# Barrington Hospital

John Knox


***Barrington Hospital*** *President and Chief Executive Officer Erik Landers is faced with a variety of crises including: An aging neurosurgeon whose deteriorating skills become evident when he performs an unnecessary surgery that maims a 16-year-old girl; an emergency room error that results in the death of a patient; aggressive union negotiations culminating in a strike that embarrasses the Hospital and the death of a nurse; and the Hospital's financial challenges magnified by the country's healthcare reform via the Affordable Care Act.*

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The characters and events in this book are fictitious. Any similarity to real persons, living or dead, is coincidental and not intended by the author.

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# Introduction

Hospitals are complicated organizations. Physicians diagnose and treat literally hundreds of diseases utilizing thousands of different procedures and thousands of drugs. The potential for error is great and the struggle to avoid errors is an ongoing one. The number of patient safety programs within hospitals and other healthcare organizations has grown to address medical errors. Solid safety systems and conscientious staff are key to the avoidance of serious errors.

The success of individual hospitals is largely dependent on the quality of physicians, nurses and other health care professionals who serve as the backbone of the system. Like any other profession there are many good ones, some are great, and some should not be in the healthcare profession. Effectively operated hospitals know how to attract the best talent, how to motivate staff and how to move out those who should not be in the profession.

The events and people described in this novel are fictitious but I have drawn on more than 24 years of experience as a President and CEO of multiple hospitals to describe what goes on in hospitals, both the good and the bad. It is an industry undergoing transformation. I have been fortunate to have worked for very good hospitals and I look forward to positive changes in the industry that will continue to drive significant improvement in patient care.

John Knox

# Chapter 1

As administrative director for surgical services, Julie Newman had one of the toughest jobs in Barrington Hospital. Her oversight of eight operating rooms included responsibility for scheduling of the surgical cases, obtaining appropriate supplies and staff for each case, ensuring safety protocols were followed and keeping the more than twenty five staff surgeons happy. The surgical staff included general surgeons, orthopedic, ophthalmologic, heart, urologic, ear, nose and throat among others.

The personalities of staff surgeons were as diverse as their specialties. Some were reasonable and easy to work with. Others were egocentric, demanding and damn near impossible to satisfy. Most of them were not Barrington Hospital employees but rather independent physicians with privileges to do surgery at other hospitals. The independents tended to leverage their ability to go elsewhere with their patients and frequently threatened to do so if Barrington Hospital didn't accommodate their every need. Their preferences ran the gamut from music to supplies to surgical tools. One surgeon would demand opera while another preferred jazz. One of the surgeons liked the operating room totally quiet so he could concentrate and avoid distractions. Different specialists had different preferences for components used in surgery. For example among the five orthopedic surgeons, each liked to use different orthopedic appliances in their patients. There were more than five manufacturers of artificial hips and Barrington was currently using them all. This made it difficult to standardize supplies and control costs. It was Julie's world and she had been doing it for more than twenty years.

She drew a hard line when it came to safety. Surgeons who failed to follow established safety protocols heard from her and she never hesitated to get support from the Chairman of the Department of Surgery and the Chief Medical Officer if needed. Nationwide studies had showed how often mistakes occur in surgery. As a result, the hospital had mandated that surgeons mark the surgical site on patients prior to surgery and a "time out" procedure had been implemented where the entire surgical team paused to review all elements of the surgery before making the first incision. The time out checklist included verification of the patient's name, the surgical site, type

of anesthesia and a host of other variables. Newman had worked at hospitals prior to Barrington Hospital where safety was not taken so seriously. She remembered vividly the time when one surgeon removed a patient's healthy kidney rather than the diseased one. There had been no surgical marking or time out procedure in that hospital. She felt the public would be shocked at how often surgical mistakes or "near misses" were made. Barrington Hospital had used the airline industry as a model in developing safety measures and the checklist. When certain surgeons had refused to follow the "time out" process, she called them on it and some had their privileges suspended until they agreed to follow the protocol.

Dressed in green scrubs Julie moved from operating room to operating room ensuring that cases were moving along as planned and without any major difficulties. Her surgical cap concealed a full head of light brown hair that was starting to show some streaks of grey. An expression of concern showed in her youthful face as she left the operating room of Dr. Ralph Nichols.

Her gut told her that Dr. Nichols was in trouble. The aging neurosurgeon had a long history at Barrington Hospital. For more than thirty years Ralph Nichols had been seeing patients and performing surgeries at Barrington. As a member of an elite specialty where the demand far exceeded supply, Nichols had developed a certain arrogance and conviction that he was always right even when faced with evidence to the contrary. The patient under his scalpel currently was a young woman who had presented with headaches, visual defects, balance problems, and nausea. Her head CT and MRI images revealed a mass that Nichols determined to be a tumor. He quickly convinced the patient and family that the tumor was compressing a vital intracranial artery and that surgery was the only viable option.

