THE GROUP PRIVATE PRACTICE OF ANESTHESIOLOGY:
A TESTED PLAN OF ORGANIZATION

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The purpose of this report is to present in detail the plan of organization that has evolved over a period of six years in the operations of a private group of eight anesthesiologists in Seattle, Washington. It is presented chiefly for the benefit and encouragement of those who would organize similar groups of anesthesiologists in the private practice of our specialty.

ADVANTAGES

Webb and Leigh (1) recently have reviewed clearly and convincingly the advantages of the private group practice of anesthesiology as it benefits the patient, the surgeon, the hospital and the anesthesiologist. In brief, the successful private practice group should be able to provide expert skills at reasonable fees to the patient without sacrificing ethical principles. Larger numbers of surgeons may expect more efficient and more capable service and patient-care from a group than they may from individual anesthetists. Emergency services, intern and resident teaching programs, and auxiliary services, such as oxygen therapy, are more likely to be on a higher plane in the presence of a group of closely cooperating anesthesiologists within the hospital. The advantages accruing to the anesthesiologist within a private practice group are: (1) more regular hours with a definite call schedule to allow time for study, teaching, and recreation, and time to play the good parent; (2) an opportunity for each member to continue to learn by sharing in the experiences and special knowledge of each of the others in the association; (3) by each man sharing equally in the work of the group, attainment of a reasonable yearly income without exploitation of the patient or of other physicians, and (4) freedom from any marked degree of dependence upon institutional administrative offices for a livelihood. In the competent numbers of a successful private group there is strength to resist the temptations of those who seek to exploit the specialty of anesthesiology, be they hospital administrators or other physicians who would subjugate the anesthetist financially or who would render him subservient.

Plan of Organization

The group under discussion consists of eight anesthesiologists of whom seven are full partners, and six have been certified by the American Board of Anesthesiologists. Each of the associates has a somewhat different background in training, making for a more stimulating and democratic organization. Two of the partners participate regularly in the program of lectures on anesthesiology at the University of Washington School of Medicine. All members participate in clinical instruction of interns and residents at various hospitals in the city, and it is the intent of the group to intensify its activities in the instruction of anesthesia residents and of medical students. Members of this group serve regularly as Chief of Anesthesia on the staff of three of the hospitals in the city of Seattle. One of the partners is consultant to the Naval Hospital of Bremerton, Washington.

Patients are billed directly on a fee-for-service basis. Cases are scheduled, for the most part, through the group office, located apart from the hospitals in a doctors' office building. We occupy a suite of three rooms consisting of bookkeeper’s office, conference room, and block therapy room. Most of the work is performed in four hospitals in Seattle.

There is an equal division of income among all partners of the group except for the division of the annual emergency reserve fund, to be described. Other members of the group are paid a predetermined annual salary plus a bonus when collections exceed normal expectations. The finances are examined and partnership income is computed twice yearly by a certified public accountant who has been auditor for the group since its inception.

The group provides liability and malpractice insurance, secretarial service, anesthesia equipment, and a minimal monthly allowance in the event of temporary physical disability of less than five months' duration.

To encourage postgraduate study and attendance at professional meetings, a travel fund has been set up to pay hotel bills and to cover transportation costs to approved regional and national meetings. An average of more than $1,500 has been spent each year for such travel expenses.

It is our belief that this group is somewhat unique in two respects: (1) It is a relatively large partnership group and yet has remained both highly democratic and efficient. Anarchy has been avoided, yet there has been no necessity for any individual to be set up as "boss" or group dictator. (2) A workable system has been devised to provide at least partial nominal compensation and recognition for members when they contribute to the group by their participation in professional or administrative activities beyond those of the immediate demands of the daily clinic schedule.
In this group of anesthesiologists the following factors have contributed to its democratic spirit, its efficiency, and its stability: (1) the competence and cooperation of its members; (2) provision for full partnership at the end of one year; (3) a system of group officers for the division and delegation of necessary administrative duties; (4) recognition of extraclinical contributions to the group; (5) frequent staff meetings and conferences, and (6) encouragement of continuing postgraduate education by means of staff meetings, Board requirements, travel fund, and the like.

Partnership. It has been the experience of this group that the full potentialities of any associate are not realized until he has been given an equal voice in determining the policies of the group. It is a cardinal principle of the group, therefore, to set up minimal standards for partnership, and to seek to make all new men full partners at the earliest possible date in keeping with these standards.

Specific requirements we believe desirable for the formation of a partnership are:

1. At least twelve months' work with the group to determine the desirability of admission to partnership. It requires about this length of time for the new associate to become well-acquainted with the group and with the demands of this type of practice. One year should provide enough time for the group in turn to become acquainted with the candidate and to determine whether or not his personality and his abilities are suitable.

