

Why I Declared Independence From the Hospital

Edward A. Schmitt, M.D.

In 1776, a brave group of freethinking individuals realized that they had to sever an abusive relationship with an unjust administration. After spending years trying to rectify an intolerable situation, they were compelled to declare their independence. None of them took this lightly, but all agreed that they had reached the point at which further negotiation was pointless.

It is with the same sense of sadness and inevitability that I have chosen to declare my independence from all local hospitals. Having observed that the relationship between hospital administrations and their medical staffs resembled that between George III and the American colonials, I saw little other choice.

Throughout my medical career I have dealt with hospitals as places of training, as places to work, and as business associates. While training, I was to provide many hours of skilled labor to the hospital in return for an education.

Most of my time was spent serving the hospital's needs. The education that I received in return was unstructured and happenstance. I was to learn surgery by osmosis rather than by any reasonable or efficient method. As long as I was present in the hospital, there was a chance I would gain some pearl of wisdom. As there was no other way to realize my lifelong dream of becoming a surgeon, it was unthinkable to examine, let alone criticize this relationship.

When I completed my training in 1987, a surgeon had to be associated with at least one hospital. Like many other physicians, I love my work and never thought that much about my relationship with hospitals. I served on hospital committees, although most of the suggestions provided by physicians on the committee were ignored by the hospital administration and, of course, the physicians did not receive any compensation for this service.

We blindly accepted the explanations of administrators with a minimum of grumbling—anything to keep the hospital in the green and running smoothly. The universal solution to hospital problems was to have doctors work a little harder and give a little more. That seemed reasonable because it was a common thread in our training and we were used to it.

We took uncompensated emergency room call. In my case at one hospital this meant taking call every third night. These nights were usually quite busy. As physically challenging as this was, it

was unthinkable to question this duty. My work at hospitals was immensely profitable for them, bringing in literally millions of dollars. I had learned to work hard during residency, so I became used to 40 to 60 cases per week. When faced with a difficult task, my response has always been to work harder. I never questioned whether hospitals were giving as much as they were taking.

It's hard to identify a specific incident that caused me to examine my relationship with hospitals and assess it as abusive. Maybe it was the opening of a freestanding surgery center nearby. Suddenly it was clear to me that I could operate with the best nurses in town and with the best equipment. Instead of patients' complaints about shoddy treatment with outdated equipment in the hospital, I was hearing rave reviews of the new surgery center.

Although I continued to go to committee meetings, I became increasingly aware that hospitals really had no interest in listening to physicians' concerns, let alone addressing them. I learned that the phrase "I'll get back to you on that," uttered by an administrator, really meant that the hospital had no intention of addressing the issue. My role in surgical section meetings was not to discuss issues important to patient care, but to be told what the nurse in charge of the operating room had decided to do. A retired surgeon, who had lost his medical license, now chose what soap, gloves, bandages, and equipment we all would use.

All equipment and supplies were purchased from the lowest bidder. Whether the equipment worked was irrelevant. Innovative new procedures would simply not be tolerated. When I tried to introduce laparoscopic surgery, for example, the older surgeons who held power told me that it was new and experimental and that if I attempted to use it they would "get me." Those who were older and allegedly wiser said that they themselves would never use it and that they didn't want to hear anything further about it. And the administration at one of the hospitals supported this notion completely.

Next, the hospitals in town convinced physicians to become vertically integrated with them. These vertically integrated entities would negotiate contracts on our behalf and increase our business. Anyone who refused to cooperate and join them was shunned. This led to my terminating my relationship with one of our two hospitals. Vertical integration did increase business, but for physicians it was mainly business of the uncompensated kind. Closer examination revealed that the contracts favored the hospitals and their chosen

physicians, who were generally hospital-based—and often subsidized—rather than in private practice outside the hospital.

The medical group under the control of the hospital seemed to approve contracts based solely on whether they benefited the hospital. That most community-based physicians were disadvantaged wasn't an issue to be considered. I observed colleagues fully supporting decisions that were very harmful for most physicians as long as those decisions put money in their own pockets. And, if any medical staff members complained, the hospital administration had an eager group of hospital-controlled physicians ready, willing, and able to eliminate those "disruptive physicians."

As hospitals began economizing, patient care declined further. The hospitals began replacing dependable experienced nurses with inexperienced new graduates, who of course were paid less and saved the hospitals money. The position of charge nurse, who knew all of the patients on the ward, was abolished. Instead of talking to a trusted friend, the charge nurse, I had to speak to a myriad of people to get a still unsatisfactory report on my patients. The "more efficient" centralized patient charts were scattered throughout the ward, making it nearly impossible to find a specific one.

All of these decisions were made without advice from practicing physicians and could not be changed even when we objected. It became increasingly difficult to schedule cases in the operating room. When time was scheduled, I could always count on the schedule to run one to three hours late.

Emergency room duty also became more burdensome and abusive. The hospital paid a favored group of physicians to provide trauma call. Over time, it became clear that these physicians were receiving an increasing share of the insured non-trauma patients presenting to the emergency room. In essence, they were given the right of first refusal. Patients with personality problems or who didn't have insurance were selectively shunted to the on-call surgeon. Efforts to correct this unreasonable situation were simply rejected, and because the hospital's designated nurse controlled the operating room schedule, so-called emergency admissions sometimes had to wait for days to find a suitable opening for surgery.

I decided the situation had become intolerable when a new anesthesiologist, citing a lack of a transcribed history and physical on the chart, refused to provide anesthesia to a woman with a very sick heart who had a large appendicial abscess. The anesthesiologist did have the notes from the emergency room that had transferred the patient to our hospital, our own hospital's emergency room notes, a cardiologist's note, and my own handwritten note, all stating the emergent nature of the problem, but it wasn't enough. I had to call another anesthesiologist in for this as well as two subsequent emergency procedures.

When I complained about this travesty, the hospital couldn't understand why such a delay in an emergency like this would be a source of frustration. The unlicensed, retired surgeon/operating room director even tried to argue that the acute appendicial abscess wasn't a true emergency and that it could have waited for six days until the hospital transcription service could produce a formally typed History and Physical.

It became clear that there was no hope of any reasonable relationship with such a hospital administration. When someone enters into a relationship, there is an expectation of give and take. The hospital has every right to expect capable, compassionate, and skilled care from me. In turn, I have a reasonable expectation of functioning hospital facilities.

The relationship between hospital administration and physicians should be based on mutual respect, with a common goal of providing the best possible patient care. The relationship with the hospital is the single most important factor in physician satisfaction. Good relationships, however, are no longer common.

When hospital administrations become tyrants, routinely threatening their medical staffs, it is difficult to maintain enthusiasm about going to work every day. When nothing seems to be working very well and everything seems to be getting worse, frustration builds.

Although most doctors can identify the government and insurance companies as doing their part in making our lives miserable, I submit that a poorly administered hospital is far worse. Until we are willing to recognize and address this problem with Chief Executive Oppressors in hospitals, there will be continued dissatisfaction for physicians and declining patient care quality.

Meanwhile, I have declared my own independence from such tyrants.

Edward A. Schmitt, M.D., is a general surgeon practicing in Colorado Springs, CO. E-mail address: Gallbladderdoc@aol.com.

