Administrative Update

The Economic Barriers to Becoming an Anesthesiologist

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ASA's Division of Professional Affairs is fully engaged in advocating for payment levels that will support high-quality anesthesia care and patient safety. Since sharing the Division's approach to payment advocacy in this column one year ago, there has obviously been a major change in the health care economy – the massive impact of the COVID-19 pandemic (which is only starting at the time of this writing). In addition to the economic impact of the pandemic, in the past year federal surprise medical bill legislation was introduced and MACRA's Quality Payment Program unexpectedly transitioned to so-called "MIPS Value Pathways." In addition to these new challenges, the fundamental payment pressures described a year ago also remain in place: increasing stress on Medicare and Medicaid budgets, inadequate and shrinking insurance networks causing out-of-network billing, risk shifting from payers to providers through "value-based" payment models, the possible expansion of Medicare's below-cost payment rates, and continuing consolidation of health care providers.

At the same time that ASA is aggressively engaged in payment-related advocacy, we must also be increasingly mindful of the considerable costs associated with the specialty, specifically the cumulative cost of both entering our profession and then navigating the early years of practice. Confronting and addressing that increasingly prohibitive cost is the topic of this month's "Administrative Update." This full cost consists of many separate costs generated by a plethora of education, training, testing, licensure, certification, and credentialing authorities. These disconnected entities collectively create an unintentional yet expensive bureaucratic gauntlet that must be run by young physicians. As we all know, the resulting direct or *out-of-pocket* costs are substantial and are incurred within the context of the unmatched opportunity costs and delayed gratification of pursuing a career in medicine. While this is obviously a concern for all physicians, it is especially threatening to a specialty facing the exceptional payment challenges outlined above. Although most anesthesiology residencies and fellowships currently enjoy deep applicant pools, our specialty must confront the growing education and credentialing cost issue before it becomes an unyielding deterrent in the eyes of debt-laden medical students selecting a specialty – by definition an intelligent and responsible group that will necessarily factor financial costs, benefits, and risks into their career decision-making. It is also important to recognize that the growing mountain of cumulative education and credentialing costs is already discouraging some at an even earlier juncture; in lieu of applying to medical school, potential applicants can instead choose a more affordable professional route into health care (*The Wall Street Journal February 2, 2020*; *Mayo Clinic Proc* 2015;90:1735-6).

To initiate ASA's engagement on this critical issue, the Resident Component Governing Council (RC) proposed and the 2019 ASA House of Delegates passed Resolution 655-1 *Education and Credentialing Cost*. That important resolution directs that ASA liaisons to applicable education, training, and credentialing organizations work "*to make cost and affordability a top priority, and to ensure that credentialing decisions are evidence- and value-based.*" It is anticipated that Resolution 655-1 is a first step in RC leadership on this critical issue, and that they will continue to effectively advocate for increasing engagement on this insidious threat to the long-term viability of anesthesiology.

The more frequently discussed problem of medical student debt is obviously related to a more diffuse yet fundamental problem of excessive costs. Our profession's massive education and training costs cause medicine to be an extreme case within the nation's general problem of overall student debt. An October 2019 report from the Association of American Medical Colleges (AAMC) paints a sobering picture: 73% of medical students graduate with a mean debt of $201,490 and 18% with a mean debt exceeding $300,000. While educational debt is clearly a corrosive influence on our profession, it is important to recognize that medical student debt is caused by the primary problem of excessive costs. Medical school tuition and fees have risen approximately 130% in the past 20 years based on a blended average of in-state and-out-of-state students at public and private medical schools (asamonitor.pub/2xVTKo4). At the same time, inflation as measured by the consumer price index correspondingly rose by approximately 50%. (One might reasonably ask why inflation-adjusted costs in such an enlightened "industry" are not falling instead of rising.) It is worth recognizing that these tuition costs and fees do not begin accumulating until after students have paid the considerable costs associated with application submission, MCAT examination, and interview travel. In addition to medical school costs, young physicians must also finance the cost of an arduous licensure and certification process, a process which includes the United States Medical Licensing Examination (USMLE), state licensure fees, the American Board of Anesthesiology (ABA) examination process, and ABA's Maintenance of Certification in Anesthesiology® (MOCA®) program. For many young anesthesiologists, these unavoidable costs add further to their burden of debt.

There are a few possible "next steps" in ASA's engagement on this issue. One is completing a rigorous analysis of the actual comprehensive cost. This analysis would estimate the comprehensive cost of medical school applications, medical school, residency, medical licensure, board certification, DEA registration, facility credentialing and privileging, and maintenance of certification *plus* the opportunity costs of lost income in a comparative profession. Another possible next step is making education and credentialing cost reduction a pillar of ASA's outreach advocacy within the larger family of medicine and health care. While that might sound like a noncontroversial "motherhood and apple pie" endeavor, let us recognize that effective engagement will mean advocating for a major leadership shift away from what has apparently been consideration of only potential benefits to a more realistic consideration of both benefits *and cost*, i.e., value. Furthermore, "benefits" should entail *evidence-based* benefits and costs should entail *full* costs, including travel, opportunity cost of lost work time, etc. Whenever our governing entities are planning to add yet another layer of requirements, there should be a proven benefit that outweighs the additional comprehensive costs. Indeed, ASA might advocate that all current requirements and steps be transparently and rigorously re-examined and tested for true value against the above standards. When that test is not met, advocacy for change could be engaged. We should all recognize that a few well-intended but unjustified sacred cows might not make the cut.

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In short, as a specialty we should explicitly ask if the costly process of building a fully educated and trained, licensed, board-certified, credentialed, and privileged physician anesthesiologist has become excessive and unaffordable by reasonable standards, keeping in mind that the COVID-19 health care economy will probably worsen the situation. Within their Resolution 655-1, our RC leadership has already provided us with their answer and call to action:

"In order to continue expanding membership in ASA and to align with the core values of promoting high-quality, physician-led care, support for halting the skyrocketing costs of physician training and credentialing must be a priority."

Please ask yourself if Resolution 655-1, with its summary statement above, successfully serves as a wise early warning and makes the case for active advocacy. To delay addressing this problem until a critical mass of undergraduates choose options other than medical school or residency applicants choose specialties other than anesthesiology will be to have waited too long (*NEJM* 2020;381:1505-8). Once we reach that tipping point, our profession will have become the purview of only a privileged few, and adequate time for recovery will have been lost. ■