bank, will become primarily a concept--checks and credit cards as we presently know them, are both on their way out. Within a few years money transfers will be made by computers. The impact on banking, retailing, and money lending is going to be staggering.[21]

Effect of separate billing on radiology

The radiologist studied the relative value scales which had been used in Georgia and California. The point value for each examination was divided, with the hospital billing the patient for the

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[21]"Electronic Money," Forbes, IC, No. 7 (April 1, 1967), 48.

technical aspects of the examination and the physician billing for his professional service. This division of previous charge scales allowed a reasonable allocation of each charge without an increase in the total amount. Recently, the hospital has increased the charges for some technical services based upon new contractual agreements with the State Blue Cross Plan.

The change pointed out the need for establishing the true cost of each service. A study is in progress to determine this cost. A reasonable determination of indirect costs, including depreciation, will in the future give a more satisfactory basis for charges and reimbursement of the true cost of the technical service.

A copy of the radiology consultation-request report form is retained in the department for subsequent billing by the radiologist's private office. In addition, upon discharge of the patient, the business office obtains a signed insurance form or Medicare Part B form, which is forwarded to the radiologist for direct billing to the insurance carrier.

This increased clerical activity has required the hiring of one additional secretary in his private office to prepare bills and reports to insurance companies and to assist patients in preparation of claims. In the first few months he felt that the income from his practice was lower due to fewer and delayed collections. After about three months, he felt that he had reached his previous net income level. The radiologist stated that the patients were accepting separate billing very well.

An information sheet (explaining the change) had initially been given to each patient on admission to the hospital. Later it was decided to give these information sheets to the patients at the time of the examination. Patients occasionally made personal inquiries for further explanations, but there had been no dissatisfaction expressed. The radiologist felt that it was essential to have the cooperation and understanding of the hospital clerical help in providing billing information to the department and answering the patients' questions.

The impact of the changed billing method on the administration of the department was equally insignificant. The radiologist has continued to function as administrative head of the department.

The net income to the hospital from the department for the first nine months of separate billing was 14.4% less than the income during the prior similar nine-month period. The workload had a corresponding decrease of only .4%. The average bed occupancy in the latter period had increased and the total patient days of care had increased 2.4%, but the total number of patients admitted was actually 86 (1.6%) less than prior to Medicare, which is probably the cause of the decreased workload and lack of increased income in this department.

The radiologist receives no separate compensation from the hospital for his administrative and educational activities. There is no formal contractual agreement between the hospital and the radiologist.

Effect of separate billing on pathology

In implementing separate billing, each clinical laboratory procedure was considered to be approximately 80% technical service and 20% professional service. The amounts were rounded off for simplicity. The goal was to establish a schedule of total amounts which were comparable to existing Blue Cross agreements and consistent with prevailing patterns of charges in the community.

The pathologist continues to charge the same amount for tissue examinations and frozen sections which comprise less than 3% of all examinations performed in the department. The hospital charges an additional 20% for the technical portion of this service. An increase in the total charge for these examinations has resulted, but these charges are still comparable to charges by the hospitals and laboratories in the area.

The hospital is planning an extensive cost finding survey to establish the true total cost of performing each examination. Charges and reimbursement for these services may be altered by this study.

As head of the Pathology Department, the pathologist receives a stipend from the hospital for his administrative services. He also receives a fee from the hospital for each autopsy for which the hospital is not reimbursed.

The pathologist bills all patients directly from his private office; and this has required a $3,000 electronic accounting machine, an additional secretary, and additional part-time clerks to

help with the billing. The clerical help also assist patients in preparing claim forms since the pathologist does not bill the insurance carrier directly.

There has been no impact on the administrative relationships of the department and hospital since the pathologist continues to function in both line and staff roles.

The financial impact upon the hospital of this system of separate billing has been favorable. The total number of examinations has increased 6.8%, and the net income to the hospital has increased 15.3%. The initial impact on the pathologist was more alarming. In the first month collections amounted to 7%. Subsequently, collections have increased to a consistent 85%. The pathologist feels that his present income is about the same as when he received a percentage of the net income from the department. He also feels more participation in the doctor-patient relationship.

During the several interviews with the pathologist, he was frequently interrupted by technicians and asked to review blood smears, cross-matches for blood transfusions, and frozen sections. All of these studies were on patients with whom the physician had no direct personal contact, but there was equally no doubt that he was rendering a professional service. The pathologist does not have a formal contractual agreement with the hospital.

Effect of separate billing on the hospital

Since the beginning of Medicare and separate billing practices, the total days of patient care has increased 2.4% when compared to the similar previous nine month period. The total number of admissions

has shown a 1.6% decrease. The income to the hospital from the x-ray and pathology departments has increased 8.6%.

