

Confessions of a “Disruptive Influence”

Eugene F. Diamond, M.D.

Because of certain draconian measures related to the Budget Reconciliation Act of 1997, the status of many medical institutions became precarious.

This led to more hospital mergers, but also resulted in various strategies by hospital administrators to expand the services of individual institutions, to increase advertising of certain hospital departments, and to intrude into inpatient services traditionally performed by staff physicians.

The plan was to enhance hospital income by co-opting various fee-for-service technical procedures, replacing independent practitioners with hospital employees. For example, hospital-employed radiologists might take over the performance of renal biopsies formerly done in the radiology department by the attending nephrologist.

Considerable intramural tension and rivalry has resulted, in which previously cooperative ventures by attending physicians in the inpatient services have now been re-interpreted as competitive areas. Traditionally, staff attendings made use of hospital facilities by referring patients for surgery, cardiac evaluation, or laboratory surveillance while still maintaining control of decision-making and most technical interventions. Now, the comfortable cordiality between administrators and medical staff has been largely replaced in many areas by territorial competition and, in some cases, role reversal.

An Illustrative Case

This new confrontational approach played out in one hospital we shall call St. Elsewhere in a Midwestern metropolitan area. The first overt act by the hospital administration was to buy up practices from retiring physicians, or to open up community clinics in competition with staff physicians by hiring recent graduates from family practice training programs. These were first justified as measures to increase referral for inpatient admissions, but it soon became obvious that what was really intended was to put the hospital in the business of practicing medicine through salaried physicians in ever-expanding numbers and specialties.

The cardiac surgery service was the first targeted for total acquisition. Two independent cardiothoracic surgeons supplemented the hospital's group. The cardiac service had its own credentials committee. When one of the independent surgeons came up for renewal, he was denied privileges. He sued, of course, and the hospital's defense was that he still had privileges but could not access their operating suites.

This reminded me of a time when I was on a ship and was told that there was “liberty but no boats.” Everyone could go to port—if able to swim 200 miles to shore. In an equally absurd manner, the

court was told that the surgeon was free to do surgery anywhere but in the operating room. Preposterously, the judge accepted the hospital's position, and the surgeon was forced to resign.

The second independent surgeon had been designated by the quality assurance committee as having the lowest postoperative mortality and morbidity. However, an organized whispering campaign targeting his referral base questioned his health. He voluntarily submitted to an in-depth evaluation of his neurological performance and dexterity. Nonetheless, he was denied privileges and I, as the staff president, was censured by the administration for having reinstated him and allegedly “putting his patients at risk.”

The hospital group, despite having higher morbidity and mortality rates, now owned the franchise. The cardiac surgery service, because of money and alleged prestige, became the darling of the administration. Even the chapel was closed to expand the catheterization lab. The hospital advertised in the lay press that the cardiac service had been designated as “outstanding.” The medical staff discovered that paying a fee, and thereby being listed on a phony “honor roll,” could actually purchase the “award.”

The medical staff recognized that the tactics used against the cardiac surgeons represented a stalking horse for similar strategies to replace private practitioners with salaried captives in other departments.

Since I had led the opposition to the takeover, I was elected to an unprecedented third term as staff president to lead the charge. My most important strategy was to change the bylaws so that no hospital-salaried member could be an officer or department head. Howls of opposition were heard from the administration suite, and bare-knuckle campaigns were started to prevent the bylaws change. Since the hospital-owned members had not yet reached a critical mass, the change won by a single vote.

The administration complained that I had cheated by counting only the votes of the active staff members, even though the bylaws clearly stipulated that only active staff members could vote on changes in the bylaws. The chief executive officer apparently decided that the only way he could accomplish his Grand Takeover was to have me expelled from the staff as a “disruptive influence.”

There followed a huge confrontation in which I was required to appear in an adversarial hearing before eight staff committees. All eight voted unanimously (with one abstention) that my conduct was not disruptive, but rather was that expected and required of the person who was elected to be the principal staff advocate.

Another committee was convened in which the officers of the system flew down from St. Louis to try to intimidate the executive committee. Again the vote was unanimous in my favor. At a meeting of the staff the vote was 122-6 to support me, even through 21 staff members were hospital employees.

