COMMENTARY

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A medical center is not a hospital: Reflections of a department chair still in the game

DR. THOMAS LANSDALE'S COMMENTARY in the September issue (*Cleve Clin J Med* 2008; 75:618–622) resonated with many physicians because he so eloquently captured the increasing frustration many physicians feel:

- Frustration at the loss of a hospital culture that many of us loved;
- Frustration at the increasing challenges of providing effective medical care;
- Frustration with the increasing difficulty of providing outstanding education to future generations of physicians;
- Frustration at the escalating pressure to increase productivity and efficiency, shorten length of stay, reduce cost, improve quality, and enhance patient safety and satisfaction, all at the same time;
- Frustration at the nursing shortage and the need for more and more paperwork that takes physicians and nurses away from the bedside;
- Frustration with the ascendancy of third-party payers who dictate reimbursement and deny payment for care that is often necessary; and
- Frustration with hospital administrators who themselves are struggling to maintain the viability of our institutions at a time of escalating financial stress in health care.

Not all change has been for the worse

I trained in the same era as Dr. Lansdale and Dr. Brian Mandell (editor of *CCJM*), though at a different institution. Dr. Lansdale perfectly captured the ethos of the hospitals where I worked. Those were the days when house officers and nurses were in it together and bonded, when "everybody knew everybody," when house staff and nurses ran patient care, and when we kept patients in the hospital for as long as we deemed necessary and got reimbursed for it. Those were also the days (before Libby Zion) when attending oversight was sometimes marginal (attending rounds happened on the wards three times a week for 45–60 minutes), when 36-hour shifts without sleep were common, when hospital-acquired infections were felt to be the cost of doing business and were not tracked (let alone prevented), when quality and patient safety were not articulated as drivers, when medication errors weren't on the radar screen, when professionalism was not a core competency and we jokingly referred to some patients as "gomers," when patient satisfaction didn't matter, and when answering a question that came up on rounds required a trip to the library to sort through textbooks and journals in the stacks, rather than a few minutes on the computer. A lot has changed in hospitals and health care over the last 30 years, and not all of it for the worse.

I have been in medical leadership positions for the past 16 years, as a division chief for 10 and as a chair of medicine for the past 6. Maybe I've been lucky, but I have worked at institutions where there has been a commitment to medical education and to quality and patient safety. My current institution has quality as the dominant strategic goal, and we have tried to put our money where our mouth is. Hospital administrators and physician leaders are remarkably aligned in support of this goal, and we have won numerous national awards for the quality of our care. Educational innovation is another institutional strategic goal, which we have supported with hard money to fund teaching time for our faculty. Despite these commitments, physicians in our community share many of the frustrations articulated by Dr. Lansdale. Even at institutions with physician and hospital leadership aligned around goals of importance to doctors, these are tough times.

Some ideas for the future

In the editorial that accompanied Dr. Lansdale's commentary, Dr. Mandell asked not just for complaints, but for ideas and potential solutions. Here are a few, none of them an easy or quick fix.

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- Never in the history of medicine has physician leadership been so important. We need more physicians in senior leadership positions at health care institutions and hospitals. Physician leaders need to better collaborate with and influence hospital leaders to accomplish the goals we care about. We also need to recognize the very real stresses that hospital administrators face and to work with them as partners rather than adversaries. Similarly, hospital administrators need to partner with and not marginalize physicians.
- Physicians and physician leaders need to accept and manage change. Doctors don't like change, but we need to better influence it to the advantage of our patients, our profession, and the next generation of physicians we train. As an example, Dr. Lansdale correctly laments poor hand hygiene practices. We as physicians are often the worst offenders. If physicians don't drive adoption of this simple but vitally important practice, who should?
- We need to re-engineer care in hospitals to drive it back to the bedside. This means developing multidisciplinary-team care that is patient- and family-centered. Technology needs to be used to support rather than impede that care. For example, as Dr. Lansdale noted, physician order entry and computerized software that provides medication alerts will not prevent all errors, but will prevent some. Physician leaders must partner with others in their organizations to develop systems that prevent the administration of the wrong medications to the wrong patients, such as positive patient identification.
- For those of us at teaching hospitals, we as physician leaders must protect the educational and academic missions and convince our colleagues in hospital administration of the vital importance of doing so. For teaching, this means finding money to fund faculty time.
- We also need to develop innovative educational strategies that enhance the education of medical students, residents, fellows, and nurses in this era of declining hospital length of stay, where providers see only a very short segment of a patient's entire illness. This will require redesigning residency and medical student curricula to include shorter alternating block schedules of inpatient and outpatient time that enable residents and students to follow their patients after hospitalization through the continuum of care. We need to employ simulation technology to teach students and residents technical and critical thinking skills.
- We also need to embed quality measurement and improvement, patient safety, and the development of teamwork skills into our medical school and residency curricula. These are vital skills for the future.
- For better and worse, hospital medicine is likely here to stay. The system has many advantages but some disadvantages, mainly related to the lack of nuanced knowledge about new patients and the issue of handoffs. We need to devise seamless and standardized systems that optimize communication and patient safety at admission, during hospitalization, and through the continuum of care.
- We need to be far more aggressive at challenging denials from third-party payers for care that is appropriate. That said, we as physicians and physician leaders also need to look for ways to provide more efficient and effective care. This means constantly re-examining our practices. Our patients and insurers have every right to expect quality, and we have an obligation to provide it. In turn, third-party payers have an obligation to pay for it, and not just with paltry quality incentives whose true goal sometimes appears to be to deny payment and reduce overall reimbursement.

Medicine is still a great profession

My oldest daughter, Sarah, is a third-year medical student at another institution and is now completing her last core clerkship. She chose to apply to medical school after working for several years after college. My wife and I, both physicians, were silent about a career in medicine until she ultimately asked our opinion. Despite the many challenges outlined by Dr. Lansdale, we encouraged her. Medicine is still a great profession where, despite our challenges, one can wake up every day and make a contribution to peoples' lives. I talk with Sarah each evening. For her, the excitement of the hospital is no different than what Dr. Lansdale and I experienced 30 years ago.

For me, the most discouraging thing about Dr. Lansdale's commentary is its conclusion. I do not know Dr. Lansdale personally, but I know of him. He has the reputation of being a superb clinician and teacher. It's disappointing that he has hung up the cleats. We desperately need people like Dr. Lansdale in the game because it is far more than a game. If we as physicians and physician leaders don't solve the problems we face, who will?

Times are tough, but I'm still a hospital guy. ■

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