The administrative relations have continued to be cordial and effective, and there have been no unfavorable reactions from other members of the medical staff. Providing the data for billing to the physicians has not been an additional burden to the business office. The hospital's new concentration on the technical aspects of the examinations has stimulated interest in true cost findings which will probably result in improved accounting procedures.

Theoretically, any other qualified pathologist or radiologist could seek admission to the medical staff and perform the professional aspects of the examination for which the hospital provides the technical component; however, general shortage of these specialists makes this unlikely. Similarily, staff physicians could be granted the privilege of reading x-rays or interpreting tissue slides that come within their competency or specialty field.[22]

Effect of separate billing on patients

Of the thirty-one patients interviewed, eleven were over sixty-five and were covered by Part A of Medicare. One patient did not have Part B coverage, but did have commercial insurance. The remaining ten had Part B coverage, and two of these had additional commercial plans which covered the deductible portion. Twenty patients were under

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[22]Robert C. Love, "X-ray Interpretation," Hospitals, XLI (May 16, 1967), 29.

sixty-five and three of these did not have insurance coverage. Six had Blue Cross coverage and eleven had commercial plans.

None of the patients expressed dissatisfaction related to receiving a separate bill from the specialists. Four had not received the information sheet or had forgotten it. Two of these paid after questioning the hospital business office, and two paid after inquiring at the doctors' offices. Three of the patients had received assistance in completing insurance forms from the pathologist's private office. Five patients expressed mild annoyance with the trouble and inconvenience of filling out the forms in general, and two expressed moderate annoyance but not specifically with the radiology or pathology forms. Four patients expressed moderate dissatisfaction with their insurance coverage; three of them were upset because the service was not covered by Blue Cross, and one appeared to be moderately dissatisfied in general without any specific target.

This survey was neither a large enough sample nor in enough detail to be of statistical importance. It did not indicate any significant impact of separate billing by these specialists upon this group of patients.

Summary

Of the five alternative methods of compensation for the radiologist and pathologist at Seton Hospital, Austin, Texas, only one is clearly preferable. The salary method is not possible under present civil statutes. The leasing method would present taxation

disadvantages as well as unnecessarily segment administrative patterns. Compensation on the basis of a percentage of the net or gross department income was successful for a number of years, but the College of American Pathologists and the American College of Radiology consider this undesirable.

Separate billing by the specialists has proved satisfactory during the nine months of its use. It provides a method of identifying the charge of the professional aspect of each examination distinct from the cost of the technical portion for reimbursement under the provisions of the Medicare Act. It allows all patients within each department to be billed in a similar manner.

The fiscal impact on the hospital by the new method has been, if anything, favorable. There has been no significant impact upon a group of patients who were interviewed. The physicians' income has not been affected. An increase in administrative and clerical activity by the physicians has been balanced by their increased participation in the doctor-patient relationship. Neither the radiologist nor the pathologist have a formal contractual agreement with the hospital. The hospital requires the continuous services of these specialists in order to meet its objectives in the delivery of medical service. Although the radiologist apparently receives an equitable income, he does not receive compensation for his teaching or administrative activities.

CHAPTER IV

CONCLUSIONS AND RECOMMENDATIONS

Conclusion

The most equitable method of compensation for the radiologist and pathologist at Seton Hospital, Austin, Texas, is that of separate billing by these physicians for the professional component of their services. This method meets the ethical standards of the College of American Pathologists and the American College of Radiology. It has proved satisfactory to the doctors, to the hospital, and to at least one group of patients who were interviewed.

There are important and complicated ethical and economic considerations in the relationship between specialists and the hospital. These mutual obligations, responsibilities, and privileges are essential to both the specialists and the hospital in attaining their individual and mutual goals. Although these relationships have developed satisfactorily on an informal basis, a formal agreement is necessary to prevent problems and misunderstandings.

These specialists' administrative and educational services to the hospital are substantially greater than are similar services by other members of the medical staff. These services are recognized in the case of the pathologist, but not in the case of the radiologist.

Recommendations

It is recommended that the present system of separate billing

by the radiologist and pathologist be continued. It is recommended that the terms of the relationship between these specialists and the hospital be recorded in a formal contract. It is also recommended that the radiologist receive a separate stipend in consideration for his administrative and educational services to the hospital. A proposed contractual agreement to implement these recommendations is included in Appendix C.

