The Hospital's Hand

As part of their ongoing commitment to the ethical climate and organizational culture of the institution they serve, the ethics services of a large metropolitan hospital in the Bay Area proposed a qualitative research project addressing possible impediments to ethical professional practice among a specific medical specialty group, adult hospitalist physicians, at their four campuses. A non-staff researcher was hired to conduct voluntary individual interviews of a representative sample of possible candidates. Hospitalist physicians were asked why they had chosen their specialty and their degree of satisfaction with that choice, followed by open-ended questions about their work load and working conditions. Results are summarized below.

Background:

In the last two decades, the US health care system has undergone disruptive changes. Among the factors that influence health care delivery are advances in technology, shifts in patterns of medical practice, changing reimbursement patterns, consolidation on both institutional and practice levels, and pressures for standardization in medical practice, all of which have impacted both the individual providers and the institutions in which they work. With the recent passage of a long-awaited health care reform bill there is every reason to believe that the next few years will see further transformations.

The Bay area has been as subject to consolidation as any in the country. After a peripatetic 140 years of medical history, the current four campuses consolidated in 1991 and became the flagship of a regional system 5 years later. That larger system, Sutter, is itself expanding to include over 20 hospitals and numerous clinics and specialty practices in the region. In the last two years the institution has been further consolidated by incorporation into a regional sub-organization, Sutter West Bay.

Hospitalism as a medical subspecialty has grown rapidly in the past decade. It has been estimated that there were almost 20,000 practitioners in over 1200 hospitalist programs at the beginning of this decade, and the number is increasing.[1,2] The institution at which this research was conducted was an early innovator. Physicians have been serving in that role since the '90s, even before the official formation of its first hospitalist group. The institution in which the research was conducted has two adult hospitalist groups, a large generalist group (52) and a small specialist group (8). Several of the physicians interviewed for this research had been with the larger group since its foundation under an influential and charismatic leader in 1998.

Objective:

It is to the advantage of their organizations, the physicians themselves, and the patients they serve to minimize stress, frustration and low morale in this centrally located important population of health care providers. Physician burnout has become a subject of national discussion, and for the first time recently the language of 'moral distress,' a concept much discussed in the nursing literature for the last 30 years, has begun to be applied to other healthcare professionals. Whether described as 'moral distress' or 'physician dissatisfaction,' the consequences are staff turnover, decreased efficiency, and

in the context of health care, decreased patient safety, worse process outcomes, and a lower quality of service.

This research was designed to inform organization leadership about the impact of recent structural or systemic changes on function, morale and job satisfaction on this crucial interface between patients and organization in one hospital.

Method:

An outside researcher was hired to conduct individual interviews of a representative sample of possible candidates. Potential subjects consisted of 59 adult hospitalists in two groups working in 4 campuses of the hospital. In the first stage of research, 25 physicians in a 30-minute interview (face to face (=14) or telephone (=11), depending upon the preference and work schedule of the participants) were asked about why they had chosen their specialty and their degree of satisfaction with that choice, followed by open-ended questions about their work load and working conditions, and which, if any, constituted in their view possible impediments to their ethical practice according to their own highest professional standards. Five to seven proposed additional interviews will bring the percentage of potential subjects interviewed to 50% of the total and 50% of those employed at each campus.

Results are summarized below, grouped under several headings: hospitalist practice; work load and work flow; and factors affecting physician morale. In the Appendix the themes elicited from the interviews are mapped on a recently published national quantitative survey of physician dissatisfaction[3] in academic medical centers.

Demographics collected were age, gender, hospitalist group, number of years working as hospitalist, number of years working at CPMC, medical school attended, and site of residency. A third of those interviewed (8) had been residents at CPMC, and several had been with the larger hospitalist group since its formation. Half of those interviewed had been hospitalists for more than 10 years (median 9.8). Gender was evenly divided (12 f, 13m). Several (5) had worked as hospitalists at other institutions before coming to CPMC, and their experience provided useful insight into working conditions at this institution. Several (3) had left private practice for hospitalist positions, instancing a national trend.

Context:

Hospitalist as subspeciality:

Physicians who have chosen this subspecialty really like their work.

They like the variety, the intensity, the kind of care that in-patient medicine demands. For the most part their patients are very ill, with specific problems. It's just more interesting than annual physicals. They take satisfaction in working very hard to fix them, then sending them home again.[4] Too, it is the kind of medicine that their early experience had made most familiar. Very few residencies concentrate on out-patient medicine, and early socialization as residents makes the transition to a primarily in-patient practice an easy and appropriate one.

A second consideration, emphasized by some percentage of respondents, was the degree of predictability, if not control, over the time demands of their practice. The large group has a wide variety of options for schedule: a day schedule of 12 days on and 5 days off, or week on-week off; night coverage,[5] and an evening schedule running from

3pm to midnight. Although most physicians are expected to rotate through all shifts in the course of a year, there is some flexibility in scheduling. And as several (8) emphasized, when they went home, they were very often really off work. This degree of control was particularly appreciated by the physicians with families--the majority, as in any group of 30-50 year olds.

And they like working closely and reciprocally with their colleagues. There's a lot of handing-off among the physicians who work in each campus, and the great majority of interviewees seemed respectful and appreciative of the people in their group Most respondents expressed the importance of working with a group of people whose competence and values they trusted. In the generalist group, administrative tasks are rotated among the membership, practice decisions are discussed and agreed upon, and there was considerable confidence expressed in the transparency and fairness of governance. While members of the generalist group, which has a long history and stable membership, express some recent deterioration in working conditions, they generally speak very warmly of the solidarity and collegiality of the group.[6]

In short, very little experienced distress is attributable to their choice of career. On the contrary, interviewees were unanimous in their satisfaction with the kind of medical practice this choice represents. Physicians who had moved to hospitalist medicine after some experience with primary care were particularly outspoken in their satisfaction with the change.[7]

Practice structure:

The institution under study consists of 4 different hospitals scattered across a large urban area. Each campus has its own history, different patient population and service line, different infrastructure. The specialist group of 8 hospitalists, SPMF, operates only on one campus (and indeed apparently primarily on one unit in that campus), a logistically simpler arrangement than that navigated by the larger group, which operates on all four campuses. Hospitalists are hired to a specific campus; there is some mobility, but physicians do not expect to commute between them. Half of the hospitalists in the generalist group, PIMG, serve on the main campus--5 at California, 9 at St. Lukes, 13 at Davies, and 24 at Pacific.

The institution itself was in the last two years incorporated into a regional subgroup of the larger health care organization. In a research project devoted to identifying and ideally hoping to remediate structural or systemic obstacles to excellent and ethical professional practice, the most pressing and obvious question quickly arises: If you *can* find a problem--and there was no shortage of those--*whose problem is it*? Is this a problem of the practice setting, one campus rather than another? Is it a problem arising in, and potentially under the control, of the group itself? Does it originate in the local administration? To what extent are policies and practices under the control of CPMC itself, and to what extent do they originate further up the chain of command--in the regional or corporate offices of the healthcare corporation? How much of the increasing demand for documentation and imposition of externally generated criteria of excellent practice are actually determined by federal or legal requirements completely out of the control of any healthcare practitioner in the 21st century US health system?

The perception of the hospitalists interviewed, and the major source of dissatisfaction, low morale and pessimism about their work at this institution and the

future of hospitalist medicine as a career choice: the answer to the question, "whose problem is it?" in this institution at this time, is *"It's your problem."* Not "their problem." Not "our problem." Because of their proximity to the interface of patient care, their profession and training, and their anomalous status of 'employed but not employee,' any changes in procedures, initiatives, new requirements or potential improvements in quality of care tend to default to the hospitalists as custodians and responsible parties--often with no additional support to acknowledge or accommodate any additional work time that may be required.[8]

Governance:

As members of what seems to be a relatively autonomous worker-managed collective, the physicians in the generalist group, even if not currently active in group governance, feel they have a say in the conditions of their contracts, and some transparency, if not control, about tasks being added to their work-load. Group processes are described as "democratic" (8) This autonomy, although perceived to be fragile, is highly valued by the members of the group.

The perceived unity of a 50-plus member hospitalist group upon closer examination divides in practice into four groups of different size, different work-load, different expectations and working conditions, and different patient populations, scattered across a crowded urban environment on four different facilities.[9] There are monthly meetings on each campus of all the hospitalists located there, plus a monthly leadership meeting of representatives from each campus. The pervasive feeling that they are being included in all group decisions stems in part from this degree of constant interaction. But a researcher asking "what takes time away from patient care?" has to be aware that one campus is 15 minutes away from man campus by public transport; a second 20-30 minutes away by a shuttle that runs on the half-hour; and the third campus 45-60 minutes away via two shuttles. Hospitalists active in group governance[10] from outlying campuses write into their expectations of their work-load considerable time commuting to or attending meetings at the main campus. The group is, as its members (4) say with pride, "very very lean," with only 2.5 non-physician administrative people; so most of the work of and for the group is done by its members. A decision by the group to hire an additional physician to ameliorate the work load, or to add non-physician staff to handle some of the information-gathering and documentation, would presumably come out of the contractual amount paid to the group as a whole.

The issues, the atmosphere, the patient load, the work load and task distribution, is different at each campus. Individual hospitalists deal with individual priorities and obligations, their own preferred trade-off between time and money. The possibilities for conflict between individual members of a large cooperative seeking to reach consensus, and between representatives of different campuses, seem obvious. To the researcher's surprise and bewilderment, no such conflicts were the focus of attention in the interviews. The majority of those interviewed (20) expressed almost as much satisfaction with their group as with their choice of profession.

Possible game-changers foreseen by interviewees: Some members of the generalist group (3) expressed concern that there was increasing pressure to abandon their semi-independent contracting status and become employees of the hospital's Foundation--a changed relation that might threaten the relative autonomy of the present group.[11] One

person speculated that if the administration continued to prioritize cost over quality of hospitalist service there was some chance that "big hospitalist companies" might in the future become competitors for the annual contract.[12]

Environment:

The buildings: "During the day it's sheer chaos."

