A medical center is not a hospital: More letters

(SEPTEMBER 2008)

Things are what they are

TO THE EDITOR: I finished residency in 1996. I'm not sure this qualifies me to respond to Dr. Lansdale's article, but I will anyway. In 12 years, I have witnessed what he describes, even though I work in a not-for-profit military hospital (medical center). Yet I am uncertain that things are worse than they were then, even though it seems like the house staff spend thrice the time typing on a keyboard in the team room than they do at the bedside. Things are what they are. Patients are living longer—I have seen this with my own eyes. Some of them are seeing children graduate, get married, and have babies and spending final holidays with other loved ones. I often feel a sense of helplessness at exactly the sort of obstacles to true excellence Dr. Lansdale points out. However, in the spirit of evidence-based medicine, it remains to be established that spending less time touching the patient doesn't reduce nosocomial infections. We were putting Swan-Ganz catheters in 12 years ago, and I am pretty sure in retrospect we were hurting patients—we don't do that much any more. When I struggle with these difficulties and I try to figure out how to emulate my mentors from what seems like a better time, I remember what my mom told me when I was a second-grader: "Just do your best, and no one will fault you." While I understand burnout, I think a more productive approach would be to redouble efforts at preserving humanistic traditions, valuable clinical skills, and a sense of what we were, rather than to retreat.

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The current system is nuts (Excerpt: full version at www.ccjm.org)

TO THE EDITOR: To add to what Dr. Lansdale said, advances in outpatient management and what one can do in "day surgery" have reshaped medicine. Medicine is now more of an outpatient enterprise. Hospitals have contracted to take care of only the sickest. Many things have been lost, including much of the fabric and texture of medicine. There are few of us left who are trained to do primary care, or willing to do it…

…For any provider, it is uneconomic to round on one or two patients. Hospitalists, who are often last year's residents, try to manage sicker and more complex medical patients, whom they don't know well. Emergency rooms are overflowing with primary care patients who go there in frustration and for urgent care, since there are not enough primary care physicians. The most expensive place is being used for basic care, and these patients are now seen by less adequately trained mid-level personnel, with reimbursements hugely in excess of what office visits generate…

…Most of us really do know how to practice economically, use resources appropriately, and manage our patients effectively. We are simply not being allowed to do so, or not paid for it when we do. In one word, the current system is nuts.

Before it is too late, and it may already be so, we need to restructure the system. That means rebuilding it around an outpatient model where doctors are paid and really rewarded for performance, and not for how many patients they see in a day…

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The good old days weren't that good (Excerpt: full version at www.ccjm.org)

TO THE EDITOR: Dr. Lansdale's stroll down memory lane reminiscing about the "good old days" brought back lots of memories (I graduated from medical school 10 years before Dr. Lansdale) but is of absolutely no help with today's medical challenges…

…Most of the physicians working in the trenches today did not set our current health care policies, and most of us will not

change them either. That will only come from those we elect to go to Washington. I can vote responsibly, but I would not be very good in Washington. Until things change, it is my responsibility to learn the rules of engagement and care for my patients the best I can within the system we have. Like the waiter in the restaurant, I didn't set the table, I'm just trying to clean up the mess. Today's medical students and residents don't want to or will not work the hours we did 20 or 30 years ago, and I don't blame them. Maybe they will have a lower divorce rate, live longer, and practice medicine longer than our current retiring physicians…

…Dr. Lansdale worries about infection in the hospital, where handwashing between patients is abysmal. I can't do anything about my peers' handwashing habits, but I can wash my own hands. Don't like retrospective review for quality measures? We all know what is best for CHF and AMI patients, but studies show that less than 50% of our patients get the care we know is best. Physicians have always done a better job when somebody is watching. More oversight is coming. Get used to it…

…I am a hospital guy. As long as patients, medical students, and residents need me, I'll be a hospital guy.

