The hospital guy redux

In the September issue of the *Journal,* Dr. Thomas Lansdale discussed the pressures on internists trying to teach and practice medicine in 2008. He concluded that the system doesn't work for him or his patients, and he now practices internal medicine in an alternative venue. I asked for comments and solutions from our readers. I certainly got them.

You responded to the parts of Dr. Lansdale's commentary that struck a personal chord. Almost all responders shared his frustration. Many wrote that the American payer system fails to appropriately reward internists and primary care providers and called for restructuring the Medicare and third-party payer systems. Some of you took umbrage at his contention that hospitals are not safe, and that health care delivery systems do not always place quality care above economic imperatives as new programs and "centers of excellence" are implemented. And some of you reacted to the issues of physician satisfaction and difficulties in providing quality care in hospitals regulated by multiple agencies that generate unfunded mandates, while the hospitals already require high numbers of patients in order to survive financially.

I recently did a stint as rheumatology consultant at my hospital, and Dr. Lansdale's commentary was fresh in my mind. I noticed with satisfaction that the physicians and nurses were using foam antiseptic on their hands. I noted the new checks on verbal orders and a successful emphasis on preventing deep vein thrombosis and bedsores. But I also noted more patient hand-offs between house staff and faculty, and difficulty in finding doctors who actually knew the patient (or doctors that patients recognized as being responsible for their care).

The electronic medical record is legible and available from all over the hospital, and I could tell who signed the notes. But many notes were actually cut-and-pasted from earlier notes, and thus I couldn't always be sure who actually had said what and when. Technology is not an immediate panacea for the problem of limited physician time!

The house staff "lab" in the hospital with its microscope was closed due to regulatory concerns; thus, there was no easy way to look at a freshly spun urine sample for evidence of glomerulonephritis. This turned out to be a detriment to effective patient care: urine samples sent to the regular laboratory (with the usual transportation delay) rarely if ever reveal cellular casts. But we found creative, if inefficient, ways to deal with this and other problems.

At the end of the day, I realized that I still enjoy my time in the hospital. Patients' problems can be presented to house staff and students at the bedside and their diagnoses and therapies discussed in real time. Junior physicians can observe how senior physicians talk to patients and families, including the many ways we have learned to say "I don't know," and learn to appreciate the value of a well-directed physical examination. There is still a synergy and intellectual satisfaction in being one of a group of senior consultants discussing the care of a shared patient who has complex medical problems.

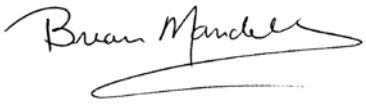
With rational and caring involvement, individual physicians can alter the trajectory of patient management and remain the primary patient advocates within a health care system that can't always easily deliver the quality that everyone desires. Caring,

patient-focused physicians must remain in charge of health care delivery, lest we pay attention only to the financial and regulatory problems.

Tom, I am older and even more cynical than I was when we roamed the hospital together every third night and never went home on our post-call day until the last laboratory result had been checked and the last transfusion had been given. We inefficiently examined every patient's urine ourselves (even from those being admitted for cardiac catheterization), and we had to convince patients of the (apparent) need for the urgent 3 AM blood draw to evaluate their 100.5° fever before we prepped the area and drew the blood. We drew blood for sedimentation rates and checked rapid plasma reagins at every admission and checked for urinary light chains in everyone with an elevated creatinine level and anemia, "just to be sure." We blindly placed Swan-Ganz catheters to monitor many hypotensive patients in the intensive care units, and we aspirated pleural effusions on the basis of our percussive examination. We talked to patients and accepted enormous individual responsibility for their care, but we were also frequently numbed by the overwhelming intensity of the training and the practice.

I am all too aware of the many forces that are eroding physician-patient relationships and that can corrupt patient care in the name of efficiency, financial necessity, marketing advantage, or regulatory compliance. Many of these forces I hope to help change. But I remain a hospital guy because I can still make a difference. I still feel honored that patients entrust their care to me as we attempt to navigate our evolving and, yes, sometimes treacherous medical system. Evading the crocodiles and fighting insurance companies are now in my job description.

In this issue we run two letters in response to Dr. Lansdale's commentary (page 762). In December we will publish more letters, though due to space limitations some will be abridged. We plan to run full text of many of the letters online at **www.ccjm.org** in December.



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