

I Remember, Lest We Forget

Frank C. Polidora, M.D.

Envy drives ruthless men to seek to control, or destroy, those who possess something they themselves cannot possess, especially authority conferred by absolute trust.

The sacred patient-physician relationship grants great decision-making power to the physician over the patient—to use what would otherwise be poisons, to cut, to remove, to amputate, to confine, to isolate, to alter behavior, to compel, or to invade privacy; but the patient allows this because the patient absolutely trusts that the true physician will try to cure, relieve, or at least comfort the patient—in short, to care for that individual and do what is best for a suffering human being.

But, this relationship can only exist if there is freedom for both parties: Freedom for the patient to seek care with another doctor, and freedom for the physician to be the patient's advocate.

Sadly, this freedom has gradually, and then in a more accelerated fashion, been eroded, until now we find ourselves in a situation never dreamed of 30 years ago. The patient has become a client, a consumer, a covered life, a pawn; and the doctor has been lumped into the category of a provider, a modular employee, a piece worker—no longer a physician. Service is not *for* the individual patient but *to* the health plan, the corporation, the group, the government.

Secular utilitarianism has replaced Hippocratic individualism.

The Incremental Loss of Freedom

I remember when Diagnosis Related Groups (DRGs) were thrust upon us (the Prospective Payment System, 1984). We thought DRGs were to control our fees, but my senior colleague more wisely said they were to control *us*.

Also in the '80s I remember when the giant medical facilities in our state used their political pull to influence the auto insurance laws so that they were reimbursed at cost-plus rates, while our two hospitals were stuck with rates at 110 percent of what Medicare would allow. This was the beginning of the decline of our two hospitals, with fewer and fewer young doctors coming to the area to practice, and the loss of services such as neurosurgery.

I remember when our medical staff voted to give up autonomy on the advice of the hospital administrators and their Pittsburgh lawyers. We were told it would protect us as a medical staff from being sued by rejected applicants to the hospital staff. Then, in the 1990s we found our committee and staff meetings more and more attended by administration and other hospital employees, and the agendas made and controlled by the hospital administration.

I remember when a new hospital administrator came to town in the early '90s. He came from a large university-affiliated hospital from out of state. Why he left there, I don't know. There are no data banks for hospital administrators.

He assumed the position of chief executive officer (CEO) at the financially distressed hospital in town. His professional survival depended upon his gaining control of the other hospital. He craftily studied the situation, the doctors, and the hospitals. A few months after his arrival in town, he brought in an outside consultant. The consultant said our fee-for-service anesthesiologists should be replaced with a unified anesthesia group for both hospitals, with the anesthesiologists as hospital employees. The boards of directors of the hospitals were persuaded, and the independent anesthesiologists were forced into the group in the spring of 1995.

About one year later the head of the anesthesia group, who had an office near the administrator, knowingly hired a drug addict as an anesthesiologist. This drug addict stole drugs, even from the epidurals of women in labor. Hired in June, he was arrested in August 1996, and subsequently convicted and sentenced to prison. This caused a scandal that was reported on national television on ABC's *20-20* on Sep 11, 1997. An undefendable medical malpractice suit against the hospital also resulted. It was settled years later. No action was taken against the hospital administrator or his associate administrator, who was "responsible for anesthesia services."

The head anesthesiologist and his group were terminated from the hospital.

I remember that this administrator allied himself with the most influential lay member of the hospital board, a retired executive, who really did not like it that physicians had power, prestige, and independence. Together, they convinced the boards of both hospitals that an "alliance" should occur; in reality it was a merger. Arrogantly, they named the hospital system after the name of the management group. I opposed the merger in public, including in the newspaper.

This merger occurred in 1996. Despite the scandal about the drug addict, the boards made this administrator the CEO of the merged hospital system. Predictably, he proceeded to consolidate and concentrate his power.

I remember that in 1997 another physician and I orchestrated a vote of no confidence against this hospital administrator and his administration. Seventy-five percent of the hospital staff voted no confidence. The board of the hospital criticized the doctors and ignored the vote.

My colleague and I subsequently became targets.

I remember that I began getting 990s and financial statements of both hospitals and of the other entities of the merger, and publicizing salaries and other data. This administrator called me his "arch enemy."

I remember being told in 1997 that this administrator was having trouble hitting a golf ball at a hospital fund-raising golf tournament. He was not a good golfer. Someone suggested he imagine the face of Tom Jarriel of *20-20* on the ball. He said, “No, better, a certain orthopedic surgeon.” Me.