The facilities of the four campuses vary in age and structure, and the condition of the workplace has an effect on the morale of hospitalists in the various settings, but in sometimes unexpected ways. The campus to which the lowest morale is attributed, Davies, has the most modern building. The way the space is utilized is more damaging than the condition of the building itself. There is a perception that there is money for the construction of a new hospital, apparently awaiting only approval from the City of San Francisco; but it will not replace all four of the present facilities, so present disadvantages of setting may well remain, absent serious remodeling of the surviving campuses.

And the major disadvantage, at two of the four facilities, is the absence of work space: not enough computer work stations (12), or even desk space (3), and competition for what is available from everyone else working on the unit--nurses, therapists, consultants, and on one campus, students and residents. No room--with or without a door that closes--into which a physician can go to make or answer an important call, or catch up on charting, or even to avoid constant interruptions, from patients or families or staff or colleagues.[13] Distraction (7) is widely seen as an impediment to excellent medical practice.

There is some feeling that not all the space / geography problems currently impeding work flow are irremediable. By administrative fiat some work space might be carved out, but that might require reducing patient space by a room, and the occupancy rate makes that difficult on some campuses. That occupancy is more important than physician effectiveness is a priority particularly resented at one of the campuses with a recent history of accommodating recent care initiatives that increased an already high patient load.

Pacific campus is so complex that no one was able to even point to a floor where the work logistics looked manageable, with the possible exception of the unit where most of the patients for the specialty group are located.[14] In addition to the crowd of nurses, therapists, chaplains, social workers, family members, visitors and consultants, that campus houses residents and medical students; and a single physician may have a daily case load with patients scattered across as many as 4 floors.

The computers: "EPIC is coming! EPIC is coming!"

The single most universally deplored aspect of the present practice environment (22) is the computers, which like the new hospital, is promised ("this year, next year, sometime, never") to be replaced in the future.[15] For current practice, a physician must interact with sometimes as many as 5 different computer systems, none of which communicate with each other.[16] For the patient's chart, paper is still standard-- and although there were several cynical remarks about the idea that paper charts should be standard of care in a busy urban hospital,[17] several physicians (3) remarked that at least they were accessible and likely to be accurate. The current IT for physician orders is not

only cumbersome and outdated--it was frequently (5) described as an invitation to error and a threat to patient safety.

The program currently slated to be introduced next year has the advantage of being used by (some, but not all) other Sutter institutions and doctors. Many of the current obstacles to intercommunication within the wider medical community will remain, since many patients come to the institution from other area hospitals and systems, none of which intercommunicate.[18] Internal communication, however, should be improved if the hospital moves to one system rather than five.

Not that everyone is looking forward to the rollout of a new system: the transition from the old to the new is not anticipated with pleasure, save by the few who are already familiar, from other settings, with the proposed system. There will be a steep learning curve. Everyone expects some additions to their already-onerous workload and cumulative inefficiencies as they familiarize themselves with the new system.[19] Greater automation, as considerable literature attests, comes with its own hazards.[20] And as one physician remarked, the environmental problems, if not separately addressed, may well be exacerbated.[21] The greatest worry, and one expressed at length by a physician familiar with transition problems from another setting, was the question of whether the institution would provide the support and preparation necessary to successfully institute a new system,[22] or would just say to the hospitalists "it's your problem." It is hard to know whether that skepticism stems from past disappointments, or anticipation of future cost constraints, but the two reinforce each other.

Work load: "More work for less pay."

There is a universal perception that the work load has increased, not just over the last decade, but perceptibly over the last two years, as is attested by both long-termers and recent arrivals.

. Patient load always goes up and down within units. At one campus it seems to only go up--never down. Morale at that campus, according to reports not only by hospitalists at that campus, but in the perception of other members of the group, is very low.[23]

. Regardless of the number of patients, the amount of work for each patient is increasing, primarily in the amount and kind of documentation expected.[24] Even something that can take only an additional minute per patient, for a hospitalist covering 12-16 patients who has to find the chart or find a free computer or an open shelf or desk to write on, can add up to another hour in the work day. Hospitalists at Davies (5) reported 10-13 hour workdays were norm for that campus.

--Many of the documentation and reporting tasks are time-sensitive. One conscientious physician showed the researcher his cell with an alarm set to go off at 10 pm every evening to prompt him to check if all the documentation required within a 24 or 48 hour period had been completed.

--If a patient has been discharged a few hours before a physician goes off service, some tasks must be completed in off-time--a challenge to the frequently-touted advantage of hospitalist practice, that when you leave the hospital, you're off duty. One single parent confessed a preference for taking a cut in pay to spending off-time on work related tasks that didn't directly affect patient care.[25]

Much of the information-gathering that takes away from patient care need not be done by physicians; but when the interviewer asked if any of it could be delegated, the obstacle perceived was that the cost of hiring ancillary help to do some of that work, rather than being shared as a joint responsibility of the hospital and the physicians, would be the sole fiscal responsibility of the group, and come out of the contractual amount divided among the group physicians.[26] One physician, commenting on the range of non-medical tasks that were the sole responsibility of hospitalists on his campus, commented "It's like I'm an attending and a resident and an intern." [27]

Some of the increase in work load is required. Some of it affects the pay of the individual physician. Some of it affects the reimbursement rate. Some of it affects the rating of the hospital. Some has been voluntarily assumed by the group, beta-testing specific strategies in anticipation of future regulation. Some may improve patient care, or patient satisfaction, although there seems to be little actual empirical data to confirm or disconfirm that hypothesis.

But the cumulative effect is more unacknowledged, unsupported, and uncompensated work, for the same number of people, for the same, or possibly for less, pay.[28]

Work flow:

In organization theory it is well known that many problems for which individuals assume, or are given, responsibility, have systemic roots and up-stream causes, and that instituting or perfecting processes can contribute to the effectiveness, efficiency, safety and quality of work. This system and this institution, on all levels, are devoting a great deal of time, effort and attention to processes, and the contrast between theory and practice was one of the most interesting results of this research. This group of physicians often preceded any criticism with an acknowledgement of the good intentions behind various initiatives and the importance of quality improvement strategies, and expressed their hopes for useful outcomes--even when they were skeptical about whether there would be any. More useful to leaders of the organization may be the perception of these front-line workers of how things are working out in practice.

On a given day, time talking to patients, a high priority and major source of satisfaction to the people interviewed, is bracketed by time spent in documentation and administrative tasks associated with 'taking part in the life of the hospital'-- a category that includes group meetings and sitting on various task forces, working groups and committees. Time distribution varied, with people with primarily clinical roles reporting as little as 15% of their time in such 'administrative' duties, while some split their time between clinical and administrative or teaching roles. Communication (with colleagues and computers) and information gathering occupies a lot of what is defined as clinical time.

Time spent seeing patients is important to how these physicians see their job. The more time gathering and verifying information about the patients' condition, the better they perceive the quality of their patient care. Time spent in documentation, time at, or hunting for, computers, is time they cannot spend with patients.

Communication on transfers between hospitalists on service and between shifts seems to be unproblematic. The standard established within the group for handovers includes both oral and written reports, as well as beeper-access off service, and the high

degree of collegiality seems for the most part to give hospitalists confidence in the extent to which a plan of care will be consistently carried out.

Communication between the hospitalists and other staff and consultants also seemed, upon exploration, to be well within normal parameters of personal trust and confidence. The hospitalists spoke very highly of the competence of the nursing staff, while being very sympathetic to their case load. Staffing and job description for case managers / discharge planners was viewed with a mixture of sympathy and alarm,[29] but as one hospitalist noted, there was nothing they could do about that except fill in the gaps themselves--and a great deal of time seems to be spent doing things that could in theory be delegated to non-physicians.

The most problematic issues in communication between hospitalists and other staff were clearly systemic.

. One recent arrival to the institution was surprised (and appalled) at the absence in the chart of a nursing-physician communication form--a cheap and easy way to improve work-flow and simplify information exchange.[30]

. Another relatively recent arrival to the Pacific campus was frustrated daily at the difficulty in locating which of the discharge planners was assigned to the patient that she was under time pressure to discharge on a given day.[31] Here too there was an apparently cheap and easy solution: "They write with a red or green marker the doctors assigned to each patient. Why can't they write the name of the case manager... right there [on the board], so the doctor can identify who it is?"

Other suggestions about improving work flow, although easy, would probably not be so cheap--and that was perceived as a problem by hospitalists aware of working in a 'lean' group in a 'lean' hospital.

. In a previous institution in which one interviewee had worked, not only the charge nurse, but every nurse had a telephone, with a 5-digit number clearly posted on the unit.[32]

. Medication reconciliation tasks, on either end of the hospital stay, could be better supported--but not without hiring hands dedicated to that task.

. At other institutions at which some physicians had worked, billing and coding was supported.[33]

Communication between the hospitalists and external physicians was more problematic, not least because of the difficulty of locating the people to talk to. It was discussed at length in the interviews, primarily in terms of communication around admission and discharge. Unpacking 'communication' reveals issues in information gathering, and in documentation requirements--some of which are not directly related to patient care, but associated with various pay-for-performance requirements or 'quality improvement' initiatives.

Admissions:

The medical issues post- admission are fairly unproblematic: the patient enters a controlled system with a problem, and the medical issues can be easily addressed. The documentation issues, here as everywhere in this institution, can be more complicated. and some of those are an artifact of the computer system, with various in-built computer hard-stops and checkboxes.