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We're chart doctors now

TO THE EDITOR: Dr. Lansdale appears to have jumped from the frying pan into the fire. In clinical medicine he will quickly find out that the quality of patient care has become nearly irrelevant. The quality of the medical record (chart) is all that matters to insurance companies, bean counters, and government agencies. I have been a primary care internist in private practice for 29 years. Instead of taking care of patients, I now spend most of my time taking care of charts. I'm a chart doctor.

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Let's not retreat
(Excerpt: full version at www.ccjm.org)

TO THE EDITOR: It would be rare to find a physician who has witnessed the changes in the last several decades of medicine who does not share many of the sentiments and observations of Dr. Lansdale. The key to a solution lies in examining a very telling phrase of Dr. Lansdale: "retreating to the privacy of clinical medicine."

We are living in an era of unprecedented opportunity for physicians to lead us to new levels of care by combining molecular and population levels of understanding of disease and health that will greatly dwarf the many public health victories of the mid-20th century. We need the deep and careful clinical descriptions of individual patients to inform genetic and molecular understanding. But we also need every practicing physician linked to wider improvement of both rare and common diseases through research registries and through practice-level and population strategies. We need various specialties to link efforts around patients rather than to retreat into their own intellectual and economic silos. We need to reclaim leadership stature by putting ourselves in service of solving the heath care crisis rather than retreating to the privacy of clinical medicine…

…The problem is that as the focus of medical care and medical education naturally and inevitably widened beyond the hospital, we have not developed the infrastructures to support this broadened approach. One of the fundamental ingredients to begin building this infrastructure is the community orientation of physicians. Let us not lament the great community spirit of the training hospital environment of old. Instead, let us translate it to the larger medical community beyond the confines of the hospital.

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The perfect is the enemy of the good
(Excerpt: full version at www.ccjm.org)

TO THE EDITOR: My initial impression is sadness—sad that a dedicated physician should

feel this way about his career. I'm not an internist, but rather a cardiac and transplant pathologist and member of the editorial board of the *Cleveland Clinic Journal of Medicine* and recently retired from Cleveland Clinic. Two days ago, at a social event, a grandmother approached me and told me with pride that her son was doing well in pre-med and was interested in oncology. She asked for my thoughts. I told her that I had had a great career, that I thought medicine was terrific, always stimulating and exciting, as well as demanding, and that I was well compensated. I still feel that way. I sympathize with Dr. Lansdale but wish he had taken to heart the message from *Future Shock*, ie, that the current rate of change is far faster than it has ever been, and that the rate of change is constantly accelerating…

…I'd like to end with another thought: the perfect is the enemy of the good. I found medicine to be a great career, and I'm afraid that too many physicians are dissatisfied because it isn't perfect.

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I was never a hospital guy (Excerpt: full version at www.ccjm.org)

TO THE EDITOR: …Up until this year, I took care of patients both in and out of the hospital, but this year I succumbed to the distinct yet subtle pressures at my hospital and turned over my inpatients to the hospitalists. We have a fine, conscientious group of hospitalists. Nevertheless, the transfer of care of my patients back to the community is suffering terribly from what it was when I was treating patients in both hospital and office. Despite the hospitalists' best efforts to dictate, copy med lists, and review situations with the patients, the patients arrive in my office confused, taking medicines incorrectly, and with no idea of what happened to them. I was crushed with the first few. Never mind the load of guilt they all presented me with for abandoning them. It was not in words, but in their eyes. "How could you leave me to them?" was the question in their eyes. I had no answer.

Maybe I'll get used to it after a while. My days are certainly more ordered. I am now more "efficient"…

…Dr. Mandell asked for solutions. I have a couple of suggestions. Put the medical students out in the offices. But put them with good doctors, practicing state-of-the-art medicine and happy with what they are doing…