The surgery was entering its' sixth hour and Julie discerned a look of concern from the anesthesiologist. One of the surgical techs that had left the room shook his head as he passed Julie. Nichols rate of surgical complications had taken a jump in recent months and last year he had a serious malpractice case that ended with a sizable settlement for the family before it ever reached the court.

Julie ducked into her office and decided to call the Chief Medical Officer, Dr. Gerald Crindall. She expressed her concern and asked for advice; “He’s been in surgery for six hours. The case was scheduled for four and my staff looks very worried. Any suggestions?”

Crindall knew that Julie was not one to push the panic button lightly. If she was worried there was probably a good reason. He responded that he was on his way to the OR and they would sort through what to do.

As a general surgeon, Crindall knew he was out of his league. He never operated anywhere near the brain. Nevertheless Julie’s call alarmed him enough that he decided to gown up and offer Nichols help.

When Dr. Crindall entered the operating room, Nichols looked up with an expression of surprise and confusion. “What brings you here Gerry?” he commented. Crindall moved closer to the operating theater and quietly noted, “ I was in the neighborhood Ralph, and heard that this case was running considerably over schedule. Thought that there might be a problem and wanted to offer my help as an assistant if you needed it.”

It was hard to read facial expressions behind surgical mask, but Crindall felt sure that if he could, he would see a smirk on Nichols face. He would never admit he was in trouble or that he needed help. The anesthesiologist, on the other hand, appeared to let out a sigh of relief. Despite his typical condescending attitude, Nichols looked tired and a little dazed. “I encountered some brain swelling which has slowed me down,” he commented. “Perhaps you can help me wrap this up.”

Although he was no neurosurgeon, Crindall didn’t like what he was seeing. Nichols appeared to have removed a significant amount of brain tissue…too much from his distant recollection of that part of the human anatomy. He would have felt much better if another neurosurgeon was available to help but unlike other specialties, Nichols was the only full time neurosurgeon on staff. Barrington Hospital had made arrangements with a hospital an hour away to provide neurosurgical coverage when Nichols went on vacation or was otherwise unavailable.

Another half hour passed before Nichols, with minimal assistance from Crindall finished the surgery. He looked drained of all energy as they shed their scrubs in the change area. Their physical features presented a study in contrasts. Nichols towered over Crindall with his six foot two frame housing a lean body. He had piercing green eyes and a straight nose that was somewhat oversized for his face. Removing his surgical cap, he freed a thick main of grey hair. Crindall at five foot eight sported a rotund figure that had barely squeezed into the large sized scrubs he now tossed into the laundry basket. He had a ring of dark hair that circled a glossy scalp, a salt and pepper beard and glasses thick enough to make his eyes look smaller than they were. He attempted to pump Nichols for more details about the case but Ralph turned the conversation to small talk, clearly avoiding any further focus on the surgery.

Nichols casual conversation was camouflage for his inner fear. His mind was already churning around a number of troubling questions. Had he taken too much tissue? Would his patient recover without deficit or would there be some impairment? Would it have been better for him to refer this case to another surgeon, another hospital? True to form his biggest concern was how this impacted him. Would a negative outcome spur a lawsuit that would cost him time and energy to defend?

As Gerry Crindall reached his office, he felt a hand on his shoulder. He turned to face Dr. Sanjeev Reddy, the anesthesiologist handling the case Dr. Nichols just finished. “Thank you, for helping. I was getting very worried,” he said.

“You’re welcome Sanjeev,” he responded. “What went wrong?”

“Almost everything. There was considerable bleeding, then brain swelling. Ralph lost control of the case for a while. I’m still concerned with the outcome,” Reddy paused as if debating whether to say more. “I’m concerned Gerry. I’ve seen a change in Ralph. He seems to be slowing down. These cases are a struggle for him and he doesn’t always show the best judgment.”

“How would you rate his judgment in this case?”

"Not good. I'm not sure he should even have done this case."

"It sounds like I may need to send this case out for peer review." Ordinarily other surgeons of the same specialty at Barrington Hospital were asked to review cases where a question regarding quality of care was raised but there were no other neurosurgeons to evaluate this case.

"We should track this patient's progress over the next few days," Sanjeev observed. "If the results are poor, and I expect they will be, you won't have much choice but to send it out for review." Reddy looked at his watch, "Gotta run Gerry. I've got another case coming up. Thanks again."

"Thank you Sanjeev. And…keep me posted."

"Will do," he replied without turning as he walked quickly down the hallway.

Crindall made a mental note to call the hospital president to discuss what to do with the good Dr. Nichols.