Many of the admissions at the Pacific campus seem to come through the ER and are done by the nocturnists and the people covering on afternoon or evenings. Some

admissions are routine; some (as the name 'emergency department' might suggest) are not. The offices of the primary care providers of people admitted late in the day are of course closed. Some admissions from Sutter physicians and clinics may come with their information fairly complete, [34] but that does not account for all the admissions through the ED. And not every patient has a primary care provider.[35]

The hospital is evaluated on time spent in the ED, so there is currently a great deal of emphasis on ED "throughput"--how long the patient spends before being sent home, admitted for observation, or transferred to some unit in the hospital--a metric that is, like many metrics in this institution, attached to the name of the admitting physician. Getting it right and getting it fast, especially on a busy night in the ER, may be at odds. [36]

Important information for admission includes a list of medications the patient is taking; and that information is crucial for communication on the other end of the hospital stay, too, because it must be reconciled with the patient's medications on discharge. But the patient may not have brought a list in; they may not get the names of the drugs right; they may not have any idea what they are supposed to be taking--or may not be compliant with their prescribed medications at all. But verification of the meds is a computer stop on documentation; you can't go any further with admissions until that box is checked.[37] There are a few other computer hard-stops as well, apparently: code status, and verifying immunizations.[38]

Figuring out where to locate an admitted patient in the hospital sets the stage for many of the complexities of hospitalist practice the next day. Typically physicians on the medical service at Pacific campus have patients scattered across different units on different floors, depending on where beds are available. One option is placement in an observation unit, an area of the hospital that has been the object of much process-improvement scrutiny.[39] Patient location is less of a problem for the specialty group, most of whose patients are on one unit on one floor; and one physician reported on the triumph of one team of the other group who had figured out how to program the ED computer to send their patients to one unit--"not translatable to the entire hospital, unfortunately."[40]

Discharges:

Communication and continuity of care at discharge is more difficult than at admission. Collecting patient information from 5 computers that don't interconnect, locating the patient chart, which may or may not be in its slot, getting the medication reconciliation right, and coordinating with the relevant discharge planner and nurse, may have to be done in order to decide whether a patient can be discharged today by the relevant decision time--11 am, on Pacific campus. (see fn 31)

Physician to physician communication on discharge is generally viewed as cumbersome but appropriate. Well established routines within the practice govern communication with external physicians and institutions upon discharge: as well as a written discharge summary, the outside physician receives a telephone call. (Rumor has it that in a recent innovation the written version must also be faxed to the outside physician--an extra step that seems to some a bit redundant.)[41] Office hours, phone trees and busy schedules make communication with external physicians (if the patient has one) time consuming, but most of the people interviewed thought that communication with their peers was not a task that could or should be delegated.[42]

But if talking to colleagues should not be delegated, getting through the preliminaries of finding out who the primary care physician is, locating the office number and finding out when he will be available for a phone call, certainly could be.

Within the last year, a period of time that was most highly impacted by increased work load, the generalist physician group initiated an additional communication task for the hospitalists in their group: a post-discharge telephone call to locatable patients. One rationale for the initiative was that it might have an impact on "patient satisfaction" scores (about which more later). It hasn't been in place long enough to know whether it will (or even could). But it could have some impact on the adequacy of post-discharge medical care, and the hospitalists interviewed were fairly positive about this addition to their work load. The physicians like getting information from actual patients, rather than computers; that's one of the reasons they went into medicine. The patients are often glad to hear from the doctors. If no one knows whether it has an effect on patient satisfaction, no one really cares; that is not a metric that anyone interviewed (20) has any respect for or trust in. But it does add time to the work day.[43]

Quality and Care: "Who is the judge of the quality of care?"

Much of the work of the hospitalists is devoted, one way or another, to improving the quality of care; and they are experienced and sophisticated judges of what good quality consists of in the work they do. The work environment--the processes and systems that support the work they do--is under constant scrutiny, by the hospitalists and by the hospital, in hopes of maintaining or improving the quality of care. In the course of the interviews, the researcher heard stories of quality-improvement projects initiated from the bottom-up, and quality projects initiated top-down. There are a lot of them.[44] Some quality initiatives are directed toward efficiency; some toward financial viability; some toward effective care, originating from every level of governance, from the hospitalist group, through the administration, the corporate level, or CMS.

Bottom-up:

Over the years there have been various iterations on bottom-up suggestions on changes in procedures to improve patient care. Several physicians (3) had isolated inadequacies in systems and had suggested protocols or strategies to improve them. Some told stories about the time and effort required to get improvements through an administration that didn't seem to be listening to their suggestions. An improvement in electrolyte measures suggested 2 years ago went into beta-testing two months ago.[45] A hospitalist at the Pacific campus reported having to work for about 5 years to persuade the hospital to invest in software for medication reconciliation--a safety measure still problematic, but an improvement over the previous, paper-only version, described by one physician as having been "100% inaccurate."[46]

Top-down:

In the last few years CPMC, under a new director of quality improvement, has committed to a process improvement methodology known as 'kaizens'. Not all the workshops are specifically directed to hospitalist procedures, but as the workhorses of hospital processes, many of those interviewed had been actively involved in workshops, some in more than one; and all respondents had observed, and many commented on, both the processes and their results.

This latest methodology (termed "the method *du jour*" by one physician) is explicitly directed to improve efficiency of processes, not quality of care, as one physician noted.[47] And it is intended as a "lean" program: the stated objective of the week-long workshops is to "improve the process at *no increase in cost.*"[48]

--The process sometimes required the addition of a "team of consultants with clipboards"[49] to an already-chaotic unit, exacerbating the work-flow problems.

--Some improvements in process--as the above mentioned bottom-up suggestions for improvement in medication reconciliation, or a desire (expressed below) for help with medication reconciliation --can't be implemented without cost.

--The implementation of the results of any particular kaizen was

. occasionally sporadic: either it didn't help, or it was not consistently adopted;[50]

. and occasionally not even attempted.[51]

Although the hospitalists interviewed are clearly concerned with improving processes, as their concern with workflow reveals, some expressed suspicion or skepticism about the kaizen process. For those involved, it consumes a great deal of that scarcest resource, time; and there was a pervasive worry that a lot of time and effort (and pay to outside consultants) was being expended upon something that might miss its objective. Is increased efficiency an end in itself, or a means--an important means, but just a means--to the end of improving patient care? The people who had been most involved in the most kaizens were the most skeptical. Several (3) reported having 'burned out' on the process; some changed shifts to avoid them.

The source of some of the many and varied quality initiatives introduced in the hospital over the last few years is not always obvious, given the complexity of the organization and its many layers of accountability. One of the cornerstones of the original Toyota methodology requires involving the front line workers in the process of identifying problems and appropriate solutions, but it was unclear to several of our respondents to what extent that grass-roots part of the process was respected in its application to hospital management.[52] It was unclear whether the topics for kaizen attention were issues isolated for attention by the front line workers, or introduced from the corporate level, designed to encourage uniformity across Sutter institutions.[53] It was also unclear how and to what extent the results of the workshops were communicated back--or at least, communicated in such a way as to make the adoption of the suggested solutions natural and inevitable. Respondents reported occasional "pearls" emerging from the process; but frustration was more common than triumph in the interviews.

One physician, citing repeated frustrated attempts to introduce multidisciplinary rounds in the Pacific campus, suggested that not every process, however valuable in theory, was necessarily possible in every environment.* One physician suggested that attention was being diverted from the things that were idiosyncratic to this flagship institution (like the residency program) for the sake of common-denominator templates inappropriate to the setting.* Some of the initiatives--such as the current well-received pilot of call-back to patients--are introduced by the hospitalist group, but it is not clear how many of the 'quality initiatives' have this very important grass-roots buy-in.

Who is the judge of the quality of care? One hospitalist expressed a concern shared by the researcher: "We aren't making cars here. We're looking after people."[54] Why hire excellent physicians, and then tell them how to do their job?

Some specific issues:

The educational mission

Among the things that set CPMC apart in the Sutter family, the educational mission is one that is valued very highly--by the hospitalists who came from that program, a third of the participants--and by the hospitalists that contribute to it, a half of the participants in the research project. Currently hospitalists consider themselves responsible for the bulk of the education of residents and students, although they are not convinced that their contribution is always appreciated. Some of the people most involved in the program were very articulate about their fears that the commitment of the institution to that program was weakening--fears either resulting from, or contributing to, recent dramatic turnover in the leadership of the program.[55] For that percentage of those interviewed who were themselves products of the program, the concern was particularly intense. One of the major contributors to their high opinion of their choice of specialty was attributed to their respect and admiration for their mentors in the program[56]--"They were just the most amazing doctors. When I was a resident, they exemplified what I wanted to get out of my career." Several people who had been through it (3) returned to CPMC from better-supported hospitalist positions out of affection for the program.

Patient satisfaction

One of the most unfortunate developments in medicine in America is the interpretation--or mis-interpretation--of the IOM's recommendation, in its 2001 report on quality in medicine,[57] of "patient centered care" as a demand for attention to "patient satisfaction." The latter is a consumer-oriented concept, more appropriate for hotels than hospitals; but despite its irrelevance to patient outcomes and to quality of care, measures of patient satisfaction look to become embedded in the quality measures by which institutions and individual doctors are evaluated nationally.[58] As of October 2012, CMS is reported to be reducing by 1% the base operating DRG payments to hospitals to create an incentive fund. How this money is distributed to hospitals will depend on their performance on several quality measures, an astonishing 30% of which will be based upon how patients rate their hospital stay on a patient satisfaction survey.[59]

There has been a great deal written about the difference between "customers" and "patients", and about the subjectivity of "satisfaction" criteria and their dissociation from outcomes and service quality,[60] as well as from safety, effectiveness, efficiency and equitability, competing goals of the IOM report. For hospitalists, there are particular problems with this anticipated link of patient satisfaction scores with CMS reimbursement policies, stemming not only from idiosyncrasies of the instrument itself, but intrinsic to the nature of hospitalist medicine.[61]

The hospitalist on service on the day a patient is discharged is the name associated with "the physician" for that patient's hospital stay--in the metrics, if not in the mind of the patient. Any given patient may have been under the supervision of, and had interactions with, anywhere from 3 to 20 hospitalists, depending upon the length of stay. The discharging physician may, or may not, have been one of them, save for the moment of discharge.[62] The survey on which the metric is based, currently a Press-Ganey document addressing a relevant subset of 70 possible questions in 9 categories, is mailed

to the patient two weeks after discharge, and has a return rate that varies from 13% to 25%. The topics addressed include the room and meals, and 7 questions address the respondent's satisfaction with the physician, including the time spent with the patient and 'friendliness and courtesy'.[63]

The almost-universal criticism of patient satisfaction as a criterion for quality ranged from its philosophical presuppositions to its practical applicability. The number of responses is statistically insignificant; the results are difficult to interpret and impossible to link to appropriate providers; there is no way to account for confounding factors; satisfaction is associated with expectations, and people's expectations may have little to do with what is possible--or with what is medically appropriate care.[64] The call-back initiative from the group is being piloted to see if it will have any influence on already-unreliable patient satisfaction scores. The initiative has not been in place long enough to tell if it will be useful as a means to that end, and considering the unreliability of the patient satisfaction scores in general, that question may prove irrelevant. Whatever its usefulness as a means, as noted above, patient call-back does seems to be viewed as appropriate and generally satisfying as an end in itself: potentially time consuming, but a good thing to do.

