Senate Finance Committee

May 17, 2006 James C. Cobey, M.D., M.P.H., F.A.C.S.

Good morning Senator Grassley, Senator Baucus and Committee Members. It is an honor for me to appear before your committee on an issue of patient care that has concerned me for a number of years. That is the issue of patient safety and specialty hospitals.

I have been a practicing orthopaedic surgeon for 30 years in Washington, DC. I have a Masters in Public Health from Johns Hopkins and have been looking at issues in health care in the United States and abroad for most of my career. I have worked with many international organizations and non-governmental organizations in disaster relief, refugee health care, medical education, and most recently on the epidemiology of landmine injuries.

In preparation for this testimony I have reviewed the case in Portland, Oregon where a patient died in the evening following a lumbar laminectomy. The removal of a lumbar spinal disk in a lumbar spine laminectomy can be relatively simple, but it is a delicate operation and at times it can be very difficult. The patient had a respiratory arrest and died unexpectedly on the ward the evening after surgery. There were no physicians in the hospital (which is not a requirement for hospitals since there are many small hospitals in rural areas where it is impossible to staff hospitals with physicians around the clock.) However, the hospital in question was not in a rural environment but in a large metropolitan area. The staff should have been able to use the crash cart to perform CPR or cardio pulmonary resuscitation. No one was available to put in an endotracheal tube to ventilate or breathe for the patient. Maintaining an airway is the most necessary first thing that must be done to resuscitate a patient. The patient died before the ambulance could arrive on a 911 call. We should expect that any hospital providing major surgery would be staffed with someone who can resuscitate a patient and maintain an airway, especially in an urban environment for elective major surgery.

In the last three decades I have observed health care in large hospitals such as the Washington Hospital Center and Georgetown University Hospital as well as smaller ones such as Providence Hospital and Sibley Hospital in Washington, DC and a community hospital in Charles County, Maryland.

When I look at my practice and the concept of orthopaedists starting hospitals just for elective orthopaedic cases, I worry about the health of patients in these setting unless there are physicians from other medical specialties there in house. Though ninety-five plus percent of I and my colleagues doing elective orthopaedic procedures have no problems, one must always be prepared to handle the unexpected.

Let me give you some specific examples:

- In the last ten years I have had at least three patients who developed, with no preoperative signs, acute bowel obstructions that needed specialist work up and emergency surgery within 12 to 18 hours of my elective total joint procedures.
- I remember clearly one situation where a patient in the recovery room was noticed to have a cold pulseless foot after total knee surgery. Fortunately we had an expert radiology team in house and a vascular surgeon. We found that a simple atherosclerotic plaque had broken off in the femoral artery under where we commonly place the tourniquet. The plaque caused an occlusion to all blood flow in the leg. After we obtained an emergency angiogram from an interventional radiologist, a vascular surgeon was able to do an endarterectomy within two hours of my surgery and save the leg.
- I had another patient a few years ago come in for routine total shoulder replacement surgery. Everything was going well in what is usually a straight forward procedure when there was severe unexpected bleeding. I needed the help of a vascular surgeon to control the bleeding. The patient did well, and when we did a postoperative angiogram we found a rare vascular malformation.
- Just two months ago during a routine total hip procedure on a patient with mild hypertension controlled by a mild diuretic, the patient developed severe hypertension during induction for surgery. The anesthesiologist was able to control it, but the patient developed severe cardiac arrhythmias after the surgery started. Post operatively she kept having arrhythmias. We were able to have the patient monitored after surgery and seen that day by a cardiologist in house to change the medications and stabilize the patient.

I have informally canvassed a number of my colleagues about post operative or intraoperative problems they have had for elective orthopaedic

procedures. It is the elderly patients over sixty-five where most of the complications may occur. The most acute problems are vascular, urinary, or abdominal.

Let me give you a few more examples: Many, if not most, older patients undergoing elective joint surgery have some underlying vascular problems. In any case sudden unexpected vascular compromise needs immediate care, as did the problems I mentioned above. One of my colleagues had torn popliteal vessels (the large blood vessel behind the knee) during revision knee surgery. The vessel had been scarred into the tissues around the prosthesis that was being removed. When the vessel tore during careful removal of the prosthesis it took emergency vascular surgery to successfully save the leg. Another of my colleagues had a similar problem just a few weeks ago.

