Chapter 12
Things You Should Know About Hospital Administration

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> It is hard to imagine a more stupid or more dangerous way of making decisions than by putting those decisions in the hands or people who pay no price for being wrong.
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> – *Thomas Sowell, Senior Fellow Hoover Institute, Stanford*

You have now completed your specialist training and will soon be joining the faculty of a university teaching hospital or starting in a private practice in a community hospital or outpatient facility. Wherever your career now takes you, there is one aspect of modern medicine that you probably have not been directly exposed to during your residency – hospital administration.

There has been a dramatic increase in the number of hospital administrators in this country over the past several decades. Just between 2005 and 2015, there was a 50% increase in administrators [1]. During your residency, you were shielded from them, but in the future, you will need to interact with hospital administrators. This chapter will serve as an introduction to hospital administration and discuss the following:

- How many hospital administrators do we need, and are they of any value?
- Press Ganey Survey. Any problems?
- Metrics. Benchmarks. Mandates
- Hospital committees. Physician-led healthcare?
- Another take on physician burnout
- Suggested solutions

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12.1 How Many Hospital Administrators Do We Need and Are They of Any Value?

All physicians took an oath to improve quality of life and to save lives. Unfortunately, hospital administrators at the helm of our healthcare system are not committed to the same ideal [2]. In a book by Elizabeth Rosenthal entitled *An American Sickness,* she states that the American health system has stopped focusing on health and even science [2]. Instead, they are only concerned with profit.

In 2018, the author (JGBU) compared two similar-size California hospitals, each with about 800 beds and 12,000 employees. There was a large difference in distribution of employees doing direct patient care (45% versus 78%) between the two hospitals. In one hospital, 22% of employees were involved with nonpatient care, while the other hospital had a whopping 65% of employees in nonpatient care roles. Just so you know, there are no state or federal government standards, so every hospital can do their own thing. Each CEO, CFO, and COO decide on their own needs. There are no checks and balances. Interestingly in one of these hospitals, there were 40 VPs while the other had only 6.

Hospital administrations justify their existence by supposedly improving efficiency and quality of patient care [3]. However, the actual value of hospital administration, especially CEO's, has come under increasing scrutiny [4–7]. There is no correlation between hospital CEO salary and hospital quality, financial performance, and community benefit.

To summarize, between 2005 and 2015, physician's wages grew to $37 billion, while the salaries of nonclinical workers grew to $58 billion. Nonclinical workers are employees that have no direct involvement with patient care.

There is an increased financial burden caused by excessive increase in nonclinical workers in the US health care [1]. Dr. Danielle Ofri (*New York Times*, June 8, 2019) states that there has been a 3200% increase in healthcare administrators since 2005, all paid for by patients and their insurance. We need a reduction in nonrevenue-generating healthcare workers.

In 1968, hospital administrators were viewed as being frugal, having a lack of ostentation, with a trace of puritanism and humility [8]. In 2019, those same administrators were described as practicing poor governance, receiving excessive pay, lacking deep corporate culture, and experiencing corporate malaise [8]. We need to get back to cornerstones of hospitals as they were in 1968.

12.2 Press Ganey

Press Ganey (PG) surveys measured patient experience and attempt to provide strategic solutions to hospitals. In many cases, physician salaries depend on their PG score. The range is 1 (poor) to 5 (excellent). Often, if you, as a physician, do not get an average of 5, then there can be a reduction in your salary. Most patients give a

4–5 response, while a considerable proportion give a 3. These scores can have unintended consequences. For example, in 2018 in one university hospital, a physician received an average PG score of 4. That doctor investigated her patient's responses and found that certain population groups never gave more than a score of 3, thereby bringing her average score down. She then refused/minimized her exposure to this low scoring population group, and as a result her salary was raised dramatically!

12.3 Metrics – Benchmarks – Mandates

These terms refer to a variety of different "quality" measurements including average length of hospital stay, time to the patient is seen by a doctor, patient satisfaction scores, hospital infection rates, HIPAA compliance, etc. US hospitals must now report over 500 metrics a year. This is an obscene number as all data collection for all metrics are unfunded/unsubsidized. The hospital pays, which really means the patient and/or the insurance company pays. We need to "reduce" the number of these metrics. However, more and more metrics are added every year. The introduction of HIPAA has made us all much more aware of protecting patient's personal information. That is obviously a good thing. But the hospital's cost of maintaining HIPAA is passed on to the patient by increasing their insurance payments. Hospital expenses to maintain HIPAA compliance include wages to personnel to oversee its implementation, software development, and paying outside companies for document management and shredding.