2. The candidate must desire partnership; all the partners must accept the candidate as a full partner. Partnership is not the right of any individual, but must be earned by the individual and approved as desirable by the legally constituted partners.

3. The candidate must be a member of the local county medical society.

4. The candidate must be a qualified anesthesiologist. "Qualified" has been interpreted arbitrarily as being certified by the American Board of Anesthesiologists or being a Fellow of the American College of Anesthesiologists. Recently this has been modified if the candidate has passed the written examination of the Board and has pledged his intention to complete the Board examinations when he has qualified as to time in practice. Once a candidate is mutually acceptable for partnership he signs the articles of partnership with their amendments and becomes a full partner with an equal voice in the business and policy-making of the group.

The details of the partnership agreement are a matter of legal record and include such matters as requirements for partnership, necessary insurance protection, a guarantee of a minimal monthly income up to a period of five months in the event of a temporary disabling illness or accident, and procedure for dissolution of the partnership in the event of the resignation or death of any partner.
Staff Meetings. Weekly staff meetings of about two-hours’ length are held for the purpose of discussing scientific developments in anesthesiology and the related sciences, for arguing clinical problems, and for making business decisions. Such meetings contribute immeasurably toward the democratic nature of the group. They provide opportunity for the resolution of misunderstandings and allow for active consideration of all minority opinions. No important bit of group business is transacted without due consideration of the important objections of the minority. Also, we think it is a mistake to try to force any member to abandon any technique he believes to be a good one or to accept any method, drug, or technique to which he is opposed. In other words, our group would probably be neither good nor long successful if it attempted to interfere with the individuality or the professional integrity of any member.

Group Officers. It has been said that no large group of anesthesiologists can succeed without a “boss” to direct and regulate the activities of its members. It was a compelling desire of each of the men in this group that no such authority be vested in one individual. Yet a loosely organized association or partnership of anesthesiologists may rapidly degenerate into anarchy and inefficiency unless there is provision for the delegation of certain responsibilities and for the division of necessary administrative chores. Accordingly, a system of group offices has been set up to see that responsibility is properly delegated and that administrative chores are equitably distributed. The offices are administrative in nature and may not be considered as policy-making positions. The officers are elected and subject to recall at any time by a majority of the partners.

The officers of the Associated Anesthesiologists of Seattle consist of Personnel Manager, Office Manager, Accounting Manager, Recording Secretary and Equipment Manager.

The duties of the Personnel Manager are: (1) to deal with problems affecting personal relationships within the group; (2) to deal with the following matters relating to the physician-employees of the group: (a) personal relations, (b) procurement and indoctrination of new associates, and (c) contracts; (3) to set up and post the annual vacation schedules; (4) to administer the travel fund; (5) to call staff meetings and set their pattern, and (6) to set up the monthly call schedule.

The duties of the Office Manager are: (1) to be directly responsible for the office employees, their problems, vacations, salaries and the like; (2) to supervise personally the billing of patients; (3) to supervise and give assistance in the daily problems of scheduling cases; (4) to act as Business Manager for purposes of negotiation, such as fee settlement, setting of fee schedules, and dealing with insurance companies.

The primary responsibility of the Accounting Manager is to supervise and to advise in keeping the group on a sound and efficient financial basis.
The specific duties of the Accounting Manager are: (1) to supervise the bookkeeper and the auditor; (2) to provide the group with the necessary data for the estimation of monthly salaries and withdrawals, of partnership shares, and of the value of shares in the reserve fund.

The functions of the Recording Secretary are: (1) to record the minutes of the weekly staff meetings; (2) to be responsible for the Plan of Organization of the Associated Anesthesiologists, and (3) to organize the clinical and scientific portions of the weekly staff meetings.

The duties of the Equipment Manager are those required for the maintenance of group equipment and for the replacement of dated or worn equipment. All ordering of equipment is done through the Equipment Manager.

All partners have an investment in anesthetic equipment, and it is the Equipment Manager’s purpose to protect that investment and to provide equipment which is always dependable, flexible, and up-to-date in meeting clinical needs.

In addition to gas machines and other equipment stored at the office and in various operating suites throughout the city, each member of the group carries a bag containing the equipment he requires for the techniques he prefers. Most of this equipment is owned by the group until it no longer has a depreciation value for tax purposes.