# Chapter 2

Chicago certainly deserved to be called the “windy city” thought Erik Landers as he walked out of the revolving doors of the Hyatt Regency into the brisk air and wind that took your breath away. The Hotel, located across from the Chicago River and within a block of the Michigan Avenue Bridge was the center of activity for the yearly American College of Healthcare Executives Conference. Hospital administrators from across the country came to hear a variety of experts provide presentations on topics ranging from new techniques to improve quality to the latest update regarding healthcare reform.

Years ago the conference had been held during February, one of the worst months to be in Chicago. Within the last five years ACHE had moved the date to late March, making the weather more palatable but still running the risk of suffering some cold days. Today was one of those days. Erik signaled the doorman that he needed a cab. The doorman blew his whistle and motioned for the next cab that sat in waiting on the nearest side street to respond. Erik thanked the doorman as he entered the cab and gave instructions to drop him off at Lowry’s.

The yearly conference gave him a chance to catch up with college friends and peers who faced the same challenges that he did running a medium sized hospital in the Detroit area. A number of them would be dining at Lowry’s where one could enjoy some of the best prime rib available in Chicago surrounded by an elegant atmosphere. As he rode solo in the cab, he contemplated what to do with Dr. Ralph Nichols. The call from Dr. Crindall had caused him great concern. Erik had suggested that the case be sent to The Greeley Company for professional peer review along with other recent cases that had resulted in complications. The Company was well known for objective review and the results would likely suggest next steps that would need to be taken. For years Nichols had operated without any visible untoward outcomes but the malpractice case that he settled almost a year ago and recent complications made Erik wonder what was going on. Dealing with physician problems was never easy. Barrington Hospital, like the majority of hospitals across the country, was comprised of non-employed

physicians and the medical staff bylaws had to be followed closely in pursuing any kind of corrective action. They provided a fair process for corrective action but they were complicated and cumbersome.

Landers recalled the first serious physician issue that he dealt with at another hospital where he served as President. His Operating Room Director showed up at this office with tears in her eyes to inform him that they had just finished a routine hysterectomy on a patient that she felt wasn't going to make it. He recalled being so stunned that it took a few minutes for him to collect his thoughts. As he pressed for the details, Erik learned that the patient was very obese. The surgeon appeared to have difficulty seeing what he was doing during the case and as a result he badly perforated nearby organs that resulted in the patient bleeding to death. It turned out that the surgeon had developed cataracts. He had told no one about the cataracts and no one had picked up on his poor eyesight. The OR Director hadn't acted quickly enough to get assistance and by the time another surgeon joined the case, the damage was beyond repair. Multiple units of blood had been administered to the patient but it took too long to repair all the damage. She died within a couple hours of the surgery from a procedure that's done daily on women without any difficulty. These days' hysterectomies were often performed by surgeons using a robot half way across the operating room. New technology was decreasing recovery time and improving outcomes.

Erik had immediately suspended the physician, until the case was properly reviewed. As expected the review showed that the surgeon had been grossly negligent. The hospital's credentials committee and medical executive committee agreed to revoke his privileges to practice surgery at the hospital and the board of directors agreed. The revoking of his privileges was reported to the National Data Bank, which keeps track of corrective action and makes the information available to other hospitals as they consider physicians for staff privileges. Erik wondered what happened to that surgeon from his earlier days in hospital administration.

The impact of that case had never left Landers. It made him very attuned to physician quality issues. After speaking with Crindall, Erik had called the Hospital's Quality Improvement Director and asked her to assemble data

regarding Dr. Nichols surgical complications over the last four years along with specifics of the complications. The analysis was to be waiting for him when he returned. At that time, he would review the information with Dr. Crindall, along with the findings from The Greeley Company and together they would determine what next steps should be taken.

The cab pulled up to Lowry's, Erik paid the fare and shook off thoughts of Dr. Ralph Nichols as he entered the well known restaurant. He spotted Frank Hubbarth at the bar. Frank smiled as Erik headed towards him. Hubbarth was a former classmate of his in the University of Michigan's Health Services Management and Policy Program and later worked with him at the first hospital where Erik served as President. He hadn't changed much over the years. The sides of his dark hair had turned grey but wrinkles had not yet ravaged his face. His boyish appearance and infectious smile compensated for a body that was about thirty pounds too heavy.

"Boy, they'll let anyone in here," Frank said when Erik came within earshot.

"Apparently so, they let you in," Erik responded in kind. "How are you Frank?"

Erik grabbed the vacant seat next to Frank and the two shook hands. He reflected on his image in the mirror behind the bar. His mind retained a mental image much younger than the one he now viewed. A full head of salt and pepper hair was brushed carefully straight back over his head. Fine lines discernable in his forehead and a hint of crow's feet around the corner of his eyes made it undeniable that he had reached his mid fifties. In his biased assessment, the face was not unattractive but he longed for a pill that he could take that would remove the lines and give him back about fifteen years. His slim figure, maintained through rigorous exercise helped him appear a little younger than he was. Erik returned his attention to Frank and waved over a nearby bartender to order a Glenlevit on the rocks. After placing his order, the two administrators provided updates regarding their family before diving into a discussion regarding the current status of the field they had chosen.