I was watched, scrutinized, and analyzed. I could not be successfully attacked on issues of quality, service to my patients, compassion, or medical records. I had good rapport with the nurses and other hospital staff. My Achilles heel was my concern for my patients and their care.

A Case Study: Attacking a Doctor by Attacking a Patient

Medicare provided this administrator with a weapon—length-of-stay issues—specifically, my admitting some patients the day before major surgery and admitting frail patients who were having Short Procedure Unit (SPU) operations. I have always treated my patients as unique human beings, not as cases or statistics.

Administration’s arguments were financial, saying that I was costing the hospital money. The number of patients I admitted in this way was small. I repeatedly asked how much it took to “bed and feed” a patient with the room, the staff, the food already being there—the actual cost, not the charge. They gave me no answer. I noted that the big costs of any surgery are on the day of the surgery, with decreasing costs thereafter. They ignored me, or so I thought.

I remember when this administrator said we needed a medical director. I publicly opposed him. The hospital and management boards agreed with him. They created the position and hired a doctor from our medical staff. He became the administration’s attack dog against me.

I remember that in August 1998, the medical director (an internist) and the assistant medical director (a pediatrician) promulgated a “Same Day Surgery Policy,” which prevented admission the day before surgery without the medical director’s approval. The purported purpose was to improve the merger’s bottom line.

In 2001, a more stringent policy, “The Surgical Admission Protocol,” was put into effect by the board of the management group. Again, the purpose was to hinder admission the day before surgery without the medical director’s approval. Violations were to be handled by a “Task Force,” mainly of lay people. Punishment would entail suspension of privileges temporarily or permanently.

Fellow physicians told me that these policies were composed specifically with me in mind. Before this second policy was implemented, something happened that I will never forget. I would never have imagined that the hospital administration would attack me by directly attacking my patient.

This event occurred on Sep 1, 1999.

I live in a rural area near the small city where I have practiced for more than 30 years. One of my neighbors, an independent dairy farmer, needed a total knee replacement. She had private health insurance, which she and her husband paid for. She was not a Medicare patient.

She elected to be admitted the day before surgery. She was aware that her insurance company probably would not pay that cost, estimated at \$400. She and I believed she had the freedom to pay the cost herself. After all, this is America!

But, freedom and dictatorial control are incompatible, and the attack began. The day before the planned admission, she was called by the Quality Assurance/Case Management directress and told not to come in on Sep 1—even though my office secretary had informed the medical director that the patient would pay personally for the day before surgery.

I spoke with the patient. She wanted to be admitted the day before surgery. I told her to come in early on Sep 1, and I would have her admitted.

Hospital “controllers” were waiting for her. They barred her from being admitted not once, but twice. The second time, they kept her sitting in the utilization office.

They were waiting for me also. When I went onto the medical surgical floor looking for her, the medical director arrived, as did the directress of Quality Assurance. A nursing supervisor was also present. They were there to witness my reaction to what they were doing to my patient. Perhaps they were hoping to provoke a reaction that they could use against me in a sham peer review.

There was a chilling silence on the part of the nursing staff. They had been told not to do anything for me concerning this patient. I asked one of them, the head nurse, to accompany me downstairs to care for the patient. With tears in her eyes, she said she had been ordered not to do that, but morality and a strong sense of duty to the patient supervened, and she went with me.

We brought the patient to the emergency room and noted that her blood pressure was elevated. Her husband asked, “What are they [the administrative people] trying to do, give my wife a stroke?” He stated that the medical director had said to his wife, “Unfortunately for you, you’re a test case to see that rules are followed.”

I consulted the patient’s family doctor and admitted the patient to my service. Even so, the medical director tried to bully the family practitioner into admitting the patient to her service, so that the patient could not have her surgery the next day. If the doctor failed to go along with the coercion, the medical director would accuse her of patient abandonment and get another doctor to admit the patient. Things were becoming more surreal and absurd. The hospital administration’s willingness to use the patient as a pawn to enforce its cost-containment surgical admission policy, even if it meant harming the patient, was repugnant and reprehensible.

My orders were not being implemented. The medical director and Quality Assurance directress verbally ordered the nurses on the telemetry floor to disregard my orders. I advised the nurse to document this fact, and to follow my orders, or she would be held responsible for harm to the patient.

The medical director had also directly ordered the nursing staff not to give my patient a tray—to deny her food or water! He prevented the nurse anesthetist from visiting the patient. He attempted to bully the operating room supervisor into canceling the case.