The Share System. As the group evolved, the need became apparent for some sort of nominal compensation for those who made special contribution to the group above and beyond the needs of the daily clinic schedules. A system of shares was then devised to provide such recognition without interfering significantly with the principle of equality of partnership. Shares are redistributed semiannually on the basis of a specified plan. The number of shares in the possession of each associate is the basis for the division of funds which remain in a special emergency reserve at the end of each accounting period. In general, one share is awarded for each year of longevity in the association, one share for certification by the Board or by the College of Anesthesiologists, one share for partnership status, one share for each officer of the group, one share for being chief of anesthesia at any of the local hospitals, one-half share for serving in offices or on committees in certain professional organizations, one-half share for acting as consultant to the Armed Forces, and one-half share for certain teaching activities during the year. It is intended that a share or a portion of a share be given to any member who spends time or energy on any project that is good for the general welfare of the group, the practice of anesthesiology or the practice of medicine in general. In such a fashion at least partial compensation and recognition are given for longevity, partnership, teaching, specialty recognition, and administrative services to the group. Nonpartners as well as partners participate in this system. Individual portions of the reserve fund for the first six months
of 1953, computed on the basis of this share system, varied from $550 to $1,075.

**Discussion**

It must be conceded that the private group practice of anesthesiology does not necessarily meet the needs and desires of all ethical anesthesiologists. The cloistered academic and perhaps more heuristic atmosphere of the teaching institution is a great attraction to many despite the frequent lack of independence, the inequities of salary distribution and the marked tendency toward hierarchy. By proper direction and adequate drive a large, democratic group, such as the one described above, can participate in teaching, in resident training, and in modest research projects while performing its primary function, the rendering of uniformly proficient care for the surgical patient. It is my opinion that a private practice group such as ours can in time perform most of the functions of the university hospital department without subjecting itself to the disadvantages commonly found in such an organization. We make no pretense as yet to having attained this goal. We believe, however, that it is the logical direction for a group such as ours. Neither do we present the details of organization of our group as ideal for all private groups of anesthesiologists. The principles are much the same, but the details of organization must be determined by local conditions of practice and by the personalities, the abilities, and the desires of the members of the particular group.

A partnership group is not likely to appeal to the extremely independent anesthetist who finds it a burden to work with others. When a partnership group is entered into it must be with the realization that some degree of independence is sacrificed in order that the group will function and remain intact. This disadvantage should prove small in comparison to the advantages.

Although partners may share equally in the net receipts, it must be realized, also, that not all individuals may be equal in other respects. For example, although one individual’s professional abilities or earning capacity may exceed that of others in the partnership, this does not entitle him to special privilege, to freedom from the obligation to work equally with his associates, or to a much greater financial gain than his partners. In order for a partnership group to exist amicably and fairly it must be accepted from the start that there should be an essentially equal division of income among the partners and an equal distribution of the work load among all members of the group.

**Summary**

This is a detailed report of the plan of organization of the Associated Anesthesiologists of Seattle, a partnership group consisting of eight full-time anesthesiologists in private practice on a cooperative, but democratic, basis.
There is no group "boss"; rather, the responsibilities for maintaining a group are delegated and divided into various offices, such as Office Manager, Personnel Manager, Recording Secretary, Equipment Manager and Finance Manager.

Qualifications for partnership are listed and are such that a new associate who meets these requirements may become a full partner after one year. All partners share equally in group income except in the division of a small reserve fund at the end of each year. This fund is divided according to a "share" system—shares being awarded on the basis of longevity, activity in group offices, Board certification, activity in professional organizations, administrative duties in the hospitals and time spent in teaching. This serves to encourage and compensate, at least in part, for time spent above and beyond the daily operative schedule.

Weekly conferences are held to discuss scientific publications, to argue problem cases, and to decide group business.

There is a travel fund to encourage attendance at national and regional meetings.

REFERENCE


EIGHTH NEW YORK POSTGRADUATE ASSEMBLY

The New York State Society of Anesthesiologists has announced the Panel Subjects and Panel Chairmen for its Eighth Annual Postgraduate Assembly to be held in New York City, December 9–11, 1954. They are:

Physiological Aspects of the Anesthetic Experience William S. Langford, M.D.
Progress in Analgesics, Hypnotics and N-allylnor-morphine Nathan P. Eddy, M.D.
Hypothermia Charles P. Bailey, M.D.
Physiology and Pharmacology of Cardiac Arrhythmia with Particular Reference to Anesthesia David Scherf, M.D.
The Absorption and Elimination of Anesthetic Agents Seymour S. Kety, M.D.
Cardio-Pulmonary Laboratory Daniel S. Lukas, M.D.
Anesthesia for Infants and Children Robert M. Smith, M.D.
Breathing Machine James V. Maloney, M.D.

A program of papers to be presented by residents in anesthesia has been arranged for Saturday, the final day of the Assembly.