"How have you found the College sessions this year?" Frank asked.

"The most interesting one I attended concerned the implications of the Affordable Care Act. Life as we know it is going to change. You heard I suppose that the Supreme Court upheld the Act today, including the mandate for each individual to have health insurance, while allowing for a few exceptions."

"So I've heard. It was a 5 to 4 decision by the justices and the argument that carried the day was that the insurance coverage mandate was consistent with Congress's power to tax. The exceptions to the mandate include allowances for financial hardship, religious objections, undocumented immigrants and incarcerated individuals." Frank added.

"Some of the Act is good. I've always felt that it was wrong that insurers could refuse to sell coverage or renew policies because of pre-existing conditions. That will no longer be the case. Forcing health care providers to move towards electronic medical records is also important. We both know how far hospitals are behind other businesses like banks in that area. One bankcard and I can access my accounts and get funds from almost any ATM in the world. In healthcare we often ask for the same information multiple times in the same hospital."

"I believe electronic medical records will help avoid some of the mistakes that are made today. But if anyone thinks this Act is going to reduce health care costs," he shook his head slowly, "I hope so, but I doubt it. Health care costs in this country have gone from $256 billion back in 1980 to $2.7 trillion in 2012 and still climbing," Erik noted.

"So you don't buy the argument that the "health care exchanges" and greater coverage of preventive services will drive down cost?"

"Hardly. The increased insurance coverage will mean greater use of health care services, not less, and while the Act does provide better coverage of preventive diagnostic services, it doesn't address the American public's lifestyle. American people, for the most part, eat too much and exercise too little. A third of the population is obese and that leads to diabetes, heart disease, stroke and a host of other problems. No…health care costs will

continue to increase and the government will continue to come after hospitals to make up for the increased expenditures."

Frank looked at his rapidly dwindling drink and thoughtfully observed, "Yeah and for all the money we spend on healthcare we're not considered the best. The World Health Organization rates the United States as 37th out of 191 developed countries for overall performance. The Institute of Medicine's report "To Err is Human" didn't add to our credibility either. According to the IOM report, at least 44,000 people and as many as 98,000 people die in hospitals each year as a result of medical errors that could have been prevented. That doesn't exactly inspire confidence. Not only are we paying plenty for healthcare but the public has to worry about things like medication errors, wrong site surgeries, and hospital acquired infections."

"I know. That hit close to home. I've been talking with my Chief Medical Officer today. Sounds like we have a problem with one of our key surgeons."

"What happened?" Frank asked with interest.

"Ah…I better not tell you. I might be violating HIPAA if I did." Erik referred to the Health Insurance Portability and Accountability Act that had been passed and that put into place strict guidelines for the confidentiality of patient information. He held up his Scotch and added, "I better be careful. Another couple of these and I'll be giving you chapter and verse of the case."

"Sometimes I think the more legislation that's passed, the worse our health care problem gets. I understand why Medicare was passed back in 1965 under President Johnson, but I think that Medicare is part of the reason we're in the mess we now face today," Frank noted.

"What do you mean?"

"The Medicare program established all the wrong incentives," Frank continued. "When the program was first established, hospitals didn't worry about controlling their costs because the government reimbursed them whatever their costs were. Physicians faulted on the side of doing more

diagnostic tests than less because they knew that their patients weren't paying for them and they didn't want to be sued for missing something. Better safe than sorry. Competition among hospitals has been more on the level of beating one another to the latest technology gizmo rather than on cost or even quality. When President Regan enacted Diagnostic Related Groups (DRGs) in the 1980s as the method of payment it changed the game. Hospitals got paid a set fee based on the patients' diagnosis for an inpatient stay. That caused hospitals to reduce the emphasis on inpatient care and move more of the work to the outpatient setting where the reimbursement remained good."

"Now comes the next attempt to fix the system," Erik chimed in "the Affordable Care Act. Health care costs have been like a run-away train. No matter what you put in front of it, the train won't slow down. I wish I had the answer."

"So do I," Frank responded. "In the meantime we have to work with what we have."

Erik noted that some of their classmates were heading into the dining room for dinner. "Enough shop talk. It looks like we'd better join our colleagues for dinner. Besides, I'm starving." As they walked into the stately room of dark wood and mirrors he turned to Frank and said, "Let me ask you a really important question, how's your golf game?"

# Chapter 3

For the moment Amanda Gibbons slept soundly as Dr. Nichols stood over her reflecting what orders to write for her third post-operative day. Her recovery had been worse than he imagined. Amanda had suffered a stroke. Her speech had been severely impacted by the surgery and her vision was impaired. Her cognitive ability also appeared to be impacted. In short Amanda was less functional post surgery than she was prior to surgery.