12.4 Hospital Committees

Hospital leadership touts that all their patient-related hospital committees are physician led. This is not true! Actually, in an unpublished study conducted by the author (JGBU), over 100 anesthesiologists were surveyed at the CSA Annual Meeting in San Diego in 2019. Ninety percent of those surveyed reported that as committee members they were able to attend only 10–20% of all those committee meetings a year. Hence, they could not contribute to the meeting and hospital protocols are being generated by those in attendance, usually nurses and administrators. The lack of physician input leads to an increase in

- Expense for patients
- Burden for patients
- Time wasting for physicians
- Healthcare cost increase without any evidence of improved healthcare delivery

To be clear, physicians cannot attend meetings since they are busy generating income for the institutions. Also, meetings are usually scheduled between the hours of 9 am and 4 pm, times inconvenient for clinicians.

12.5 Another Take on Physician Burnout

Physician burnout has become a major health problem. "Wellness experts" blame physician burnout on personal failure. They believe burnout can be remedied by, for example, coaching of the physician [9]. However, most authorities like the American Medical Association state that burnout is mainly caused by the hospital leadership taking advantage of physician dedication. Physicians are being forced by the hospital to increase their clinical and clerical responsibilities and have little or no control over their working environment [10].

12.6 Suggestions to Solve the Many Problems are Mentioned Below

1. You must become involved in hospital governance and leadership and thereby hopefully take control of your workspace.
2. Medicare and other insurers should link hospitals and medical school's reimbursement to a verifiable ratio of administrators to active healthcare providers. This is to reduce cost associated with nonrevenue-generating healthcare workers.
3. A government/state institution should investigate how many hospital administrators are needed for hospitals of certain sizes, number of sick patients, etc.
4. All future hospital mandates should be paid by the regulatory body that prescribes them, not the hospital. Let the people decide what is needed as regards mandates.
5. HIPAA should be replaced with a law stating that if a healthcare provider is the cause of a HIPAA violation, that worker either loses their license or lose their license after one stern warning.
6. Hospital executives should have their salaries curtailed, and the number of administrators should be decreased. A CEO hospital salary in a large California hospital is over $7 million a year, which includes bonus.
7. Some of the cost savings above [6] should be used to employ physicians to be part of the administration of the hospital management as it pertains to the practice of medicine by attending and contributing to the running of the hospital. This should help to decrease "burnout."
8. Time may be ripe to join a Union of Doctors [11]. Most doctors get a 1099 and therefore are entitled to form a union.

To conclude, you must be involved with the governance of your hospital and hopefully change your workspace to the benefit of all healthcare personnel and the patients we serve. At the same time, always remember to maintain your "good name," that is, be professional (see Appendix D).

Lastly, I like to quote from Margaret Mead:

Never doubt that a small group of thoughtful, committed citizens can change the world; indeed, it's the only thing that ever has.

References

1. Du JY, Rascoe AS, Marcus RE. The growing executive –physician wage cap in major US nonprofit hospitals and burden of nonclinical workers on the US healthcare system. Clin Orth Relat Res. 2018;476:1910–9.
2. Rosenthal E. An American sickness. How healthcare became big business and how you can take it back. New York: Penguin Books; 2018.
3. Porter ME. What is value in health care? NEMJ. 2010;363:2477–81.
4. Centers of Medicare and Medicaid, March 28. 2018.
5. Harvard Business Review September 23. 2013.
6. Joynt KE, Le ST, Orav J, Jha AK. Compensation of chief executive officers at nonprofit US hospitals. JAMA Intern Med. 2014;174:61–7.
7. The Boston Globe April 1st 2018.
8. Makary M. The Price we pay. What broke American Health Care and how to fix it: Bloomsbury Publishing; 2019.
9. Dyrbye LN, Shanafeldt TD, Gill PR, Satele DV, West CP. Effects of a professional coaching intervention on the Well-being and distress of phsyicans: a pilot randomzied clinical trial. JAMA. 2019;179:1406–14.
10. Brock-Utne JG, Jaffe RA. Addressing physican burnout by restoring contol of healthcare to physicians. JAMA. 2020;180:334.
11. Siebert K. Has the time come to join a union? ASA monitor October 2020.