One of the best spine surgeons in the city injured an aberrant vertebral artery during routine anterior cervical spine surgery a few years ago. The patient almost died. The interventional radiological vascular team was able to stop the bleeding and the patient did very well.

Another of my colleagues had a patient develop a stroke during surgery that was first notice in the recovery room. The stroke team consisting of neurologists and radiologists took over and handled the patient well. The patient recovered well with appropriate therapy.

One can say that specialty hospitals should only do the simple procedures where these complications are not expected, but that means the more costly cases are shifted to the community hospital. Vascular compromise is rare and too often completely unexpected, but when it happens there is little time to call in help. For safe orthopaedic surgery, other specialists must be immediately available to handle these problems

Another problem area is urinary system function. I have had many cases of spine surgery and total joint surgery where I needed to have a urinary catheter placed, due to the length of the procedure. Many times I have found totally unexpected strictures where I have needed to call in an urologist to pass a special catheter often by fiberoptic endoscopy, and a few times by a suprapubic approach. If an urologist had not been available in house, we would have had to cancel the case and wake the patient up. Remembering

that the most difficult times in anesthesia are induction and waking the patient, that is not a great choice for the patient.

Besides the life and limb threatening medical needs of patients with major surgical procedures, I am worried about the effect on the financial viability of general hospitals which have emergency rooms and end up carrying for many patients with little or no insurance. The major multiple specialty hospitals need the revenue from patients admitted for elective surgery if they are going to survive with adequate resources to take care of the general community. I am concerned that these specialty hospitals take a smaller percentage of Medicaid patients compared to community hospitals.

When I was in medical school at Hopkins forty years ago our philosophy as students was to take care of patients as our calling. Making money was irrelevant to our reason to become physicians. I feel that many of the physician owned facilities exist more to help doctors in business than in taking excellent care of all patients irrelevant of their ability to pay for care. Of course physicians are small businesses and need to make enough income to cover their costs- especially medical liability insurance cost. Once those costs are covered, - which is by no means small (in DC it is 100,000 a year for an orthopaedists) our goals should be to treat patients in facilities that best meet their needs, not a physicians convenience or profit.

According to an article in the New England Journal of Medicine April 2005, since 1990 the number of US specialty hospitals that are partly owned by physicians has tripled to approximately 100. Physicians are attracted to investing and practicing in specialty hospitals for two main reasons: to directly control hospital operations in relations to patient care and to augment their income. MedPAC has found that these hospitals generally take patients with less severe illnesses than do community hospitals and provide less uncompensated are. The average size of orthopaedic specialty hospitals reviewed by MedPac in 2005 was only 16 beds. It is hard to keep meaningful ancillary facilities for emergencies for hospitals that small. The sicker patients then end up at community hospitals costing them disproportionably more money in resources.

The American Hospital Association has also reviewed the issue and is concerned about the problem of physician conflict of interest when the have ownership in a hospital. I am concerned about this conflict of interests for hospitals and also for the proliferation of outpatient surgical centers owned

by physicians. There is an obvious conflict of interest in all of these facilities encouraging physicians to refer the best insured patients to facilities that they have an interest in. The MedPac study showed the specialty hospitals have a lower share of Medicaid patients than community hospitals.

I personally served on a board of a community hospital for nine years, and I know that hospitals cannot survive on Medicaid and Medicare alone. It is unfair for specialty hospitals to discriminate against Medicaid patients to the detriment of community hospitals who are struggling to give excellent care to all regardless of ability to pay or insurance type.

In conclusion, all hospitals must be able to be ready for the unexpected. We can not let dollars get ahead of patient safety and quality of care issues.

1. Report to the Congress: Physician-Owned Specialty Hospitals, Medicare Payment Advisory Committee, March 2005.

2. Protecting the Health Care Safety Net: Limited –Service Hospitals, the American Hospital Association

3. Oregon Department of Human Services- Complaint Investigation Report: Physicians Hospital, August 2005

4. Iglehart, J; The Uncertain Future of Specialty Hospitals: New England Journal of Medicine, 4/7/2005, pp1405-1407.

5. Hackbarthm G, Physician-owned specialty hospitals, Medicare Payment Advisory Commission, May 2005