Currently the group has been able to exclude individual ratings associated with patient satisfaction from their negotiations with the administration, but there is some concern that in the future, as in some other hospitals, those scores, however inappropriate, may become more important in contract negotiations.

Medication reconciliation

Medication reconciliation is crucial at all transitions, particularly admission and discharge, and getting it right is important to the hospitalist. At admission the information must be accurately acquired, in order for post-discharge medications to be appropriately managed. Both patient safety and readmission rates, important for both the individual physician and the institution as a whole, can be negatively impacted by errors in this process. If the information entered at admission is in any respect incomplete or inaccurate, the recommendations of the discharging physician can, without careful scrutiny, perpetuate those errors. Physicians at every stage of the hospital stay collate, supplement and correct this initial information; and the discharging physician, who ends up with h/h name attached to the record, is wise to check it again, for accuracy, for drug interactions, for completeness.

Collecting the information at admission, whether through the ED or on the unit, can require research and collation from at least 6 sources: the patient, who usually knows their home med list, but not always; the family, often helpful at establishing an accurate med list, but not always; the primary care physician, who is usually accurate, as long as the office is open; the specialist, if the patient also has a second outside physician; and the outpatient pharmacist, assuming the pharmacy is open and the patient doesn't use a mail-order pharmacy. The previous chart can also be helpful, assuming the patient is within the system and the last visit wasn't too long ago. [65]

The amount of time required at every transition to a different level or site of care within the hospital and at discharge depends upon the accuracy and comprehensiveness of the medication list, and several of those interviewed had been at other hospitals where with either the acquisition of the initial information or with ongoing and discharge

medication reconciliation, the hospitalist had additional support --from non-physicians, whose job description included the initial acquisition of a medication list, checking it with all possible alternate sources, (2), and/or from a fellow professional, a pharmacist or pharmacy resident, checking for accuracy and potential errors or drug-interactions through the course of the hospital stay and before discharge(3).[66]

The potential for adverse drug events in the institution or after discharge is a subject for national concern,[67] sometimes estimated as accounting for 60% of medical error. The process at this institution improved with the introduction of a software program (see fn 37), which will itself probably be replaced by something in EPIC. But national data suggests that software alone is no solution to this important problem.

Institutional identity

Mergers of separate institutions into health care systems throughout healthcare have had an effect on organizational identity and organizational integrity across the country as the industry consolidates. That organizational moral distress seems to be hitting this hospital this year, more perceptibly than in previous decades.[68]

The people interviewed for this project, half of whom had been at CPMC for over 10 years, identify strongly with their institution. They lived its history, informed its traditions, consider themselves as much a source as a beneficiary of its reputation for excellent medical care. When they say they love the job of hospitalist , what they love is how that role has developed at this institution--their residency, in some cases, or their years working closely in the hospitalist group with colleagues they admire. If they worry how much longer they will continue to do it, they are reacting, not to their past experience, but to the impact of present changes in practice on the expectations formed by that experience. To what extent is CPMC continuing to retain its autonomy, its individuality, under pressure of increasing system consolidation?

Some of the issues discussed above express that worry: Concern about support of the residency

. Administrative reluctance to add support for an increasing work load. Less interest in their suggestions for how to improve that work, in comparison to the suggestions of outside consultants, with initiatives designed to increase system-wide standardization. To what extent are matters of professional practice and medical decision making being punted to regulatory and legal, rather than ethical, default systems? How much of how medicine is practiced in the institution is determined by its physicians, rather than externally imposed?

Various hypotheses were forwarded for the lower morale: National changes in regulations and reimbursement. A greater focus of attention upward, toward corporate, than downward, toward the patient-physician level of medical care. Changes in various parts of local administration. Most discouraging to those interviewed: a sense of a reduction in the importance of, or in the model represented by, CPMC within the Sutter family. They have, with some justice, viewed their hospital as a model for emulation. Will the demands of system integration force them toward a lower, a common-denominator, standard? To what extent is CPMC continuing to retain its autonomy, its individuality, under pressure of increasing system consolidation?[69]

Trust in the numbers and the ethics of metrics

The problem with 21st century medicine is that the institution the hospitalist serves has not only to provide excellent patient care--it has to be seen to provide good care. To be seen to be providing good care, there has to be documentation, empirical evidence that good care is being given.

Currently there are various criteria--metrics--that are being taken to be surrogates for excellent care. Some of them--bedsores, falls, vaccination checks--measure medical effectiveness.[70] Some of them--ER throughput, time-sensitive charting or call-backs--are service quality metrics, measuring efficiency. Others -- criteria for maximum reimbursement rates, case load, utilization data--have implications for the financial and economic viability of the hospital. But the justifications are different, and can be at odds[71]. The 'best' patient care in terms of outcomes for a particularly complex individual patient may be a lengthy hospital stay with painstaking, time-consuming trial and error with different treatments, which while effective, may not be particularly economical or efficient. Outcomes, save for the Final Solution of mortality rates, are notoriously hard to measure. Efficiency and cost containment are much easier to quantify than effectiveness.

Increasing demands for documentation are an important factor in hospitalist morale at this institution at this time. For the hospitalist, there are two important questions: Is this metric trustworty? Is it reliable? And the other: Is this metric relevant to my role in the institution? Is it validly associated with excellent patient care?[72] That the hospitalists are struck by, and often oppressed by, the amount and kind of documentation required of them was obvious in all the interviews. More disturbing was the extent to which respondents considered some of the information that they were required to spend time accumulating at best irrelevant to patient care, and at worst misleading.

Data is ethically neutral. Ethical problems can arise with how it is collected, and in how it is used. It is a valid source of institutional concern if the physicians do not trust or value the metrics. If the data collected is unreliable, it is of no use to the institution, and does not contribute to whatever goal, be it effectiveness, efficiency or financial viability, for which it is a surrogate.

How it is collected

The most unreliable data collected by the institution, the patient satisfaction data, discussed at length above, is not collected by the physicians. The admission medication lists, also discussed above, are.

For reasons discussed above, the admission data on medications can be unreliable simply because it is not available to be gathered. But if the computer, via a hard-stop, insists that it a box be checked saying it has been, there is a sense in which unreliable data has been forced to be declared valid. Because the hospitalists, via their rotation to all shifts, have been on each end of the process, the discharging doctor, often on a different shift or a different campus, knows the problem; so the information is checked and re-checked. But there is a lingering sense of resentment that the colleagues have been forced, by the situation, by time-pressure, and by the system itself, into lying. It is a testament to collegiality that the distrust remains impersonal and doesn't undermine group cohesion.

This "verification under duress" applies to other element of the admission record, particularly anything affected by a computer hard-stop. Although the research to date has inadequately explored the extent of the problem, anecdotal evidence from interviews suggests that DNR status, the influence of family history, and confirmation of examination of 10 physiological systems have been equally affected.[73]

The duress that affects the reliability of data is not confined to computer stops on admission data. Work load and work flow create time pressures in the course of daily care that can make busy physicians feel that they must choose between patient care, which affects outcomes they value, and its documentation--between providing excellent patient care, and providing evidence that they have done so.

How it is used

Metrics can be neutral, or even useful, in suggesting ways in which service quality in an institution can be improved. It becomes more problematic when tied in with financial incentive programs, which create potential conflicts of interest or commitment in individual practitioners.

Pay-for-performance initiatives, in the form of penalties or bonuses are already in place in this institution, and look to become more widely entrenched.[74] As noted above, patient satisfaction scores, currently excluded from contract negotiations, may be included in the future, presenting a particular problem for hospital medicine. Pay-for-performance is viewed with particular indignation by its critics: it somehow presupposes that the primary motivator of the professional is monetary, and that excellent professional practice needs to be externally and extraneously motivated, rather than part and parcel of an intrinsic professionalism.[75] And tying metrics to incentive programs has not been shown to improve outcomes.[76]

Readmission data is viewed as questionably related to excellent patient care[77] especially insofar as it is "all cause" data. As one physician suggested, readmission rate as a metric is problematic in itself, when interpreted as an outcome measure. A patient whose serious condition has been treated and is sent home healthy and happy may be readmitted before 30 days for an entirely separate condition--a car accident, a case of the flu. But if readmission rates, for which either the hospital or the discharging physician, or both, may be penalized, is "for any reason" it is an inappropriate metric, for its failure to accommodate the possibility of independent causation. Admission #2 may have nothing to do with the precipitating cause for admission #1--but may be counted as if it did.

Patient call-back rates, as noted above, are unreliable as an influence on patient satisfaction rates, although they may be a better surrogate for patient satisfaction than any of the current alternatives. One obvious question is whether the data is controlled for 'attempts to call back.' Their use to impact physician reimbursement is unfair to physicians responsible for at least two obvious patient populations: the unbefriended, homeless or unbephoned patient; or, equally problematic, the busy, returned-to-health members of the workforce, who screen their answering machines and are never home to be contacted.[78]

Length of stay can be an unreliable metric, if measured from when the data hits the computers, not from when the patient actually leaves the hospital, and unfair, if discharge is delayed past reimbursed time for medical reasons,[79] or if the physician can't track down the necessary relevant information before the recommended time for

discharge. (Cf. fn 28) One physician commented "Length of stay is calculated from when it goes into the computer. The actual date of discharge can vary by two days." The patient is not disadvantaged; there is no effect on patient care. Is LOS important to the individual hospitalist, or to the institution? If it is a factor in individual pay-for-performance reimbursement for the physician, a physician may opt for time over money, entering the data into the computer after the weekend (cf. fn 25), or only at 10 pm when the phone alarm goes off --which is fair enough. If it is important for the institution, it is a financial question, not a measure of quality of care; and the physician is being pressured or penalized for something that is more important to the institution than to either the physician or the patient--as if it were a marker of quality of care.

Even if metrics are ethically managed in terms of the version of 'moral hazard' that ties them inappropriately to incentive programs, there is an ethical question in the distribution of responsibility: if the hospitalists are under increasing time and work pressure for documentation for economic reasons, the institution, to whose advantage the benefit accrues, should share in the cost of any additional staff and support required.

