COMMENTARY

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A medical center is not a hospital

Editor's note: We are interested in your thoughts on this article. See the Editor-in-Chief's comments on page 616.

I USED TO BE A HOSPITAL GUY. I was only a few days into my third-year medicine clerkship in medical school nearly three decades ago when I fell in love with the hospital and knew I was going to be an internist. The hospital wasn't called a medical center back then. It was a fascinating and magical place, where internists were fired in the furnace of rounds, night call, and morning report. I loved the association with the great case, the flush of excitement that accompanied the difficult diagnosis, the hard-earned annual promotion through the hierarchy of trainees seeking the rarefied air of the attending physicians. We bonded as fellow house officers more tightly than with friends outside the hospital. We prowled the wards, intensive care units, emergency room, and laboratories and never slept. The hospital was the most exclusive of clubs, and our training granted us lifelong membership.

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A humming beehive of academic activity, the hospital was also a web of powerful social relationships. Everybody knew everybody, from the hospital CEO to the night security officer. The nurses called you by your first name and worked with you for weeks at a time, fostering mutual respect and sometimes even affection. In those days, nurses actually nursed their patients, spoon-feeding them broth with their medications, washing them in bed and bathroom, holding their hands and heads. Patients came to the hospital to be diagnosed and treated until they recovered from whatever illness had felled them. They stayed long enough so that you knew them and their families as well as you knew your own.

I have been a general internist and clinician-educator for 23 years, working in two university hospitals and one community hospital. That's more than seven generations of house staff with whom I've toiled and learned. Somewhere along the way, I became increasingly aware that teaching clinical medicine to students, interns, and residents was getting harder and harder. The patients were sicker and stayed only 3.2 days in the hospital. What we were teaching wasn't how to diagnose and treat diseases, but how to manage only their most serious complications—the respiratory distress from pneumonia, the ketosis of uncontrolled diabetes, the septic shock from infections. The wards became intensive care units, and the critical care units the province of "intensivists" who were more adept than we were at taming all the machinery and technology. We struggled to keep up with the unending deluge of arcane demands from the accreditation organizations watchdogging our teaching efforts. We pretended that we somehow distinguished teaching rounds from working rounds, and documented the silliness in computer files. Medical education slowly slipped from being a calling to folks like me, finally succumbing to bureaucratic lunacy. The pace of teaching and caring for acutely ill patients became intolerable. Rounds went from the bedside to the classroom to the cell phone. The house staff were getting cheated out of the whole point of residency—the miracle of turning medical students into attending physicians in a little over a thousand days.

Worse, though, was the ebbing of the lifeblood of the hospital. Now the medical center, riddled with "centers of excellence" instead of departments, answered only to administrators who cared nothing about medical education, except for the Medicare dollars they would lose if they cut the training programs. They

spent enormous amounts of money marketing the centers of excellence, and they cut everything else to manipulate the bottom line.

The biggest casualty, of course, was the nursing staff. Underpaid, depleted of leadership and morale, they simply disappeared. They were replaced by agency nurses who worked their shifts and didn't know the doctors or the patients. The complex bedside care of increasingly sick, old, and vulnerable patients was delegated to people with high school equivalency degrees. Nurses now cared for their patients by managing their own support staff, and spent much of their time entering useless information in the computer. The doctor-nurse collaboration I grew up with as a trainee and young attending didn't exist anymore, and patients suffered as a result.

In 2000, the Institute of Medicine informed the public and the medical community that being a patient in an American hospital was dangerous.[1] We were told that at least 44,000 and perhaps as many as 98,000 patients die annually in US hospitals as the result of preventable medical mishaps, more deaths than are attributable yearly to motor vehicle accidents, breast cancer, or AIDS.[1] Although there has been an emerging body of literature pertaining to this epidemic, not much has changed, at least not in my hospital. We remain absurdly complacent about rising iatrogenic infection rates, knowing all too well that we are allowing immunocompromised patients to die unnecessarily in our intensive care units. There are alcohol-based hand-washing gels everywhere, but no police or policy with teeth in it to enforce handwashing. We lurch toward physician computer order entry, clinging to the false belief that software programs will prevent adverse drug reactions and delivery of the wrong dangerous drug to the wrong patient. We understaff our pharmacies so that they can't get the medications to the patients on time or alert us to our own prescribing errors. We burn out our nurses despite years of loyal service. And worst of all, we capitulate to the for-profit insurance industry that informs us they won't pay for day 4 of Mr. Jones' hospitalization because he has failed to meet some arbitrary criteria in their manual.

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I stepped down as chairman of my department 3 years ago because I couldn't stand it any longer. I couldn't stand the management retreats in which we obsessed about "customer service" while the waiting time in the emergency department ballooned to 12 hours because there were "no beds." There were plenty of beds, but no nurses to staff them. I was marginalized when I protested the budget cycles bleeding out support of medical education in favor of the annual purchase of new scanners and surgical gizmos. I couldn't get anybody fired up about patient safety.

Retreating to the privacy of clinical medicine, I realized the other day that my real job is not to diagnose, treat, and teach about diseases anymore. My real job is to do everything in my power to keep my patients out of the medical center. I walk the halls now and don't recognize the institution I grew up in and came to love. Everywhere I look, I see not magic and promise, but dirt and danger.

I'm not a hospital guy anymore.

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REFERENCES

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