In his mind, Nichols consoled himself that despite her impairments, he had saved her life. After all, removing her tumor was crucial to relieve the compression on her intracranial artery. He had successfully convinced Amanda's parents of this. They viewed Dr. Nichols as a savior despite the fact that Amanda's mother spent most of her time crying over Amanda's new impairments.

At sixteen years old, Amanda had appeared to have a wonderful future in front of her. She was a slim, attractive, blue-eyed blond who did well in school, enjoyed many friends, including a boy friend who thought the sun rose and set over her. Until her recent problems she had excelled at tennis and was widely considered one of the best players at her school.

Her future no longer looked very bright. There was little hope that she would recover from her impairments. Dr. Nichols had removed a good deal of healthy brain tissue along with the tumor area that had been his focus. He would prescribe rigorous speech and physical therapy but it would be slow going for her to recover even a portion of the functions that she had previously enjoyed.

Kathy, the nurse caring for Amanda looked concerned as Nichols stood in the doorway of Amanda's room. He looked depressed and lost. Nichols had another patient in the Hospital and was desperately trying to think of the orders he needed to put in place for him. He knew that he was forgetting something but try as he might, he couldn't recall what it was. As he walked slowly to the nurse's station, Kathy approached him.

"Are you alright? You look worried," she remarked.

"Fine, Fine…..No I'm fine," he responded as he looked at her continuing to wonder what he forgot.

"Mr. Riley has been complaining to me that his pain score is at a 9 and was hoping you could increase his pain medication."

That was it, Dr. Nichols realized. He had committed to change his pain medication. How could he have forgotten? He had just talked to him that morning and had promised to increase the medication. It wasn't like him to forget details.

"I was just about to do that," he lied to Kathy. No sense letting her know it had slipped his mind. He pulled the patient's chart and made a notation regarding the increased pain and altered the medication to address it. The Hospital was soon going to convert to electronic medical records in the spirit of meeting President Obama's incentives to computerize the hospital medical record. This meant that Nichols would have to do his charting and medication orders on line. Nichols was basically computer illiterate and he was already thinking of ways he could circumvent the requirements to enter his orders on line. Perhaps he could cajole the nurses to do it for him.

After completing his charting he started to head for his office. As he walked, thoughts of Amanda's surgery ran through his mind. The embarrassment of having Dr. Crindall stop in during the case still stung. No one ever interrupted his cases, let alone imply that he was in trouble. What right did a general surgeon have to question a man of his training and expertise? Nichols had graduated from the prestigious University of Michigan Medical School and after completing his residency at what was once Harper Hospital, he had spent years improving his craft and taking on difficult cases. He had relished the more challenging neurosurgical cases that other neurosurgeons steered clear of.

Nichols' office was conveniently located in a medical office building physically attached to Barrington Hospital. As he walked in the front door, he ran his

hand through his great mane of grey hair. His receptionist grimaced and gave him an exasperated look.

“What’s wrong?”

“You have patients waiting,” she almost whispered. “Some have been waiting almost forty five minutes. You’re late.”

“Well I’m here now,” he responded testily. Who worked for whom here, he thought. After all, the kind of work he did and the patients he took care of, delays were unavoidable. Just deal with it, he mentally commanded his receptionist. It did seem that lately he was finding it difficult to keep up. Time passed more quickly. He had more difficulty remembering things. His wife was after him the other night for forgetting a dinner party she had told him about just the day before. He didn’t remember her telling him. But what if she did. He had a lot of things to remember. All of them were more important than a dinner party.

He pulled the patient’s chart from the plastic holder on the door and walked into the exam room. The charm returned as he smiled, asked about the patient’s family and listened sympathetically as she described her aches and pains. Dr. Nichols had long ago mastered the art of patient relations. He knew what to say and when to say it. He exuded confidence. Patients loved him. His reputation had been secured a long time ago when he was a young neurosurgeon. New patients tended to rely on recommendations from friends and they trusted that Barrington Hospital wouldn’t have him on staff if he wasn’t competent.

Physician report cards were beginning to sprout up over the Internet but the indicators used to compare competence were pretty basic and in many cases not very understandable for the general public. To the average person there was no evidence that Ralph Nichols, M.D. was anything but a highly competent neurosurgeon, spending his days saving patient lives.

# Chapter 4

As he parked his black BMW 335 XI in the Hospital employee parking lot, Landers was already reviewing in his mind the day's itinerary. It was 7:30 am and he had promised to meet Dr. Gerry Crindall to review the information that had been gathered regarding the Ralph Nichols case prior to the Medical Executive Committee meeting at 9:00 am. They also needed to discuss the smaller issue of a general surgeon whose behavior had continued to become outrageous. He berated operating room staff that assisted him for slowing him up with the "time out" process, threw temper tantrums when he couldn't get his cases scheduled exactly when he wanted and generally made life miserable for everyone.