Because my patient had absolute trust in me, she still wanted me to do the surgery, and at this hospital, because that’s where I was.

I complained to the chief of staff, the chief of medicine, and the chief of surgery. I finally got in touch with a hospital administrator (not the one who considered me his “arch enemy”). I demanded that the medical director be suspended for endangering my patient.

Perhaps, seeing that they were wrong but refusing to admit it, and seeing that they were becoming caught in their own trap, the hospital administration came up with a scheme to admit the patient to the family physician’s service for “observation,” and to allow her to be admitted to my service the following morning for surgery.

The next morning in the operating room, the patient asked me about the medical director: “Is he here? I don’t trust his eyes.” Her surgery then went ahead, and she was discharged four days later.

Subsequently, the hospital sent her a bill for more than \$1,000. Some of the charges were for items specific to her surgery like pre-op sedation, antibiotics, and skin prep. They charged her for Catapres patches used to treat her administration-induced hypertension.

None of the administrative people who attacked my patient were ever punished or reprimanded to my knowledge, despite my protests, written and oral.

Like any abuser who has gone too far and gotten away with it, the hospital administration continued to use my patients to attack me, but never again in so direct and coarse a fashion.

They used Medicare rules to issue Advance Beneficiary Notices (ABNs) to in-patients they wanted discharged or to prevent admission of frail SPU patients. They used outside reviewers to support or to “compel” their actions.

Because I gave advice to my patients in combating what the hospital administration was doing to them, and because I documented this in patient charts, I was placed on “probation” in 2002 as a “disruptive” physician making “inappropriate” remarks in charts.

I continued to be my patients’ advocate.

Administration (of the merger management group) tried to attack me through the Surgical Admission Protocol but failed, probably because of the problems with its formation.

Fighting Back

I reported the hospital system to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and to the state health department. There were inspections, but no citations to my knowledge. The health department wrote to me: “In order for a citation to be written, the surveyor must observe the practice or be able to prove from documentation in the record, or from interviews with staff and others, that deficient practices had existed.” This policy is an abuser’s dream. It helps explain why the hospital administrators did not want written evidence of their conduct in the chart.

I noticed that the hospital administration, through the use of the Quality Improvement Organization (QIO), was using patients’ own medical records against them.

Therefore, on Sep 11, 2002, I composed the “Patient’s Instructions for Reviewers” of their hospital charts (see box). Patients were free to sign it and bring it with them upon admission to the hospital. A number did sign to reinforce their Right to Privacy. This really hit a nerve!

The out-of-state QIO threatened, through a Washington, D.C., lawyer, to report me to the Office of Inspector General (OIG) and have me blacklisted from Medicare unless I stopped my patients from using these forms, and had those who had already done so “unsign” them.

I reported the lawyer, the QIO, and its executives to the OIG and to Attorney General Alberto Gonzalez. I accused them of conspiracy to violate my patients’ Constitutional rights—a criminal offense. No action was taken against me, or them. Sen. Rick Santorum’s (R-PA) office told my staff that it was a “hot potato.” I was never sanctioned.

Towards the end of 2002, administration tried yet another attack. They tried to force me to sign an agreement that essentially said I would not be my patient’s advocate. Because I refused to sign it, my privileges at both hospitals “lapsed” as of Dec 31, 2002, and the administrator, the CEO of the merger, went around the hospital posting notices that the nurses were not to follow my orders, even though I had two patients in the hospital.

I didn’t relinquish my privileges. They were not removed or suspended. They simply “lapsed.” It was an ethical choice to not continue to practice at an institution that placed control over physicians above doing what is best for patients.

I am not in the National Practitioner Data Bank.

None of the administrative people who attacked my patients were ever punished or reprimanded openly. But at the end of 2003, the administrator “retired” with a nice severance package. The medical director was eventually let go. He subsequently died in 2009. He was not much older than I.

In October 2003, I was approached to come back to the medical staffs of the hospitals. I declined.

In March 2003, I obtained privileges at another hospital about 26 miles from my home. It was like a beautiful *Twilight Zone* episode—returning to the past, to a place where patient care was paramount and doctors were respected. I was able to practice there for my patients and according to my ethics. But even in that wonderful place, Medicare intruded, slowly but surely, and in 2008 I could see that even though they didn’t want to, the administrators were being forced by Medicare to enforce managed care.