APPENDIX A

EARNINGS OF DOCTORS EMPLOYED

FULLTIME IN NON-FEDERAL HOSPITALS---1965

EARNINGS OF DOCTORS EMPLOYED

FULLTIME IN NON-FEDERAL HOSPITALS---1965[1]

	Median Gross Income	Median Net Income
All Physicians	$18,600	$17,100
Pathologists	23,200	20,500
Radiologists	29,500	26,000

Percentage Distribution of Earnings Levels

Gross Professional Income	Percent of Hospital Physicians	
	Pathologists	Radiologists
$40,000 or over	12.6%	25.2%
$31,000 or over	26.0%	44.5%
$25,000 or over	43.8%	63.2%
$22,000 or over	53.6%	76.3%
$19,000 or over	67.0%	85.5%
$16,000 or over	84.0%	94.0%
$13,000 or over	92.0%	97.0%
$10,000 or over	97.3%	98.0%

[1]"Physicians in Hospital Practice Report their Income," Hospital Physician, January 1967, p. 31.

APPENDIX B

PATTERNS OF HOSPITAL-PHYSICIAN AGREEMENTS

PATTERNS OF HOSPITAL-PHYSICIAN AGREEMENTS

Source: Harris, 1958.[1]

	Radiologists	Pathologists
% of Gross	59%	26%
% of Net	21%	17%
Salary	11%	26%
Lease	3%	2%
Fee for Service	6%	29%

Source: Steinle; 120 Short Term Voluntary Hospitals, 1958.[2]

	Radiologists	Pathologists
% of Gross	38%	29%
% of Net	35%	37%
Salary	21%	30%
Lease	6%	4%

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[1]Seymour E. Harris, The Economics of American Medicine (New York: Macmillan Co., 1964), p. 126.

[2]John G. Steinle, "Medical Specialist-Hospital Relationships," Hospital Topics, XXXVI (June, 1958), 40.

Source: Roemer; 2,434 Non-government Hospitals, 1964.[3]

	Radiologists	Pathologists
Salary	16.7%	28.7%
Salary plus Other	5.5%	8.7%
% of Net or Gross	69.8%	45.0%
Fee for Service	5.0%	13.8%
Combination	3.0%	3.8%

Source: California, All Practicing Physicians, 1965.[4]

	Radiologists (1,157)	Pathologists (803)
Salary	29.0%	50.4%
Fee for Service	35.5%	23.7%
Fee for Service plus Part Time Salary	6.7%	4.2%
Full Time Salary plus Some Fee for Service	3.6%	10.0%
Group Practice	25.2%	11.7%

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[3]Milton I. Roemer, "Growth of Salaried Physicians," Hospital Progress, XLV (September, 1964), 80.

[4]"Sources of Income and Principal Employers of California Physicians, August 1965," California Medicine, CV (July, 1966), 71.

Source: American Hospital Association Survey, 1965-1966.[5]

1965

	Radiologists	Pathologists
Salary	14.9%	24.5%
% of Gross	54.1%	38.3%
% of Net	16.5%	-----
Separate Billing	13.5%	11.1%

1966

	Radiologists	Pathologists
Salary	14.5%	24.3%
% of Gross	50.0%	37.3%
% of Net	14.9%	-----
Separate Billing	30.1%	17.9%

[5]"Hospital Billing for Specialists Declines," The A M A News, X (May 8, 1967), 14.

APPENDIX C

PROPOSED CONTRACTUAL AGREEMENT

PROPOSED CONTRACTUAL AGREEMENT

Agreement

This Agreement made the ____ day of _____ 19__, between Seton Hospital and _____, M.D., hereafter designated as Pathologist or Radiologist,--("Specialist" is used for either term in this sample agreement).

Witnesseth

Whereas, the "Specialist" has been appointed to the Medical Staff of Seton Hospital in accordance with the rules and regulations of the Medical Staff and the Governing Board of the Hospital; and

Whereas, the parties have agreed upon the terms and conditions under which the "Specialist" shall serve as Director of the Department of Pathology (or Radiology) of Seton Hospital and desire to reduce such terms and conditions to writing;

Now Therefore, in consideration of the mutual promises of the parties set forth below, it is agreed as follows:

I. The hospital appoints the "Specialist" and the "Specialist" agrees to serve as Director of the Department of Pathology (or Radiology) of the Hospital during the term of this agreement. In such capacity the "Specialist" shall assume and discharge all responsibility for the administrative and professional management of the department, in keeping with the policies of the Hospital, the rules and regulations of the Hospital's Medical Staff and all applicable laws and regulations.

II. The Hospital shall make available during the term of the contract the space designated for the Department of Pathology (or Radiology), and in addition, the Hospital shall make available such equipment as is required for the proper operation and conduct of the department. The Hospital shall also keep and maintain said equipment in good order and repair. The Hospital shall furnish the department with utilities and with such ordinary housekeeping, laundry, and other services as may be required for the proper operation and conduct of the department. The Hospital shall purchase all necessary supplies for the department, such as glassware (or film), chemicals, stationery, and similar expendable items and shall keep accurate records of the cost thereof.