Erik could think of no other business where non-employees controlled so much work and cost. Physicians controlled patients entry to the hospital system, controlled the orders for treatment and medications and the patient's length of stay. Yet most physicians were not on the Hospital's payroll. As independent professionals they used hospital staff, supplies and equipment to care for their patients but billed for their professional services separately from the Hospital. Only a few systems like Mayo, Cleveland Clinic, Henry Ford Health System and Kaiser Permanente employed all their physician staff.

As independent physicians they operated under the Medical Staff Bylaws and could only perform services reviewed and approved by the medical staff and hospital board of directors as part of the credentialing process. The credentialing process included checking that each physician applicant completed their medical education and training appropriate to their specialty and had successful experience performing the procedures that they requested privileges for. Medical degrees were verified, state licenses checked, references received and review of the national data bank completed for any quality issues. Barrington Hospital's Board was comprised of twenty members from all walks of life including a lawyer, business people, physicians, bankers and educators. All served without compensation as the Hospital was not for profit. A segment of each monthly board meeting was dedicated to a review of individual physician requests for privileges. Although they all

received a significant amount of information, they relied heavily on recommendations from the Medical Staff Executive Committee, which was comprised of the medical staff leaders. Performing due diligence upfront was crucial because once a physician obtained privileges, it was difficult to take them away because of due process and appeals rights afforded physicians through the medical staff bylaws. From Erik's perspective it was much easier to terminate a nurse for incompetence than it was to remove hospital privileges from an independent medical staff member.

As he entered the Hospital, named for the millionaire entrepreneur who donated the land and money to build the original hospital, he enjoyed seeing the fruits of a recent renovation. The incorporation of more windows added light and brightened up the corridors. It made a more pleasing atmosphere for patients and visitors. The Hospital had also been converted to all private rooms, 250 of them to be exact. That decision was based on health care literature that showed private rooms help decrease hospital acquired infections while decreasing recovery time for patients. Landers attention to detail caused him to note a patch of carpet that needed replacement. Hospital activity was high as employees from the night shift checked out while the day shift replaced them. Barrington Hospital qualified as one of the areas major employers with around 1,000 employees on payroll. Erik waved at the volunteers staffing the Hospital Gift Shop as he approached the administrative offices off the lobby on the first floor.

His executive assistant, Shelly, greeted him as he walked through the door to administration. Older than Erik, she sported white hair coiffured to perfection and it always stayed that way. You could tell this was a source of pride for her and Erik suspected that she went through a case of hair spray a month to maintain the effect.

"Good morning Erik. Haven't seen you for a whole five days. How was Chicago?"

"Cold and windy. Nevertheless, I managed to enjoy myself and learn something in the process. How was your weekend?"

"Just great. Bob and I attended a rap concert," she smiled innocently.

"Yeah right. And I did a little skydiving while I was in Chicago. Of course that was before I tried bungee jumping from the bridge."

She laughed and added on a serious note, "Gerry Crindall is on his way over and don't forget you have Medical Executive at 9:00 am this morning."

He took a swig of the coffee he had just poured himself and started to head into his office.

Lowering himself into a comfortable leather chair behind his desk he quickly flicked his computer on to do a quick scan of his e-mail. The amount of e-mail messages he received easily topped 100 per day and there were times when Erik longed for the days prior to e-mail, cell phones and faxes when he could occasionally escape from work. Now, even at night he found himself responding to e-mails via his I-phone. The office was large and comfortable with a picture window overlooking a courtyard complete with patio, sitting area, flowers of all colors and shrubs. As he stared out the window, Gerry Crindall entered and welcomed him back.

"Wish we didn't have to welcome you back with this nasty business, but I have a great deal to review with you. By the way….nice suit."

Landers had a weakness for clothes and he had not passed up the chance to replenish his wardrobe while in Chicago. He had enough suits to wear a different one every day for two workweeks. His suits were always well pressed with a well-selected tie and a pocket-handkerchief that either matched his tie or shirt. Crindall on the other hand could care less about clothes but he did enjoy Erik's sartorial style.

"Thanks. I got it when I was in Chicago. Did we get the results back from The Greeley Company review?" Landers asked.

"We did and it's not good news. You're familiar with their scoring system?"

"I am."

"Well they graded the patient care at a level of 6, meaning the physician didn't follow the standard of care and actually caused patient harm." Crindall watched as Erik massaged his forehead with his hand as if to relieve a massive headache.

"Better give me the rest of the details."