Finally, as the bylaws required, an ultimate appeals court was convened to consider my expulsion. The hospital administrator

frantically intervened to make sure that the members of the appellate court were mostly my enemies, or certainly not my friends. After a long and acrimonious half-day hearing, in which I was represented by a fellow staff member and the administrator was represented by the vice-president of the system corporation, a vote was taken and for the 10th time it was unanimous that I should be reappointed. The result was sent to the corporation board with the recommendation by the CEO that, despite the overwhelming results of the required due process procedure, I should still not be reappointed.

Both sides began to assemble litigation teams in anticipation of a court battle, but the corporation's attorneys had concluded that their case could only be based on spite and retaliation. I was, accordingly, reappointed to the staff with the proviso that I could no longer hold any office or chair any committee. Since I had been staff president three times and a department chairman 17 times, I gladly waived my rights to re-enter what had become a bitter and confrontational staff governance process.

Although I had won a Pyrrhic victory, the stress on me and on my family could not justify the triumph over the totally undeserved and illegal attack on my integrity and my professional standing.

It is deplorable that medical staff and administration have renounced traditional, amicable cooperation and taken on unfamiliar, adversarial roles in response to economic pressures. It is inescapable that the Master of Hospital Administration degree in no way confers understanding of the professional or economic dynamics and nuances of medical practice.

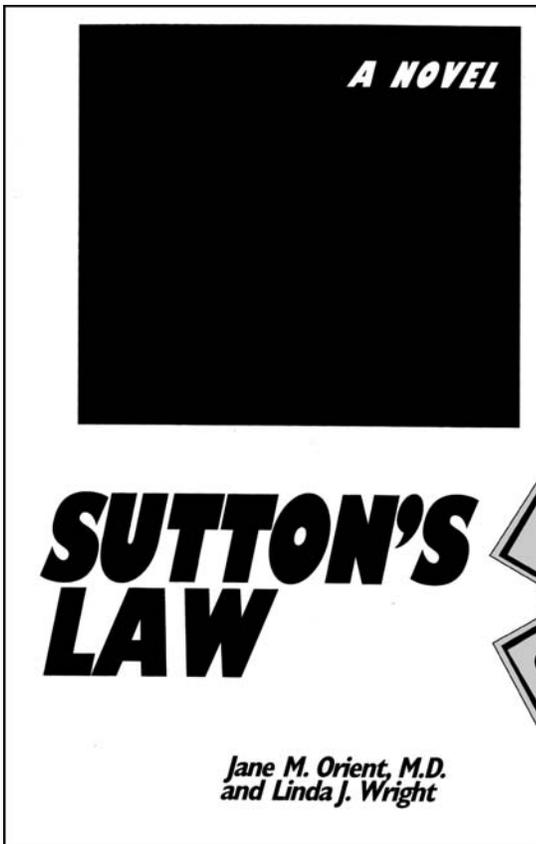
Postscript

The hospital's flirtation with staff control was a disaster. Because of the imbalance in the promotion of cardiac surgery and other hospital-based activities (e.g. women's center and weight reduction), the hospital's position as a full-service community health center dissolved. Staff members started independent surgical centers separate from the hospital. These centers, able to cherry-pick elective surgery, and to avoid the 24-hour staffing necessary to handle trauma and emergencies, began to thrive as the hospital surgical service dwindled. Procedures formerly done on inpatients, such as cataract removal and cytoscopy, became office procedures. The census could not be sustained, and the hospital continued to lose millions of dollars. Competitive cardiac surgical centers started up and attracted most of the referrals because of the superior quality of their surgeons and facilities.

The hospital is now for sale, and the word has gone out that the "initial capital investment will not be a problem." This suggests that the system corporation would be willing to give the franchise away to stem the fiscal disaster.

This 100-year old hospital, once a flourishing entity, illustrates the calamitous effects of poor administrative policy-making.

Eugene F. Diamond, M.D. has practiced pediatrics since 1955. Contact: enright11@wowway.com.



A NOVEL

**SUTTON'S
LAW**

*Jane M. Orient, M.D.
and Linda J. Wright*

Where the Money Is in Medicine.

Sutton's Law is a mixture of medicine, mystery, murder, and intrigue with a bit of high finance and romance. It's ultimately about greed and simple justice.

An entertaining and most enlightening thriller, a fictional story woven through with some of the more sobering realities of our time."

— Fr. James Thornton, *The New American*

"A frighteningly realistic novel"
— Lawrence R. Huntoon, M.D., Ph.D.

"...A system designed by thieves for thieves."
— Dr. Milton Silber, a character in *Sutton's Law*

The electronic medical record in action:
Read an excerpt and order the book at www.janeorient.com.
Available in hardcover.

