Numb and Number: Once a Hot Specialty, Anesthesiology Cools As Insurers Scale Back --- Health-Care Workers Find Fewer Jobs, Lower Pay In Era of Cost-Cutting --- Working Harder for $100,000

By George Anders, The Wall Street Journal
Mar 17, 1995

Patrick Kwan has as bright a resume as a young doctor could want, including four years of advanced training in anesthesiology. So when he entered the job market last spring, he expected to be showered with lucrative offers. What happened instead was a painful experience.
After six months of looking, Dr. Kwan got just one full-time offer, to join a group practice at $120,000 a year. He turned it down because the pay was less than half what other partners were making and because the job didn't make use of his subspecialty: anesthesia for cardiac surgery. He thought something better would come along. It hasn't.
Today, the 33-year-old Dr. Kwan is a migrant medical worker, driving his 1989 Mazda across Northern California so he can perform brief, fill-in stints in anesthesia at 10 different hospitals. On Christmas Day, he put in 12 hours at a big Berkeley hospital. At other times, he has spent nights or weekends at rural hospitals. "I can't afford to be choosy," he says. "I'll take whatever is available."....

"....Market realities are finally starting to hit the health-care profession. Competition is restraining the rapid escalation of medical costs, a trend that economists generally applaud. This new austerity comes with a price, however: a slowdown in the once-booming medical labor market.
For most of the past decade, health care has provided some of the most bountiful, diverse job prospects in the entire economy. People with a high-school education or less have found thousands of clerical and maintenance jobs at hospitals. Those with more training have found jobs commanding $40,000 to $80,000 a year in such fields as nursing and pharmaceutical sales. Young doctors who picked the right specialties have been bombarded with chances to earn $200,000 or more.
Now, though, the job picture is dimming. Health-maintenance organizations and other cost-minded insurers are pressing doctors and hospitals to be more efficient. Medical prices for the past 12 months climbed just 4.9%, one of the lowest rates in 20 years. As medical providers scramble to cut costs and skip services they judge unnecessary, they are loath to add to their payrolls.
Labor Department data show the health sector created 388,000 jobs in the peak year of 1990, one-quarter of the U.S. economy's total growth in nonfarm employment. Last year, new health jobs totaled just 254,000, accounting for less than 10% of all new jobs.
Community hospitals provided a steady source of new jobs in the early 1990s, says Mark Pauly, a professor of health-care systems at the University of

Pennsylvania's Wharton School. But "now patients aren't showing up to be admitted as often, and when they do come, they don't stay as long. Hospital employment in many places is dropping."

Bleak job prospects aren't gripping all areas of health care. Many treatments are being switched to cheaper settings, such as home care, where jobs are plentiful. And some regions, such as the Midwest and South, appear to be doing better than either the East or West coasts.

Nonetheless, major parts of the health-care work force are shrinking. Some 83,000 jobs for orderlies and nurses' aides disappeared last year. Jobs for physical therapists dropped 7.8%.

In the pharmaceutical industry, total U.S. employment fell 3.1% in the first six months of 1994, with nearly half of that decline in marketing. Bigger cuts are likely this year, because of consolidations brought on by drug-company mergers, says a spokesman for the Pharmaceutical Research & Manufacturers' Association.

Even in nursing -- a field that has long faced a worker shortage -- the outlook is changing. Most of the growth in nursing jobs last year was in outpatient care, which is more likely to offer part-time work and lower pay. Nursing schools say graduates are having a tougher time finding work in desired locations. "Getting a job depends on how willing people are to move to another area," says Janet Rogers, dean of the University of San Diego's school of nursing.

Some experts think more retrenchment is imminent. The New York consulting firm APM Inc. recently analyzed per-member outlays by some of the most aggressive HMOs and managed-care companies, to see what would happen if other health insurers adopted similar budgets.

APM's conclusions: spending cuts of 50% or greater could lie ahead for services in several medical fields, including psychiatry, radiology and plastic surgery. "We're talking about some very big numbers," says James Kagan, a managing director at APM. Other consultants say cutbacks will eliminate not just physicians' jobs, but also a wide range of technicians, office managers and aides.

A close look at anesthesiology provides a case study of how job prospects -- even in a high-paying specialty -- can rapidly sour.

For most of the past 15 years, anesthesiology has been a booming field, thanks to growing surgery volumes and insurers' willingness to reimburse most bills in full. The average anesthesiologist earned $131,900 in 1982, according to the American Medical Association. By 1992 that figure had jumped 73%, to $228,500.

Teaching hospitals scrambled to train enough young doctors in this popular specialty. Newly minted M.D.'s headed into two-year or three-year residency programs, picking up the skills they needed to become full-time anesthesiologists. By the end of 1993, the U.S. had 29,800 anesthesiologists, nearly double the total in 1980.

"I taught a lot of residents in the 1980s who were smirking at me and my minuscule academic salary," recalls Philip Boysen, chairman of the anesthesiology department at the University of North Carolina, Chapel Hill. "They were very goal-directed, and their goal was to get into private practice and make

a lot of money."