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Nails in the coffin

TO THE EDITOR: Dr. Lansdale's commentary depicting the plight of general internal medicine struck a heartfelt, emotional chord with me. I am a 59-year-old general internist with 30 years on the job as a hospital- and office-based practitioner. I've enjoyed the opportunity of being the chairman of the hospital's department of medicine, president of the medical staff, chair of the quality committee, and other assorted hospital responsibilities. I was the associate director of a medicine residency program for 3 years, so I share some of Dr. Lansdale's issues regarding "bureaucratic lunacy." The three other generalists in my practice have done the same. We all love practicing medicine in spite of the demands. Our incomes are 20% to 30% less than they were 10 years ago. We have 35,000 charts (not all active) but still accept new patients, even Medicare. Caring for an octogenarian with five to eight active medical ailments who is taking 12 medications, mostly prescribed by several different subspecialists, is more challenging than ever. I'm saddened when I see a patient who has had two or three recent MRIs ordered by different physicians for a back, chest, or abdominal complaint when some simple remedy with the proper dose of time, observation, and follow-up was all that was needed. In spite of the problems, I enjoy practicing medicine as much as ever, but the future appears dim.

What has caused this impending collapse of primary care, and what is the cure? The answer is simple. The value that exists between patients and their personal physicians has been forgotten. The payers have

cunningly refocused the values elsewhere, and the medical community and the public have let them do it with almost no resistance. I won't mention the facts or history of this disaster, as we all know the story pretty well. I will mention, however, some scary things that may seal the primary care coffin forever. Insurance ratings, tiering, pay-for-performance, and evidence-based economics will all be the nails, and not much hammer effort will be needed.

What can be done to stop the bleeding, or do we really care? When the system changes to reimburse primary care physicians as much as subspecialists, then the coffin will open. I believe the decision to do this will come from pressure on the government from the public. Somehow, the medical community must convince the public to initiate this pressure. In the meantime, primary care physicians must continue to render compassionate care to the patient. After all, isn't that why we went to medical school in the first place?

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Focus on improving care (Excerpt: full version at www.ccjm.org)

TO THE EDITOR: …The aspect of care that most of us found and continue to find rewarding—diagnosing difficult disease processes, adjusting medical treatment plans, discussing acute, chronic, and preventive care with patients and their families, and the bonding with patients and support staff—will be done in the outpatient arena. In order to make this aspect of health care more rewarding and to attract the best and brightest from the ranks of our medical schools, we need to focus on the processes that need to improve. We need to develop a team of caregivers working with the physician, just as we had in the hospital setting 20 years ago—nurses who had time to talk with patients and participate hands-on in their care. Therapists, nutritionists, and social care workers can add so much to the level of care a patients receives, and coordinating this care with the medical care given by the physician is rewarding to all involved.

Finally, we need to be fairly rewarded financially for this activity. Third-party payers, employers, and government agencies need to recognize the value in this coordination of care, the value in focusing on disease management and preventive care, and change the way we are reimbursed from the present system that only pays us for an office visit. If the average adult primary care physician had a better sense of accomplishment, could spend time on complex patients, and could be fairly compensated for this, we would have more than 2% of medical students going into medicine.

I have seen the rise and fall of satisfaction and enjoyment among internists, who can be a dour and whining group at times (I am one of them, remember). But I have also seen new physicians joining our group with enthusiasm and a realistic view of the profession they have chosen. We are focused on improving chronic care through disease management and of promoting those preventive care measures that will make a difference in the health of our patients. We are anxious to improve the system that supports these activities and controls the reimbursement for the work done to care for this growing population of our community. Finally, we want to see an improvement in the coordination of inpatient and outpatient care by the various specialists in medicine, which has always been a rewarding part of this field—colleagues working together to find the best solution for an ailing patient.

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We must work together to save health care in our country

TO THE EDITOR: Dr. Lansdale's comments sadly illustrate all that is wrong with our health care system.[1] Desperately ill patients are hospitalized for as few days as possible in order to receive substandard care from agency nurses. Physicians have become assembly-line workers who must order large batteries of tests and procedures because they don't have the time to sit down, talk to, or examine their patients. This is the type of care that medical

students, interns, and residents are learning to practice. Sadly, this is the type of care that patients now expect: an MRI provides better reassurance than a physician's competent assessment. Business, not physicians, dictates how medicine is practiced.