III. All nonmedical personnel required for the proper conduct of the department, including technologists, secretaries, and other personnel, shall be employed by the Hospital, but the selection and retention of such personnel shall be subject to the approval of the "Specialist." Salaries, benefits, and personnel policies applicable to persons employed in this department shall be uniform with those of other hospital employees in similar personnel classifications.

IV. The "Specialist" shall assist the Medical Staff and the Board of Trustees of the Hospital in efforts to attract a sufficient number of qualified pathologists (or radiologists) to provide the level of patient, consultative, and teaching services necessary to the Hospital. The "Specialist" shall accept responsibility for

the availability of professional service in the department when he is absent because of illness, vacation, attendance at scientific meetings, or for any cause.

V. The "Specialist" shall file with the Hospital a record of all services rendered to patients in the department and will assist the Hospital in the determination of all costs, direct and indirect, in performing the technical portion of each examination.

VI. The "Specialist" shall perform, without charge, such customary services (other than those for which a charge is collectible from sources other than the Hospital or its employees) required in caring for indigent patients, hospital employees, students, and like personnel.

VII. The "Specialist" shall participate in the educational programs conducted by the Hospital and perform such other teaching functions within the Hospital as are necessary to assure the Hospital's compliance with requirements of accrediting bodies such as the American Medical Association and the Joint Commission on Accreditation of Hospitals.

VIII. In consideration of the services to be performed by the "Specialist," as described in the above paragraphs, and inasmuch as these educational and administrative services are expected to be substantially greater than those ordinarily expected of other members of the attending medical staff, the Hospital agrees to pay the "Specialist" compensation in the amount of _____ Dollars ($_____) per calendar month during the term of this Agreement,

(as well as $_____ per autopsy performed--Pathologist only).

IX. The "Specialist" shall charge his patients for his professional services and shall be responsible for the billing and collection of such charges. The Hospital shall provide each qualified "Specialist" practicing in the Hospital with necessary information with which to render bills to patients served by such "Specialist." The Hospital shall charge the patient separately for the use of its rooms, equipment, and facilities and for all other costs and supplies.

X. The fees charged by the "Specialist" shall be in general accordance with customary local fees for comparable services; and the "Specialist" shall maintain in the Department, and with the Executive Committee of the Medical Staff, a schedule of such fees for the information of patients, referring physicians, and the Hospital Administrator. In the event of any disagreement as to the level of fees, such disagreement shall be referred to the Executive Committee of the Medical Staff for final determination.

XI. Nothing contained herein shall be construed to prohibit the Hospital from permitting the practice of pathology or radiology in the Hospital by other qualified "Specialists," approved by the Medical Staff and the Board of Trustees, provided that such "Specialists" shall abide by the rules and regulations covering the Department of Pathology (or Radiology) of the hospital.

XII. The "Specialist" at all times shall act as an independent practioner, practicing his profession as a doctor of

medicine. The Hospital shall neither have nor exercise any control or direction over the methods by which the "Specialist" shall practice medicine, except that the "Specialist" agrees to use the currently acceptable methods and practices of his specialty. The sole interest of the Hospital shall be to assure that these services in the Hospital shall be performed in a competent, efficient, and satisfactory manner.

XIII. This agreement shall remain in full force and effect for a term of _____ ( ) years from and after _____ (date of contract), provided that either of the parties hereto shall have the right of terminating this agreement on not less than _____ days' written notice to the other party.

IN WITNESS WHEREOF, the "Specialist" has executed this agreement and the Hospital has caused this agreement to be executed by its duly authorized officers.

Seton Hospital

By _____

By _____

_____
Pathologist or Radiologist

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BIOGRAPHICAL SKETCH

Lieutenant Colonel John E. Bancroft [redacted] He attended public schools in San Bernardino, California, and graduated from high school there in 1944. He attended Occidental College in Los Angeles under the Navy V-12 Program. After discharge in 1945 he matriculated at the University of California at Berkeley where he received a B.A. degree in 1947. He received an M.D. degree from the University of California at San Francisco in 1950 and served a surgical internship there.

After entering active duty with the U. S. Army in 1950, he served as a general medical officer before specializing in orthopedic surgery at Madigan General Hospital, Letterman General Hospital, and the Shriner's Hospital for Crippled Children in San Francisco. His last assignment prior to attending the U. S. Army-Baylor program in Hospital Administration was assistant chief of Orthopedic Surgery and Director of Intern Training at Tripler General Hospital.

Doctor Bancroft is a diplomate of the American Board of Orthopaedic Surgery; a Fellow of the American College of Surgery; a member of the American Medical Association, American Academy of Orthopaedic Surgery, and the Western Orthopaedic Association; and a student member of the American College of Hospital Administrators.