In the past few years, however, market forces have put the squeeze on anesthesia, starting with a moderation in surgery volume. Widely quoted studies by Rand Corp., a Santa Monica, Calif., research group, have suggested that at least one-third of some common procedures -- such as hysterectomies, insertion of middle-ear tubes and angioplasties -- are either inappropriate or of uncertain benefit.

HMOs and other managed-care plans have responded by nudging down surgery and hospitalization rates for their members. One of the most efficient West Coast group practices, Mullikin Medical Centers, Long Beach, Calif., now incurs only about 170 hospital days a year for each 1,000 of its members under age 65. That is barely half the national average -- but many health plans around the country say they want to emulate Mullikin's lower hospital usage.

For anesthesiologists, lower-than-expected growth in surgery means less business. "We can't exactly hang out a shingle saying: `Anesthesia for Sale,'" observes Jonathan Roth, chairman of the anesthesiology department at Albert Einstein Medical Center in Philadelphia. "We're dependent on the volume of surgery in hospitals." When managed-care plans move into a market, other anesthesiologists contend, surgery frequencies can drop 20%.

Charges for anesthesia services, meanwhile, are tumbling in many areas. Some managed-care plans are pressing anesthesiologists for discounts of as much as 30% from quoted rates. Other health plans are offering only a flat stipend of, say, 75 cents per member per month, which is meant to cover all anesthesia needs. And the federal government's Medicare program for the elderly, which traditionally has been a big source of anesthesiologists' income, has lately grown much stingier.

Since last year, Medicare has slashed its payments to "care teams" of doctors and nurses who jointly provide anesthesia in surgery. Typically, one anesthesiologist can supervise several nurse anesthetists working simultaneously in two or three different rooms. Under the old rules, anesthesiologists with enough "care teams" in action could earn much more than their usual solo billing rates. But Medicare's new rules largely prevent that.

In addition, some hospitals are making much greater use of nurse anesthetists, who typically earn $80,000 a year, less than half their physician counterparts. That switch -- and its accompanying cost saving -- is becoming especially popular as more operations can be performed quickly in an outpatient setting, without the need for an overnight hospital stay.

A recent survey by Abt Associates, a Bethesda, Md., consulting firm, looked at four different ways that hospitals could mix doctors and nurses in anesthesia units. The study noted that for many procedures, nurses could be used in place of better-trained, better-paid doctors. In the most nurse-intensive scenario, Abt concluded, the U.S. already has twice as many doctors in anesthesia as it needs.

"Managed care has kicked our feet out from under us," says Fredrick Orkin, an anesthesiology professor at Dartmouth-Hitchcock Medical Center in Lebanon, N.H. "We've been producing new anesthesiologists at a rapid and accelerating rate. It had to reach the point where there no longer would be any jobs."

Michael Borello, a third-year Dartmouth resident in anesthesiology, says he will avoid the job market for another year by starting a one-year advanced fellowship this summer in pain management. He hopes the additional training in a subspecialty will help his prospects. "For residents who aren't going the fellowship route, things are very difficult."

The same glum tone surfaces at Boston University. "Technology made this a very attractive specialty, but now we've almost saturated the market," says Marcelle Willock, head of BU's anesthesiology department. One of her top trainees, Blaine Zaid, says: "I've contacted 20-some hospitals, and the basic message I'm getting is that there are almost no jobs available."

At the University of California, San Francisco, anesthesiology department chairman Ronald Miller once assumed his third-year residents could find jobs without his help. Not anymore. "I wrote 700 letters of recommendation this year," Dr. Miller says. That has helped many of his 22 residents land jobs, he says, but often at much lower pay than usual.

Dr. Kwan, who did his residency and an advanced fellowship at UCSF, says he earns about $100,000 a year, shuttling from one temporary job to another. Against that income, though, he must pay for malpractice insurance, as well as various fees to join the staffs of hospitals where he works.

"This whole experience has been very educational for me," Dr. Kwan says. "It's just a question of how much longer I can take it. I'm still living in the same apartment I had at UCSF. I'm still cooking meals for myself to save money."

Top officials at teaching hospitals are starting to shrink their anesthesiology teaching programs, so that the supply of new specialists will be more in line with reduced demand. But many hospitals aren't cutting fast enough, says Dartmouth's Dr. Orkin, in part because residents represent a cheap source of labor.

The biggest corrective measures may come from medical students themselves. With loans that sometimes top $100,000, medical students go to great lengths to gather information about what specialties offer the most lucrative and dependable careers. Anesthesia currently is regarded as a very bad choice. Many teaching hospitals say that U.S. students' applications for anesthesiology residencies are down 30% to 50% this year. Foreign medical graduates may pick up some of the slack. Even so, many training slots in anesthesia are likely to go empty next year, for lack of applicants.

Even some residents who are part-way through anesthesiology training are dropping out -- and starting over in other fields. At University of North Carolina, for example, four anesthesia residents quit this past autumn, preferring to begin a new training track in family practice or emergency medicine. "They gave up on the field," says UNC's Dr. Boysen. "They believed that it was too much work for not enough payoff."

Credit: Staff Reporter of The Wall Street Journal