Trust in the data among those interviewed was not overwhelmingly high: not only in the data provided them by other busy practitioners, but heartfelt concern that their own data, as the workload increases and the workday lengthens, might be increasingly subject to human error. As one physician remarked, "There's no evidence that what I've been doing so far has been wrong"--and there is no unambiguous evidence that the initiatives being introduced in the name of improving patient outcomes are better. Underlying their suspicion of some of the performance data being collected by the institution is a concern that trust in the data is gradually replacing trust in the physician.

Conclusion:

Insofar as this research project was designed to explore physician dissatisfaction with their working conditions, the numbers are not that bad. At least one third of the respondents can be fairly described as 'very satisfied.' Another third considered their own morale to be fine, but worried about some of their colleagues. Another six to eight had explicit (and sometimes passionately expressed) grievances about one aspect of their work, hoping (as does the researcher) that they might be transitory, or remediable, or exaggerated. So may it prove. If the results are to any extent discouraging, it is at least in part in contrast with the "golden age of hospitalist medicine," which at CPMC, as in the rest of the country, may lie in the past, not the future.

In 1984, historian Barbara Melosh published a history of nursing in America called *The Physician's Hand*, a book that appeared about the same time as philosopher Andrew Jameton was introducing into the nursing ethics literature the concept of "moral distress." The title encapsulated grievances of a group that had viewed itself as too long denied an independent professional identity, and "moral distress" became associated with the frustration and burnout arising when they were confronted with externally-imposed obstacles to ethical practice according to their own best professional standards. Two decades later, hospitalist physicians striving to practice medicine according to their own best professional standards are beset with increasing demands for documentation of efficiency and cost-containment that compete with patients for their attention. It is not surprising if some of them begin to feel as if they are not so much the patients' doctor as the hospital's hand.

The HCAHPS survey of patient satisfaction that may eventually replace the much-reviled Press-Ganey survey asks only three questions about the physician: Were you treated with respect? Did the physician talk to you? Did the physician listen to you? An ideal physician satisfaction survey might well be modeled on this stripped-down version: Does your institution treat you with respect? Does it listen to you? Does it talk with you, or just tell you what to do?

Endnotes

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[1] Amin AN (*2004):* The hospitalist model of care: A positive influence on efficiency quality of care and outcomes. *Critical Pathways in Cardiology 3* (3) S 5-7.

[2] "There were roughly 800 hospitalists in 1995, 1500 hospitalists in 2005, and an estimated 30,000 will be practicing by 2010." Simone KG (2007): *Hospitalist Case Studies: Tactics and Strategies for 10 Common Hurdles.* HCPro, Marblehead MA; p. xii.

[3] Pololi LH, Krupat E, Civian JT et al (2012): Why Are a Quarter of Faculty Considering Leaving Academic Medicine? A Study of Their Perceptions of Institutional Culture and Intentions to Leave at 26 Representative US Medical Schools. *Acad Med 87*, 859-869.

[4] Interviewer: "What do you like about it?" Interviewee (with big grin): "Acuity, diversity, flexibility!" (#14)

[5] Both groups have a sub-group called 'nocturnists' who work only nights; the regular members rotate on night shifts to provide coverage and oversight of several units. The specialist group of 8 physicians, for instance, also employs 3 nocturnists, at 2.5 FTEs; the generalist group has over 20 'moonlighters' for nights, vacation and weekend coverage, none of whom were *[as yet]* interviewed for this project.

[6] Interviewee, comparing the present with the glorious past: "You know, morale had been so good here for so many years! I came here from [another] hospital 10 years ago, and I felt like I had died and gone to heaven. Honestly. I came here for the people, for the practice environment, a lot more common sense in the air-- It was different then." (#22)

[7] "I did end up going into primary care for 7 or 8 years. I enjoyed it, but it was sort of like joining the Peace Corps. It's a really hard job that you really like, but you just can't make a living at it." (#1)

"I was [a specialist] before I took this job, and in the 6 years I was doing that job I rarely had weekend coverage. And I was also working at 3 different hospitals as a solo practitioner. Sometimes I had people covering me for vacations, and that was obviously rare, but basically I was on call 24/7. I had great continuity of care, but it was really not a viable model. It burned me out, and now I'd never go back to that. So I quit that job to take a hospitalist job...and took a huge pay cut on top of it..." (#8)

[8] " We're asked to take on lots of these responsibilities so the hospital can meet these various demands, without any concession given on their part to help us staff up to meet those demands." (#23)

[9] The group of 8, SPMS, operates only on one campus, a logistically simpler arrangement than that negotiated by the larger group. It also has a rather different relation to the hospital, as employees of the Foundation.

[10] --And it became clear during interviews, although not something I asked about, at least 1/3 of the people interviewed had been or were presently active in group administration. "Democratic" was a term frequently used about group procedures, as was "autonomy."

[11] ..."I think the underlying issue is that the administration would like our group to come directly under direct employment of CPMC [instead of having our own company to contract with them]..." *Why?* "More control, and they can pay us less. That's why. Control, and cost." (#1) The specialist group is already employees of the Foundation.

"In my last job ... in the period I was there, about a year in or so, we went from being a kind of privately owned group --it wasn't as democratic as this group is, but as a peon it didn't make a tremendous difference to me--to employees of the hospital foundation. But I will say that as that change happened, I noticed a trend toward feeling there was less at stake in the decision making process. So having moved from that type of climate to this, I have to say that I really appreciate that least up until now we've been in a situation

where we can, within reasonable limits, make more of our own decisions. Even if the decisions aren't great, they're at least transparent and democratic." (#23)

[12] "There's constantly a threat -- I think this is true of all hospitals -- of big hospitalist companies coming in and underbidding us for the contract to be the hospitalist service for the hospital. And the threat is that the hospital is going to take that contract with a bigger group, and bring them in for less money. And what that ends up doing is destroying the relationship...You know...what they are basically doing is basically slapping us in the face and saying 'you're not worth it' and taking the other group." (#17)

[13] "Compare [this unit] to 1 North: a glass-enclosed room, where physicians, nurses and therapists can all use one of 16 computers--I don't know how many computers there are, but it's a lot more than here." (#3)

"I just feel like the distraction is huge, doing all these things is huge." (#19)

"What I've been begging for is a physicians's work room where we could have the tools we need without the interruptions. There's been tremendous resistance to that." (#2)

" There's a tremendous amount [of distraction]. It really reduces your efficiency and I think interruptions lead to errors, or it could." (#11)

[14] "We have a computer workroom, a physician work room, on our floor, and that's not true of all floors. We did a lot of moving of chairs on deck, so we found a room, so now we have a workroom close to the patients but not ON the nurses station... It's a huge boon to the quality of life where the inpatient physician has a place they can go where they are not peppered with questions, so they can focus." (#5)

[15] "Well, for day to day frustration, the EMR should be shipped to the Smithsonian. It's old and counterintuitive and clunky and slow." (#3)

"When I came to this hospital I almost walked away, because the computer system they use in this hospital was actually rolled out in a hospital that I was training in in 1985. And it was so bad that the interns went on strike and refused to use it because it couldn't be taught to give orders.... It is a very dangerous system, because it begs you to make mistakes.... Now we are hearing that they have a plan to roll a new one out in 2013. But when I started at this hospital in 2000 they told me that it would be done in the next year or two." (#2)

" Obviously the EMR here, the electronic medical record, is horrible--it's an 80s-based medical record system and order system, it's almost in DOS. It's really--and everyone knows that about the system. I think the system's literally dangerous at times to patient care. Like for example not knowing whether a patient has gotten potassium replacement or not--it's not clear. And the system is very very clunky." (#6)

An EMR called EPIC, called by one interviewee "only 20 years out of date instead of 40" (#5) is currently scheduled to be introduced by November 2013.

[16] "Communication. That's a big one... We communicate through an order system called PICEA. We communicate with radiology through their system, called HEP. We communicate with the emergency department through their system, which is called IBEX. We communicate with anesthesiology through their system, which is called PICESE. We communicate through others in the community through their systems, AllScripts or EPIC. So we're not all on the same system now." (#7)

[17] "It's shameful that this world-class institution doesn't have electronic records. Their reasoning was that with the economic downturn they'd have to stop capital projects, and this was the first capital project they put on hold...But still--to provide sub-standard care to your patients by having paper charts--it's ridiculous." (#1)

[18] It's not clear how many patients are in-system, how many out-system; that varies from campus to campus and from unit to unit. One physician estimated 10%; for another, it was closer to 30%.

[19] "ED throughput is going to go down the tubes when everybody's plugged up there, because we can't ge the orders through because we [w]on't know how to enter the stuff, and we're just learning..." (#21)

[20] Referring to a recent op ed (Horwitz, L., *A shortcut to wasted time,* NYTimes Nov. 23, 2012): "So she basically says the EMR and the automation of everything makes you believe less what is being said. You can just click things and not keep up with them. I think the other problem with the EMR is that there's going to be so much information available that it's going to be hard to get through it. It's not compiled enough to make it easy to absorb." (#17)

See also, eg., Love JS, Wright A, Simon SR, et al (2012): Are Physicians' perceptions of healthcare quality and practice satisfaction affected by errors associated with electronic health record use? *J Am Med Inform Assoc 19,* 610-614, which concludes that although 1/3 of the c. 1000 physicians surveyed over a two year period recognized that unintended errors can occur through EMRs, only 2% thought they created more errors than they prevented. Unintended consequences included workflow inefficiency as well as new sources of errors.

[21] "I think it will be more difficult [for workspace] when EPIC comes, because then everyone will be using it; but currently the nurses and the doctors use different systems. " (#12)

[22] "I think the other thing which is very big, and looming, is the roll out of the electronic health record. It has huge quality implications, not to mention patient safety, not to mention provider satisfaction, because it can be difficult. I hope they are going to put resources in. I can tell you this right now, as a hospitalist, we know that we are going to carry a big brunt of that roll out. We are going to be right there. The other doctors are going to ask us to help out, and we should help them out. The administration are going to be considering letting us staff up at least during that one month for that initial roll out, because we know we are going to be more inefficient, we're not going to be able to get to all the patients on time, because we're going to be just getting used to this system that's just come...They just flipped a switch on us, right? Even if you've got a lot of pre-education and pre-training, you know that on day one it's going to be chaotic. And you'd better staff up. And to me that's not negotiable. And yet, guess what? We're not getting support like 'yes, you guys are going to need to staff up, just to make sure...' No. They're just hoping we won't have to. And that to me is absolute insanity. But we're having to argue for that. ... Again, we're fighting, fighting, fighting, and I feel like there's always this slight friction with people on the ground who kind of know what's going on, and the administration." (#21)

[23] In the period of the research there was one resignation and rumor of a second at that campus--unusual in a group that has mainly grown over the last two decades, and that has had a reputation for loyal, long-term members.