"The most damaging piece of information is that the radiologists' interpretation of the MRI and CT images indicate that the patients growth was comprised of fat and calcification and was not something in need of immediate surgery. Yet Nichols went ahead and operated. It's not clear whether Nichols didn't review the results or he just ignored them. He maintains that the tumor was compressing an intracranial artery and charged forward with surgery. The postoperative pathological analysis is also damming. It confirms the radiologist interpretation that the mass was a benign osteolipoma and not the tumor that Nichols claims was present.

"Why would he ignore the radiologists interpretation of tests he ordered?" Landers asked obviously puzzled.

"As I said, I am not sure yet whether he ignored the results or he just didn't bother to read the results but either way he appears guilty of negligence. You better make damn sure you're right if you're going to ignore the experts that you're consulting. This girl's life has been severely impacted as a result.

"What about our review of his complications? Any trends emerge from that analysis?"

Crindall handed Landers a sheet of paper that provided a summary of Dr. Nichols complications over the last four years. The analysis clearly showed a significant uptick in complications over the last year. His rate of complications, taking into account the severity of the cases he handled was well above his peers on a national basis. They quickly discussed what their approach would be with the 9:00 am Medical Staff Executive Committee.

The composition of Medical Executive Committee always reminded him of the United Nations. There were 12 physician members from almost every ethnic background that one could contemplate. The Medical Staff President, Dr. Azar, an anesthesiologist was born in Pakistan. Dr. Russell, a hospitalist and medical director of the hospitalist program represented the African American contingent. Other members had roots from Lebanon, China, Latin America, India and then there were the plain old Anglo Saxon Americans…one of which was fluent in French. He and Erik occasionally practiced the language with each other over a glass of wine at the golf club.

Landers took his place at the u shaped board table across from Dr. Azar as the medical staff President called the meeting to order. He led the committee through the routine review of quality indicators and policy changes and finally arrived at the item dealing with Dr. Nichols' recent surgical case.

"The next agenda item," Azar began with a nervous twitch of his left eyebrow, "is the peer review findings relative to Dr. Nichols. A recent case resulting in a tragic outcome caused us to dig a little further to see if we have an issue. Dr. Crindall is here to report the findings of that review."

Crindall presented a fair and balanced narrative of why Dr. Nichols felt it necessary to perform surgery on Amanda Gibbons while explaining that the radiologist's interpretation of the CT and MRI scans would suggest that surgery was ill advised and the pathologist report confirmed the presence of a benign osteolipoma. He then walked them through the internal analysis of Ralph Nichols complications. After completing his presentation he paused to see if there were any questions.

"How is the patient doing now?" asked the Chief of Family Practice.

"Not well. She has suffered a stroke, and she has physical and mental impairments that were not present prior to the surgery," he reflected again on the large amount of brain mass that he saw removed in the operating room but hesitated to add this to this narrative.

"What are our options?" asked another member of the committee and all eyes, including those of Gerry Crindall turned to Erik Landon for guidance.

"If Dr. Nichols complication rate was low and this was the first instance of poor judgment I would be suggesting that we continue to intensely review his charts and monitor his performance," Erik began. "But as you have all heard that's not the case. He had to settle a malpractice case last year, his complication rate has climbed and his rate is well above the average of his peers nationally. We need to know what's going on. I believe this Committee should consider requiring Dr. Ralph Nichols undergo a physical and mental evaluation by a firm that specializes in performing these assessments of physicians. I have worked with a couple of them in the past. Until that evaluation is completed, I believe we should suspend his privileges temporarily."

"How long will that take?" asked another member.

"If Dr. Nichols cooperates, I suspect we can have him evaluated and get a final report within three weeks," Erik responded.

"That seems somewhat harsh," note Dr. Pierson, an orthopedic surgeon. "His income and ability to see patients will be impacted in the meantime."

Erik retained his patience while responding. "I understand that, but let's put this in perspective. We have an outside expert who has reviewed the case and stated for the record that it was mismanaged. We have data indicating that Dr. Nichols is showing complication and mortality rates well above his peers and most importantly we have a 16-year old girl whose entire future has been negatively impacted by this surgery, which ostensibly didn't need to be done. On balance, this action does not seem extreme." He watched as a number of the members nodded in agreement.

Realizing he had lost the argument, Pierson followed with another question, "Who will pay the cost of the analysis?"

"I'm open to the hospital splitting the cost with Dr. Nichols, especially since we are requiring it."

"I'm not sure we want to go there," Dr. Azar chimed in. "It could set a precedent for future cases where an analysis is needed and I think the physician should be responsible for the cost." The point was debated further but consensus was reached to have Dr. Nichols split the cost with the Hospital.

The rest of the meeting was consumed discussing the bad behavior of Dr. Emerson, a general surgeon. A couple of Operating Room nurses had filed grievances with the hospital, detailing his belittling remarks and frequent sexual innuendos. Landers laid the groundwork for the desired action.

