



ANESTHESIA SERVICES RFPs: REALITY, UNICORNS AND COGNITIVE BIAS

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Think back in time to a job interview. You dressed for success, put a wide smile on your face, and were on your best behavior.

In the advertising world, they call them “reviews.” In healthcare, we call them requests for proposal or “RFPs” for short. They’re the same thing.

If you’re the incumbent anesthesia group, your relationship with the hospital or other facility, including, if you have one, your exclusive contract, is at risk. There’s little doubt about it. If you’re an outside aspirant, there’s an opportunity to expand your business to an additional location. *Or, no matter who you are, maybe you’re just being played.*

As in the course of a job interview, in an RFP situation, *everyone* is on their best behavior. On all sides.

The hospital or ambulatory surgery center (ASC) is telling lies about how great it will be to provide services at the facility, and how supportive the administrators will be. And at the antipode, the outside aspirants for the exclusive contract are puffing about the quality of their anesthesiologists and CRNAs, and about what great service they’ll provide. And, like the administrators, their representatives will be wearing suits and ties and shiny shoes, just like on a job interview.

But the incumbent anesthesia group suffers from the maxim, “familiarity breeds contempt,” that is, from the fact that it is well known to the facility’s administrators and influential surgeons, warts and all.

Being not as well known, the aspirant anesthesia groups pitching their wares are all rainbows and unicorns, sugar and



spice, with a snuggly puppy or two tossed in for good measure.

Let’s start with the truth: professional services are not, and cannot, be a commodity. But it’s also true that many have fooled themselves (or, more likely, others) into believing that they are. In fact, there’s an RFP industry ready to help.

But, even if you’re a true believer in the commodity theory of healthcare, an RFP process for anything other than fixed items (such as for 3.72 million screws meeting Mil-Spec MS51861-1C) is a ridiculous way to make a decision. A way that exists only in a world in which those bureaucrats known as facility administrators are rewarded by *visible*, yet lazy, action, situated in a universe devoid of the knowledge that *not taking visible action* can be action just the same. A way in which decisions are made based on the lies that they’re told and the lies that they tell themselves.

Are these lies moral failings? Usually not. They’re generally more akin to

resume embellishments, nicely pressed suits and shiny shoes. But either way, they’re a fiction, a phantasy *and perhaps even fraud.*

So what to do in the real world in which my thoughts about the craziness of the process have (unfortunately) little weight?

Everyone, from incumbent to aspirant to the consultant hired to “run” the RFP (and, who must assess the risk of doing so because there can be no truly effective indemnification from the facility), must assess the reality of the RFP against the three categories into which I divide them:

1. True RFPs: These are genuine searches for the best-quality provider with a favorable ratio of quality to cost. This type of RFP is the closest in relationship to the traditional form used in industry and government. It is commonly seen in situations in which the current or sometimes very recently former group has “blown up” and can no longer provide coverage. It’s also frequent in scenarios where the current group has completely lost the facility’s trust.

2. Fictitious RFPs: These RFPs belie the fact that hospital administrators are not interested in the merits of any response; they have already decided to whom they will award the contract. Yet, for one political reason or another, they’ve decided to issue a phony RFP to project a patina of “fairness” to the medical staff, to the hospital’s own board, to some third party—or perhaps to you.

3. Fulcrum RFPs: Consider this the weaponized RFP. As the name implies,

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the increasingly common fulcrum RFPs are designed to create leverage. The facility intends to renew with the present group but uses the RFP as a tool to dictate terms by *fiat* and to pressure the group into negotiating against its own best interests out of fear of replacement. Nonetheless, the facility is open to competing proposals.

Although no outside assessment of category can be completely reliable, clues often abound. And *category dictates strategy*.

If you're the incumbent, you must have a strategy to avoid, deflect and defeat an RFP.

You must create an Experience Monopoly¹, not just perform in a service role. You must also develop a propaganda strategy, deployed over time, to educate and sway the administrators and to continuously garner the support of key influencers.

You must develop a true business that is broader than based simply on one hospital, so that you can negotiate from a place of strength. And you must have taken action to secure the cohesiveness of the group.

Is that enough to guarantee that there will never be an RFP, or that if there were one, you'd come out on top? No. There is no such guarantee anywhere. But those actions are required just the same or you're wasting time, blowing the home team advantage (losing the headwind of confirmation bias on the part of the facility's administration) and working against your own best interests.

Optimally, you need to have the ability to walk away, to say to the facility's CEO, "no thanks, we won't be submitting a proposal. But hey, good luck with that unicorn!" Developing the required structure takes time. It takes playing the long game. If you haven't already started playing it, start today.

If you're a hospital administrator reading a copy of *Communiqué* as background research for an RFP, remember what Richard Feynman, the famous physicist, said: people are easily fooled, and the easiest person to fool is yourself. Cognitive biases abound. And that unicorn may just be an ass wearing a fake horn.

If you're on the outside looking at the opportunity that exists to expand your business to another facility, understand how to play to the administrators' cognitive biases (e.g., "the existing group is dysfunctional," and, for new CEOs, "you need to demonstrate leadership"). *But be very careful about what you promise*, because in the event that you "win," you'll actually have to deliver. It takes more effort to continue to play the unicorn *after* the audience knows it's a trick.

Yes, you can count on a honeymoon period, again cognitive bias (it's confirmation bias) on the part of the administration, but at some point your unicorn horn will fall off, you'll be seen

in the harsh light of reality, and, damn it, there's probably a wart or two where that horn used to be.

Then, you'll need to be on the lookout for yet another cognitive bias—buyer's remorse. If it kicks in, know that the administrators are incapable of blaming themselves, so they'll naturally have to blame you. Your only hope is that there's some junior administrator to throw under the bus as a sacrifice to the hospital's board. (In my experience, this is usually the CFO, but sometimes it's a vice president.)

Whether you're the incumbent or on the outside, if you "lose" the RFP, then, if you've developed the larger business that I advise is required, it might turn out to have been a win in disguise, for winning the race to the bottom is like a participation trophy at the local recreation center: it isn't a real win.

And there's also always a chance that you were defrauded in the course of the RFP, either by the facility or by the consultants brought in to stage the RFP process. Don't want to be a direct party to the legal imbroglio? Then consider that, depending on the facts, "bid rigging" and misrepresentation in a fake or fraudulent RFP can lead to criminal prosecution under various state and federal laws. 

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¹ An Experience Monopoly¹ is the overall combination of the way that your group delivers services and the experience that you provide to the facilities, to the other members of the medical staff, to their patients and to the community at large, that creates a benefit that competitors, even if they understood what was being provided, would not be able to duplicate.