[24] More time at the computers means less time at the bedside. One subject noted, "My colleagues joke: 'my patients are getting in the way of my documentation.' " (#6) Another reported a rumor that a colleague on some days did not visit patients' rooms unless expressly summoned. ((#2)

[25] "After twelve days of 12 hour shifts, I need my weekend for my family." (#2)

[26] " We do an amazing amount of work every day that someone with a high school diploma could do. And by that I mean things like getting records from a doctor's office. Knowing what the medication list actually is. Having someone here at night that could potentially call a pharmacy and find out the medications and get the list of it to us. They wouldn't even have to enter it in the record, but if they could just get records for us--- simple stuff that when you're admitting 4 or 5 people and getting called from the ICU you definitely don't have time to interrupt everything and stop and start looking for these things. And I haven't seen that kind of basic support here.

"We had a person on each floor that was basically responsible for things like that. And we could type in an order that would go directly to that person, and it would say, like, 'Please call this doctor and set up a follow-up appointment for this patient...' And it made the patient satisfaction much better--it really impacted the lives of everyone, having those people there who were happy to help--that's what they were there for, and you didn't feel guilty if you asked them to do things..." (# 6)

Requiring expensive physician time for basically clerical tasks, a constantly iterated source of frustration and potential burnout, does seem a false economy. It cuts into time spent on patient care, lengthens the work day, and is an inefficient use of resources. That providing this kind of support is the sole

responsibility of the group, rather than a shared responsibility of the hospital and the group, was mentioned as a problem by many (10) of those interviewed.

[27] " And one of the other hospitalists here--he's been here for a long time--he came up to me and said "Now you're an attending and a resident and an intern." And I haven't been a resident for a long time. And yet here I am And I said, 'yah, you're right--I'm an intern again.' And I can't see the same number of patients; my efficiency's down; and I'm sure that patient satisfaction--which is obviously a huge deal these days--suffers as well." (#6) One of the campuses does have residents and interns and students, and upon investigation it turns out that some of that work can be delegated on that campus.

[28] As a matter of policy, the researcher discussed money in only the most general terms, while time was discussed in great detail. But: during the early part of the research period the annual contract was being negotiated by the generalist group, and one rumor was that the compensation to the group was to be reduced by 10% or more. And the other rumor was that the other group had been working without a contract, on a month to month basis, for most of the year:

"We still have a good group of people, and a good set-up, and a pretty good quality of life; but we've been asked to take on more clinical and non-clinical responsibilities, and actually take a pay cut as well." (#23)

" The administration has been very tight with money, and now we're re-negotiating our contract yet again, and they're trying to decrease our stipend by --let's see--20%. Yet every other department in the hospital has gotten pay raises. Every other employee." (#1) (Not sure how that worked out.)

" There's an increasing push to become employees of the hospital foundation. [The other group] are employees of the Foundation... They would like us to do that, because they could have more control...With the foundation, there's no collective bargaining. So you know what happens, is that all of a sudden they just dictate the terms to them, this is the contract, we won't renew your appointment unless you sign, and they say 'we're not signing the contract,' and we hear this all the time. You know.. "they gave me some bogus contract, and I haven't signed it...I don't know what's going to happen with my paycheck...." (#22)

" Well, we're in the middle of a contract negotiation and I would say morale is pretty low right now. It's just a constant battle.... Our last contract was two years ago, so we've been on extension since March. We've had no contract, just month to month since March. Just trying to get non-physician administration to understand what we do is like pounding your head against the wall, it's very frustrating." (#20)

[29] " And--as I understand it, the [case managers] have really changed their roles a lot recently, and they are being asked to do things that they have never had to do before, things that have nothing to do with discharge, things like meeting in-patient criteria, etc., things that have nothing to do with getting them out the door. So lots of cases just sit around waiting...so a lot of people stay here a couple of extra days who don't have to be in the hospital any more... " (4)

[30] " Another thing [in that other hospital] that worked really well to help with the efficiency of hospitalist work -- and again, this is kind of a simple thing, it wouldn't cost a lot to implement-- In the chart we had a nursing - physician communication form. And this is a form that the nurses can use--it's not a part of the medical record, but it's a form where the nurses can write down information about the patient that is non-urgent, so they can avoid those countless pages and telephone calls to the doctors when it's really something that can be dealt with within the next 12 hours, and the physician would initial it when he had seen it. It could be something like 'the patient's family would like a call from you; this is the number you can reach them at.' It could be things like 'this patient's potassium is low, but it's not dangerously low; why don't you look at it tomorrow?' And it made our workflow immensely more streamlined, just to have this way to communicate without having the constant calls. Made their lives a lot easier as well." (#6) The 'constant pages and telephone calls to doctors' were a source of frustration to most hospitalists interviewed.

[31] " Often I don't know who is in charge of which patient. The list [of case manager assignments] doesn't come up until 9, 9:15, they stick it up on the board somewhere, and there's a whole lot of papers, I have to shuffle through to find out who is assigned to my patient. .. . So when I ask the charge nurse, they don't know who the case managers are, it'll be here after nine. I say 'where?' They say 'there.' But when the [assignment sheet] comes, there are tons of papers for everyone, for hospitalists and interns--I have to

literally shuffle through all the papers to figure out which is the right paper. It takes forever. It can be a lot." (#15)

[32] " Other things that would help, having worked in other hospitals: that nurses carry their own phone. Right now, only charge nurses have a phone. By now I know many of the faces, and I know who Lisa is and I can run around the floor and find her; but when I was new, they put the name of the nurses up and I didn't know who was who." (#15)

[33] " Yeah, at my old job which was a long time ago, we had an electronic medical record and I used to just be able to dictate everything and the billing was handled through the hospital. So, they would go through the chart and handle the billing. So I didn't have to do any billing or coding then; I could just dictate my notes, which took a quarter of the time I spend now where I have to write my notes. It's a solvable problem; it's just that Sutter hasn't really put the resources into getting us what we need.... If you took away billing completely, they would have to hire a ton of billing encoders for the hospital which I'm sure they would never do. It would be really expensive for the hospital." (#20)
" It would be nice if we could find some way that someone to do our billing for us, but again I'm not sure you can do that without have someone with medical expertise. You'd have to pay for that. " (#14)
" I mean, like, coding--who ever expected a physician to be required to do the coding and submitting it to the insurance company. I mean, you spend so much of your day on the documentation and all of that, that you spend more time writing in the chart than seeing the patient." (#13)

[34] Anecdotal evidence from a CPMC patient suggests that if a patient calls her CPMC pcp with a problem, the physician may suggest that the patient proceed to the ED for overnight evaluation. For the patient of an in-system doctor, the patient record may be readily available. But not every referring physician is a CPMC doctor; and not every patient coming through the ER has a primary care physician.

[35] "When we have patients that are diverted ...--the ability to get information from other hospitals, pharmacies--we get a lot of patients transferred from the Oregon border for strokes now; we get patients from Sacramento, they've cut off their hand and have to get it put back on now and there needs to be medical consultants-- so the ability to get information at this hospital has traditionally been something that requires individual, minute by minute step by step effort for the physician . I don't really need a physician's assistant; I need a gopher. Can you go for this now? I need you to go for that...Can you Google, based on this person's town and this person's last name--can you find the primary care physician for this patient from Medford, or Clear Lake, or Lake county--all these folks that are from out of town, we have inadequate information. It pretty much causes sub-standard care, because nobody has time to basically do the leg work to get that information. It's not in the job description of case management--at least it isn't here... And you could ask why we're ordering tests for someone who was a patient at SF General and had an echocardiogram two weeks ago--we're going to order an echocardiogram here; the technician is going to do their job and get paid, but the hospital is not going to get reimbursed because it's a MediCal patient. So a lot of the duplication that is costing the hospital money could be improved by streamlined transfer of information that doesn't require a doctor to do it."

[36] " ED throughput was another thing. Get your orders in as soon as possible so we can move them up to the floor, so we did that. Then there was a problem with, like, 'well, you can't put people on observation if they don't qualify,' but you've got to get the orders in; now they are telling us we've got to commit to obs or in-patient right from the start. That's at loggerheads with ED throughput. You want me to get the obs status right, but you want me to move the patient up quickly; but then I don't have time to assess the patient, and decide if they are appropriate for whatever status. If you want me to get it right, then give me time to get to know the patient, get a proper history and physical. ... Am I going to get them through the ER faster, or am I going to get it right? Which one?." (#25) This physician, a long-term CPMC hospitalist, had been involved in kaizens on both ED throughput and observation unit intake (as well as 4 other kaizen projects), and reported high burnout with respect to perceived reduction in physician autonomy.

[37] ". I got a new patient today. Before I could do research about the patient--on our computer we have the patient, we have the labs, and the results of radiology--before I could do anything else about that patient, get any data on them, I have to click what their code status is.... They have created a kind of system for the computer...One of the things they've done over the years...If you are going to use the computer, which you clearly have to do if you are going to see patients, over the years they have created hard stops. You can't go further unless you address that issue. So they've created a lot of hard stops." (#18)

[38] "Do they really need a physician to verify immunizations? Having us do vaccination screening for all patients should not fall on the physician. " (#18)

[39] " We developed a progress note that we were supposed to use for the observation patients to help with communication that seemed like a really good thing, but it's been hard to get people to use it. But the other thing that I found out is that people aren't getting put into observation as much as they used to be. Because the other element of that is that what people need to be identified and qualified as an observation patient is a complicated insurance algorithm that is based on the objective data that they have at the time they are assessed in the ER that determines if they are going to be obs. And if you get that right, turns out there aren't that many obs patients. So it's been very hard to disseminate the use of this progress note that was supposed to help with their care, because it doesn't come up as much as we thought it would. So that was disappointing, because we put a lot of effort into it." (#25)

On the observation unit and patient satisfaction, see Chandra A, Sieck S, Hocker M et al,.An Observation Unit May Help Improve an Institution's Press Ganey Satisfaction Scores. *Critical Pathways in Cardiology 10*, 104-106, 2011.