"I'm not exaggerating much when I say the operating room staff draws straws to determine who's going to get stuck working with him in the OR," Landers noted. "He's creating an environment where mistakes can be made. We need to send a message through a formal letter of reprimand indicating that any further substantiated reports of this behavior will result in movement to suspend all his clinical privileges."

The committee went through some hand wringing and one physician went so far as to suggest the operating room nurses "had it in" for the good Dr. Emerson. In the end, reason prevailed and the committee agreed to send the letter. All in all, Landers thought the meeting went about as well as could be expected.

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Development of a Hospital budget was never an easy process but the passage of the Affordable Care Act served to increase the pressure on hospitals to reduce cost. Part of the Affordable Care Act was to be funded through phased in decreases of Medicare reimbursement to hospitals. The justification for this was that since all American citizens were going to be required to have health insurance, hospital bad debt would decline; therefore hospitals would need less reimbursement.

Kathy Chiffre, the chief financial officer of Barrington Hospital came to the budget meeting armed with information regarding the expected cuts to Barrington's reimbursement, projected volume trends and current expenses. The Affordable Care Act envisioned an expansion of Medicaid to reduce the number of uninsured and because of that, hospitals and other providers agreed to $500 billion in payment cuts over a 10-year period. There was no way to reach a reasonable positive bottom line without some planned reductions to expenses and a positive bottom line was necessary to fund capital equipment and necessary ongoing renovation of the hospital.

As a certified public accountant with a Masters in Business Administration, the slim, forty seven year old brunette felt confident in her numbers but wondered how long she could survive in an industry that was always battling declining reimbursement. It occurred to her that the others in the room including the Chief Nursing Officer, Vice President of Operations and the Human Resources Director probably had the same thought. Kathy exchanged some small talk with them while they awaited the arrival of Erik.

"Sorry I'm late," Landers apologized as he rushed into the room. "Med Exec took longer than I anticipated."

"Not a problem," she replied and began distributing budget packets to those present like a poker player shuffles cards. She took them through pages dealing with projected patient volumes for the upcoming fiscal year and requested that they review and provide her with input regarding the reasonableness of the figures. Her revenue projections were based on the volume projections. Kathy next moved to a discussion of expenses and she concluded with a zinger, "Based on these numbers, our revenue won't cover expenses for the upcoming year and we'll experience a loss. We need to consider aggressive cost cutting initiatives and explore growth opportunities."

Erik felt a strong responsibility to ensure the Hospital maintained a positive bottom line. His responsibility was not only to the board of directors but also to the 1,000 employees that earned their livelihood through Barrington Hospital. He was the first to chime in, "I haven't done the math on these figures but unless things have changed about fifty five percent of our costs

are in salaries, wages and benefits and about another 23 percent is in supply costs. If we're going to cut costs, our strategy must include those areas."

With a look of nervousness, Steve Finnes, the Human Resources Director, removed his glasses and responded, "Erik, this is a contract year and the union's already hinting at a significant increase to the nurses hourly wage. Negotiations are going to begin in a couple weeks."

"They got a 3% last year," Erik noted. "Since that time the economy has tanked. It wouldn't be unreasonable to propose a 1 percent increase and be ready to negotiate to a 1.5 percent."

Mary Osgood, the Chief Nurse Officer chimed in, "They'll never buy that and the nursing moral will plummet."

"Look folks, if ever there was a time to hang tough, this is it. We can't continue to jump the salaries in a depressed economy with certain cuts in reimbursement," Landers observed with frustration. "Steve, you have my support in taking a tough stance during this negotiation." The reassurance didn't seem to satisfy Finnes who continued to look worried about an aggressive stance with the Professional Nurses Association (PNA) local 195.

Discussion ensued on other means of reducing costs. Mark Kincaid, Vice President of Operations related the initiatives underway to negotiate lower cost for certain vendor contracts and a program underway named, "Operation Efficiency" that would focus on reducing unnecessary utilization of supplies. He explained that successful implementation of both would drive down supply costs. Young, Kincaid joined Barrington Hospital just a few years earlier. Tall, thing as a rail with light brown hair, he was always eager to tackle a new project and impress the others that he knew what he was doing.

Chiffre wrapped up the meeting by noting the date of the next meeting and she asked for input on the current projects within a week's time.


***Barrington Hospital*** *President and Chief Executive Officer Erik Landers is faced with a variety of crises including: An aging neurosurgeon whose deteriorating skills become evident when he performs an unnecessary surgery that maims a 16-year-old girl; an emergency room error that results in the death of a patient; aggressive union negotiations culminating in a strike that embarrasses the Hospital and the death of a nurse; and the Hospital's financial challenges magnified by the country's healthcare reform via the Affordable Care Act.*

# Barrington Hospital