Internists who care about quality, like Dr. Lansdale, are leaving the profession in droves. But rather than passively leave, they should become leaders in an effort to reclaim health care. If internists worked together, they might be able to enact major changes rather than passively watch as the ship sinks under them. There have been calls to do something.[2]

Some physicians are taking matters into their own hands by opting out of the system altogether; they no longer accept any type of insurance. While extreme, if done en masse this option could send a powerful message to policy makers and insurers that physicians will be pawns no longer. If physicians do decide to do this, they should make every effort to keep fees, tests, and procedures to a minimum in order to reduce costs.

The United States stands head and shoulders above all other industrialized countries in per-capita spending on health care.[3] This level of spending is not sustainable, especially in a nation beset by worsening financial conditions.[4] The United States desperately needs its physicians to be leaders in addressing our health care woes. We must work together to save health care in our country: quitting should not be an option.

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General internal medicine is extinct

TO THE EDITOR: General internal medicine has become extinct. Its practitioners have been pushed out of their leadership roles, have been pushed from clinical practice due to red tape and impediments of frustration, and have been marginalized by specialties and subspecialties, our so-called brethren. Only through revolutionary metamorphosis such as clinical homes or other unique systems by which primary care is delivered at high-quality levels such as MDVIP can general internal medicine survive.

Hospitalists are not general internists. Family practitioners are not general internists. Nurse practitioners are not general internists. And certainly none of the subspecialists are general internists. We must forge a new identity and role in the health care system because our previous identity has been destroyed.

Without our unique ability to temper high tech with clinical judgment, our system fails on quality and cost.

The article by Dr. Lansdale was more eloquent than I could express, but I believe the words written above are more accurate and to the point.

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The name of the devil

TO THE EDITOR: Dr. Lansdale's commentary[1] reveals the price we pay when we focus on one important goal to the exclusion of others. He illustrates that reductions in health care cost were paid for with reduced health care quality, and a loss of camaraderie and job satisfaction. Missing from his commentary, however, is any acknowledgment that reducing the cost of health care is an important and worthy goal—and his wistfulness for the old days suggests his willingness to trade increased cost for better quality and job satisfaction.

Unfortunately, the biggest problem in this conflict is not that Dr. Lansdale and his former administrators disagree on whether cost is more important than quality and job satisfaction, but that both mistakenly agree that each must be traded off for the others.

This hidden agreement is the chief mischief in health care today.

For example, much of the effort to improve health care quality has been oblivious to costs and employee satisfaction. Efforts to reduce errors have led to additional process steps, new checkers and coordinators, and expensive IT systems. These have increased costs, while frequently reducing job satisfaction and in some cases even failing to improve quality. Computerized order entry systems have been shown, for example, to disrupt physician-nurse communication patterns that were one of the major ways the old system prevented errors, and were a source of job satisfaction to both parties.[2] In some cases, patient mortality rates increased after they were implemented.[3] Another new system plans to police handwashing by putting video cameras in patient rooms.[4] Costly, yes, and the consequences for clinical-staff job-satisfaction are predictable.

The core problem is focusing on one-dimensional outcomes, instead of insisting that cost, quality, and job satisfaction are all vital, and that we will not truly achieve any of them until we achieve all three. Poor quality is wasteful, and waste costs money. Employees are most satisfied where they are productively employed providing high-quality services, and productive employees cost less in the long run than unproductive ones.

How can we have high-quality, low-cost, high-satisfaction health care? By fundamentally redesigning the way care is delivered, radically simplifying care processes to focus on the limited number of elements that produce health outcomes for the patient. Toyota has demonstrated that it is possible for a manufacturer to be high-quality, low-cost, and high-satisfaction by using an analogous approach, and the many manufacturers that have followed its example testify that Toyota was no fluke.[5] Early efforts are underway to apply so-called lean approaches in health care settings, but most are pruning the branches of waste instead of pulling it out by the roots, for example, redesigning labs and supply closets far from the patient's side.[6,7]

A former boss was fond of quoting economist Kenneth Boulding: "The name of the devil is suboptimization!" Let's begin by agreeing that cost, quality, and job satisfaction are all important, and commit to working to achieve all three together.

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