[40] " The [kaizen] I'm thinking of was on the geographic location of patients. Which has been a real issue. We had been able to get one team, which we called team 5, to get all of their patients on the fifth floor in this one area. And the way we kind of made that happen was that we realized that the admitting team could actually type into the ER computer system that they want this patient on team 5, and on the fifth floor. And that worked out well... It's not translatable to the entire hospital, unfortunately." (#25)

[41] "An example of one [p4p requirement] that I think is kind of silly, they just e-mailed us saying we're going to have to -- you know you have to call the primary physician when you discharge someone, and that's really important, that's fine; but they just told us that oh, by the way, we also have to send a fax to the primary physician's office. And I said--'that's kind of silly--why do I have to fax him if I just hung up from calling him?' 'Well, we need it because the hospital is going to be tracking that.'" (#4)

[42] " There are some things that the doctor has to do, like talking to the primary care doctor. The doctor talks directly to the doctor. But Googling the person, trying to find their phone number, calling their office, getting put on hold for 5 minutes, working through the phone tree--it can take me 10 minutes to get to the person, and that doesn't sound like a lot, but figure that times 5, it's almost an hour, and that adds up." (#4)

[43] " Like: calling patients back. After a patient is discharged you have a certain number of days within which you have to call them and see how they are doing. And you actually get graded on that, and the grade affects your income. So you might think that counts as spending a little more time with your patient. But you're not. You're actually spending time getting to the computer where all the information is, getting the patient's name and phone number, tracking them down, calling them, having them call you back, ... that's very time-consuming. And it's hard to know if it helps... And like I say--patient call backs can be useful, and that may eventually lead to better patient care. But it's hard to say, compared to time spent at the bedside." (#14)

"I think the doctors actually like doing it for the most part. We worried that they wouldn't like it, it was an extra thing they'd have to do they weren't doing before. The patients are pretty appreciative. The whole thing is a positive thing, actually. But when you look at the [patient satisfaction] numbers, ... it doesn't really change the scores." (#11)

[44] "There are just so many initiatives, all at once--it's like ADHD. What are you supposed to concentrate on? ...Pick one procedure, get it settled in, and onlythen move on to the next.."(#)
[45] " I try to do things to make things better according to my perception, until someone says you have to go to a committee to get it done...Sometimes it takes more time than I would like. That electrolyte protocol I suggested 2 years ago finally got approved as a beta-test two months ago." (#5)

[46] " I worked on medication reconciliation, which at some point was a Joint Commission requirement, but then they took it off because it was so difficult. I worked on that for years, and we got to the point where we got an electronic solution to help us, but I really had to jump through a lot of hoops to get it done, and the resourcing was initially not approved, even though the amount was not very big and the problem is gargantuan." (#21)
" They have a slightly better system that is now in place because it's computerized, but it's only helpful if the information that is put at the front end is correct, but often it is not. Because either the nurses--it's the nurses' job to do it--and some of them do a great job, and some of them do not. So at the discharge end, I'm the one, if I want to make sure it's done correctly then I'm the one who has to do it. So I fill out the paperwork, but then I sit down with the patient and go over it all, and that takes a lot of time. Some of the patients can have as much as 16 medications. So I would love to have a pharmacist that could work with us, and do that end of it, and the patient education." (#4)

[47] "I've participated in half a dozen of those kaizens; been a vocal member. And I've yet to see an actual focus on quality. I don't think there is a focus on quality. They're focused on efficiency. Which is a good thing to do--but I wouldn't call it a quality program." (#22)
Another respondent was even more skeptical:
" It seems to me that the initiative projects, these changes, are driven by financial things, and it seems that they are not really driven by an interest in improving patient care." (#18)

[48] " When you go in there they say 'by the way--the recommendations we make can't cost any money.' That's the stipulation. There are some exceptions, for minor things like nailing a sign up on the wall that says 'remember to do'...all these ridiculous things. They'll make an exception for that. But in general, the ground rules are don't spend any more money on that sort of thing. And it does make you think 'of course we can't spend any more money, because the hospital has already spent all the money on these damned consultants.' " (#22)

[49] "' And when they see you walking around with a kaizen group, everyone kind of gets---You know, these folks, they walk around the hospital, they observe, they take notes, they stopwatch things--and people get a little on edge, and they think, "what are you going to think of next?" (#22)

[50] " Our problem is that we're doing all these kaizens, we develop a standard work, we don't dedicate enough time, effort and maybe resources to then rolling out the work across the organization to all the people who then have to implement it. And then making sure that over time it is sustained....
"The model may not necessarily be a bad model. I think that what we're not doing is implementing it over the continuum. You can't say you're making quality improvement by just doing a workshop identifying a problem and developing some standard processes that you want to change. A process is only as good as your implementation and the stability of the process. So if you've found a process that you've identified, you need to then go roll it out in a systematic fashion and make sure it's getting done over and over again, so that it's engrained in the institution as a new process. I don't think we do that part very well." (#21)

[51] "... I've sat in the meeting after the kaizen, where you sit with the big dogs? And it's like 'well, the kaizen recommended this, but we're not going to do that; we're actually going to do this, that and the other thing, because that's what we really need to push.' So it becomes clear that ...yah, sometimes you pull some ideas from there, but it's a bit of a hoax, too, because you're using it as an excuse to do what you were going to do anyway. It's kind of the enforcement arm of things." (#22)

[52] " Top leadership may identify some of the priorities for the institution; --and I'm not sure if it's systematic, but to my mind at least there should be--a bottom-up method for filtering up concerns that people have... So I hope that other departments have a way that they feel that they have to filter and bottom up concerns of things they think might be or should be considered for the agenda of the year for quality improvement. But I don't know if there is a systematic way for that. ... I don't know that people have knowledge of how to act as inputs to this new system we're trying to use." (#21)

[53] " [Multidisciplinary rounds] may be a Sutter initiative, in fact. The corporation. They want multidisciplinary rounds to have happened on every patient in the hospital. ..And the place that the administration kind of immediately goes to to have that done is to the hospitalist group. Let's have them do it. Let's let them be kind of the guinea pigs for the hospital. Let's let them figure it out." (#17)
" I think [Sutter] tried to take a one-size-fits-all approach and I don't think it's necessarily appropriate for every institution." (#24) But the respondent then added, "but that's a minor complaint and I think it's a reasonable thing to do."

[54] See Rorty, MV, Mills A (2002): Total Quality Management and the Vanishing Patient. *Business Ethics Quarterly* 12/(4) 481-504, 2002.

[55] " We lost our residency director. Internal medicine residency director, [PR]. He was fantastic. He took the residency program here from a really crappy place that couldn't fill its match each year to a really top-flight community program that has become actually competitive. He got fed up with a lot of this stuff and took off. We lost the entire leadership; all the associate directors of the program left also. They were left leaderless. Because of, I think, distrust and inability to work with the administration." (#)
" But then there was a breakdown between the residency and the private docs, and the residency was no longer allowed -- that's what they said, "allowed" -- to see the patients of the private doctors... And as time went on there were more breakdowns in the relationship between the residency and the administration..." (#14)

[56] "The co-director of the hospitalist service resigned--he was a mentor of mine. And I was very sad to hear that he was leaving. It has been a big morale hit for both hospital staff and hospitalists. It was not so much a question of financial support, but I think he did not get recognized for his value. And that wasn't fair. He was an extremely valuable member of the hospital and the staff. It's a loss there. He was a central figure, and one that kept this hospital running well." (#25)

[57] Committee on Quality of Medicine in America, Institute of Medicine: *Crossing the Quality Chasm: A New Health System for the 21st Century.* National Academy Press, 2001. Patient centered care is one of five objectives recommended to governing hospital priorities in the future: care should be safe, effective, efficient, equitable and patient-centered.

[58] Kupfer JM, Bond EU (2012): Patient Satisfaction and Patient Centered Care: Necessary but Not Equal. JAMA 308(2) 139-140.

[59] Zusman E (2012). HCAHPS Replaces Press Ganey as Quality Measure for Patient Hospital Experience *Neurosurgery 71*(2), N21-N24.

[60] Gill L, White L (2009): A Critical Review of Patient Satisfaction. *Leadership in Health Services 22*(1), 9-18. The article describes patient satisfaction as an "unreliable construct," (p. 15), with little standardization, low reliability and uncertain validity, and suggests replacing it with 'perceived service quality'

[61] The researcher was complaining to a colleague about the problems with patient satisfaction scores for hospitalists. The response--"Yah, but our obstetricians love them." There is no doubt that they are varyingly appropriate for different areas of medical practice. The emergency medicine literature on patient satisfaction may provide the closest analogue to hospitalists.

[62] "They assign that questionnaire to the doctor who discharged them from the hospital. And if they saw a different doctor for most of the week, it doesn't matter...The patient doesn't know which doctor they're rating." (#18)
"One of the meetings I attend is on patient care. It's every week. The data they track is completely nonsensical. Sometimes they'll say 'look, our patient satisfaction is 95,' or in the 90th percentile, and the N is 3. ...I'd say less than 10% of our patients--no, considering the volume we see, even less than 10% of our patients, even return the survey." (#25)
" (T)he return rate is low, low, low. I work full time, and I may get 15 patients assigned to me, whether they're my patient or not, in a year. And I see about 300 patients, maybe. So [the response on which a patient satisfaction score could be based] is a small portion."

[63] The HCAHPS survey that will possibly replace the current Press-Ganey version has 27 items, three of which address "your care from doctors": How often during this stay did doctors treat you with courtesy and respect? How often did doctors listen carefully to you? How often did they explain things in a way you could understand? The ideal physician satisfaction survey might well be modeled on this stripped-down version: Does your institution treat you with respect? Does it listen to you? Does it talk with you--or just tell you what to do?

[64] "The data is not clean; it is not timely; it is not attributable." (#11)

[65] http://dirkmd.blogspot.com/2010/12/what-is-medicine-reconciliation-anyway.html

[66] " ...One of our jobs is supposed to be to get an accurate medicine list and enter it into that program, that HPS program, and the first step, of getting an accurate medicine list, is incredibly difficult. So if there were some support for actually having a dedicated person to actually get that accurate medicine list, like a pharmacist, that would make this process much safer and a lot more efficient, and I think that all medical care would be better. What ends up happening is that it takes so much time to get the accurate list that you just make your best guess about what it is. And you just click, 'medicine verified.' These are the medicines, and to the best of my ability and in the time limits that I have, this is an accurate medicine list. And so it says 'verified by MD,' but that doesn't mean that it's true." (#17)
" from the little bit I know of evidence for medicine-error prevention, a lot of other systems have dedicated pharmacists or pharmacy residents or people who are kind of specialists whose sole job it is to do that. And frankly, maybe they have the time and the training and dedication to do that, rather than just adding it on to the 50 other things that we have to juggle throughout the day." (#23)
See Kerwin J, Canalis AE, Bently ML et al, Process Indicators of Quality Clinical Pharmacy Services During Transitions of Care. *Pharmacotherapy 32* (11) e338-e347 2012, for a discussion of the potential role of the pharmacist in transitions of care.

[67] The Institute of Medicine devoted a report to the subject, and the AMA has issued a white paper on the topic: *Preventing Medication Errors.* National Academy Press, 2007. *The Physician's Role in Medication Reconciliation: Issues, Strategies and Safety Principles*. AMA, 2007.

[68] This season of *Grey's Anatomy* has spent a great deal of time on the perils of corporate acquisition of a struggling hospital (with an unexpected happy ending).

[68] Cursory recourse to MedLine reveals an extensive literature on the pros and cons of pay-for-performance, and it is unclear the extent to which and how p4p has been instituted in the hospital being studied. The interviews revealed considerable concern about both the theory and the practice. An eminent early critic-now-advocate had this to say on the subject:
"I find myself an extremist and therefore suspicious of my answer. But it is, nonetheless, the best answer I have yet found regarding merit pay for doctors or any group of workers; namely, “Stop it.” [Such pay] is destructive of what we need most in our healthcare industry – teamwork, continuous improvement, innovation, learning, pride, joy, mutual respect, and a focus of all of our energies on meeting the needs of those who come to us for help. We can find better ways to decide on how we pay each other and better uses

for our energies than in the study and management of carrots and sticks." Berwick, DM, The Toxicity of Pay for Performance. *Quality Management in Healthcare 4*(1) 27-33 (1995). Quoted in Wachter R: Pay for performance in healthcare: Do we need less, more or different? The Healthcare Blog, Nov.25 2012. See also Cassel CK, Jain SH: Assessing Individual Physician Performance: Does measurement Suppress Motivation? *JAMA 307*(24) 2595-6, 2012.

[69] " And I think what's happening is Sutter's muscle is flexing more, and the local hospitals are having less and less autonomy.. I get it...But that's a hard thing to do To tell a bunch of hospitals that have been locally run and operated to fall in suit with a more regional mentality." (#22)

" Another issue I think is that above the CPMC level, Sutter oversees other institutions in the West Bay, and I think they are trying to standardize salaries across the various Sutter facilities...so that's led to a push to decrease the amount of support that we get..." (#23)

[70] " There's two forms of metrics. One is clinical metrics. So your rate of bedsores, of congestive heart failure, readmissions--those are clinical metrics. Those all have sound reasons for why we follow them. The binding thought behind all those metrics is that it's just good medicine, to make sure that people don't come back to the hospital, that their medications are put up on time, that they don't fall in the hospital, that they don't have urinary tract infections and so on. So that's fine. So that's one set of metrics that are unavoidable. All hospitals are required to report those; they are required if you want to take Medicare patients, which means every hospital in the United States. Then there are the other metrics: length of stay, cost per case, that type of thing: those things that aren't necessarily grounded in good medicine, but are grounded in the financial economic aspects of the hospital. ... Thankfully, for the clinical metrics, CPMC has been fairly good about supporting physicians, and creating programs to decrease falls, to decrease pressure ulcers, programs to decrease re-admissions. So that's good." (#1)

[71] According to the IOM report, Crossing the Quality Chasm, medical care should be patient centered, effective, efficient, safe, and cost effective--criteria which can be at odds with each other, and require a delicate balancing act on the part of an institution, and good judgment on the part of a physician. The organizational climate is determined in part by the priorities manifested in the mission and values of the organization, and the excellence of patient care in part by the flexibility allowed for excellent physician judgment.

"The increase of demands on your time and the goals of hospital care are often at cross purposed with one another. You want to provide high quality medical care, you want to keep your patients satisfied, but you also want to cut costs and decrease length of stay. Something's got to give in that equation." (#23)

"If you have a [reimbursement]system where you get paid more for doing more, and try to implement more efficiencies, it just doesn't work." (#19)

[72] "Morale is so awful. When I was medical director of the utilization committee, I had a very close working relationship with the case managers and social workers. And their jobs were just so horrible--basically putting into a computer the statistics on a patient, and the computer will spit out whether the patient should be here or not. So they all have to do that with every patient every day--at the cost of actually seeing their patients." (#1)

[73] "I don't know for sure at this point if family history is irrelevant to the reason for admission. But I check the box that says it is.... Medicare thinks that these elements, capturing all these elements, means that you have done highly complex work , but in reality, what it does to make a list of elements you have to capture in order to say you've done highly complex work, is, that with human nature, people will just check those boxes off. They will just say, 'sure, I've done all this. Sure, I've captured all those elements.' And the time gets wasted checking off all these lists, even when it hasn't been done, necessarily, or when it's basically irrelevant, or kind of fake. One of the things you can say is 'tracheal midline.' It doesn't matter whether the trachea is midline or not when the patient has something entirely different. It can count as a signal that you've seen that organ system. So it becomes a game that people are playing. And that we are wasting our time playing this game instead of doing the actual thought and conversations that I think are important to medical care. It sort of destroys the integrity of the individual.... I have a problem--I can't

say I've checked 10 systems, if I've only checked 9. But I'm not sure all my colleagues have the same problem." (#17)

[74] Anecdotal evidence suggests that callbacks to primary care physicians and to patients, discharge dictation turnaround time, and billing accuracy and timing are tied to hospitalist compensation. In the time-period covered by this research, two physicians reported that they had "this week" received notice that another documentation requirement had been added: faxing outpatient physicians, in one case, (see fn 41), and a medical core measure in another: " Medicare just gave us a short notice to roll out VTE prophylaxis in the general population as a new core measure that has to start January 2013." (The date of the interview was December 5, 2012)

[75] National date is polarized on this subject; but even the literature considering it appropriate nonetheless suggests that the impact on bonuses or withholds should be minimal: Press I, Fullam F. Patient Satisfaction in Pay for Performance Programs. *Quality Management in Healthcare 20*(2), 110-115 (2011). New York City public hospitals recently made headlines by negotiating contracts with their "doctor's union" that included p4p provisions (NYTimes Jan 11 2013)--a decision that one editorial comment called "a triumph of theory over experience." (NYTimes Jan 27, 2013)

[76] Cursory recourse to MedLine reveals an extensive literature on the pros and cons of pay-for-performance, and it is unclear the extent to which p4p has been instituted in the hospital being studied. The interviews revealed considerable concern about both the theory and the practice. An eminent early critic-now-advocate had this to say on the subject:

> "I find myself an extremist and therefore suspicious of my answer. But it is, nonetheless, the best answer I have yet found regarding merit pay for doctors or any group of workers; namely, “Stop it.” [Such pay] is destructive of what we need most in our healthcare industry – teamwork, continuous improvement, innovation, learning, pride, joy, mutual respect, and a focus of all of our energies on meeting the needs of those who come to us for help. We can find better ways to decide on how we pay each other and better uses for our energies than in the study and management of carrots and sticks."

Berwick, DM, The Toxicity of Pay for Performance. *Quality Management in Healthcare 4*(1) 27-33 (1995). Quoted in Wachter R: Pay for performance in healthcare: Do we need less, more or different? The Healthcare Blog, Nov.25 2012.
See also Cassel CK, Jain SH: Assessing Individual Physician Performance: Does measurement Suppress Motivation? *JAMA 307*(24) 2595-6, 2012.

[77] "I mean, I can see from a financial standpoint why we shouldn't get paid if the readmission rate is too high, but --I don't know. It's hard to translate into my day to day interactions with a patient." (#25)

[78] The researcher's experience on get-out-the-vote telephone efforts during the recent election campaign yielded depressing data on the number of people who answer their phones: with a total of 120 telephone calls I spoke to 7 live people.

[79] --But hospitalists reported that the institution typically backed their judgment on utilization issues, even if they twitched a little about it.

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Appendix:

pharmacist for med reconciliation	23	17	23	4									
documentation cuts into f2f c patients	11	8	18	24	23	6	2	13	15	1	4	14	20
no palce to do your documentation/work	11	18	3	6	2	15	7	9					
trust in data: date wrong c LOS	11	19											
communication	7	10	9	19									
trust in data: errors in it (eg. Med rec)	11	17	6	15									
LOS doesn't correct for severity of illness	22	23	19										
just a way to give us more work s outcome	11	21	1	4	19								
locating info re phones time/unnecessary	8	18	17	6	4	7							
motivation moved from care to data	18	24	2	13	1	4	14						
patient satisfaction scores v outcomes	18	24	21	23	6	25	1	10	19				
kaizens /qda not implemented/sustained	21	23	25										
kaizens and qi financial or efficient not pc	22	21	1	20									
no support for residency	21	25	14										
turnover in trusted docs/admin/res	22	25											
regionalization and impact of sutter	21	23	25	1	10								
more work, less pay, no support	23	6	25	1	4	14							
computer problems	23	3	6	2	15	1	7	10	9	19	20		
distractions; interruptions; chaos	23	3	2	25	15	7	19						
no support for tasks that don't require MD	3	6	13	4	7	9	19	20					
initiatives: too many too fast	25	23	13	15									
low morale, possible burnout	13	1	4	14	20								
getting measured on everything	15	1	4	14	19								
patient care for politics not medicine	10	14	9	20									