After ObamaCare

When Democrats passed ObamaCare in the dead of night on Mar 21, 2010, I made up my mind. I saw where this was going. There would be further loss of autonomy due to regimentation of treatment plans, length-of-stay issues, and further government devaluation of physician services.

I resigned my privileges effective May 1, 2010, and was very public about it. One blogger queried, “Who is John Galt?”

I now have an office practice. I will continue that as long as I can be a physician and not a provider, a patient advocate and not a government employee. A slave cannot be a physician. And if I stop practicing, then my only concern is who, or what, will follow me.

The hospital’s mistreatment of my patients occurred before ObamaCare, for example, on Sep 1, 1999. What will ObamaCare bring us? Change is always unpredictable—except when it is a planned agenda by those seeking illicit power over others.

None of the entities commissioned with the duty of protecting my patients, and punishing those who harassed and abused them, carried out their assignment. This includes JCAHO, the state health department, the medical staff, the OIG, the QIO, and the hospital QA department. The system failed the patient, and it will continue to fail patients because bureaucracies, no matter how large and well intentioned, cannot really protect us from ruthless, immoral, amoral, sociopathic people, the reptiles of society, people with no feeling for the suffering of others, people who consider other people as objects to be used for their own selfish purposes. In fact, once these types of people gain control of a system, they drive out those who have compassion and courage and leave all of us at the tender mercies of the kind of bureaucracy that C.S. Lewis, in his preface to *The Screwtape Letters*, describes as Hell. The more that power is centralized and concentrated, the easier it is for one of these sociopathic types to gain control.

The Remedy

The remedy for this disease of control by sociopaths, and its prevention, is subsidiarity. As explained by the Acton Institute, subsidiarity is the moral principle that in a society, hierarchy, or other human institution, including the state, autonomy of decision making and problem solving must be as local and immediate as possible. Nothing should be done by a larger and more complex organization that can be done as well (or better) by a smaller and simpler organization. People have to be able to walk away freely—and they need places to escape to. There must be multiple checks and balances on power. People need advocates, paracletes, and champions—who have the power to protect them. We, as physicians, must be empowered to care for the individual for the individual’s sake.

The socialist/sociopathic tide must be stopped and reversed. The fact that my Achilles heel was my compassion for my patients is testimony to the twisted and abusive socialist environment we find ourselves in today. Morality in medicine must be re-instituted according to the principles of the Oath of Hippocrates:

- 1) Human life is sacred from conception till death.
- 2) The patient-physician relationship is sacrosanct.
- 3) Medicine is a profession.
- 4) The physician exists for the benefit of the sick, not the healthy.
- 5) God will judge whether the physician fulfills his or her calling.

The QIO hiding behind a façade of a “statutory mandate” for review enabled those who abused my patients and contributed to this abuse, all in the interest of control. The Achilles heel of the socialist/sociopathic juggernaut may be the validity of their purported claims to the patient’s medical record.

My privacy form struck something that no one in the federal government wanted to touch. If there is a right to privacy implied in the U.S. Constitution, why is it absent in a 72-year-old woman, as regards her medical record, but present for a 27-year-old woman who seeks an abortion?

Rule of law means that laws are applied equally and uniformly. If privacy does not exist in a person’s medical records, then it cannot be used as an argument for abortion, and *Roe v. Wade* is null and void. If, on the other hand, there is privacy, then a person can control who has access to his medical records and what they can be used for. Socialized medicine collapses and subsidiarity in the care of the sick and injured returns.

Delenda est ObamaCare!

Frank C. Polidora, M.D., has had a private practice of orthopedics in Hazleton, PA., for more than 30 years. Contact: 1710 East Broad St., Hazleton, PA 18201, telephone (570) 455-3270, email mpolidor@frontiernet.net.

**Patient's Instructions for Reviewers
Hospital Chart
ADVANCE DIRECTIVE**

- No reviewer, especially an outside reviewer, is to review my chart without first discussing with me and my family why he or she wants to review my chart.
- The reviewer must explain to me and my family, in writing and in person, the reason for reviewing my chart, and what benefit I would gain from such a review or what harm, including to my health or sense of well-being, that such a review could cause.
- The reviewer must then obtain express written consent from me to review my chart.
- Any violation of the above constitutes an invasion of my privacy.
- This supersedes any permission I or my family has given previously or will give.
- This document must not be removed from my hospital chart. To do so violates my Right to Privacy and constitutes the fraudulent alteration of my medical record.
- A copy of this document carries the same weight as the original.

Patient

Date

Time

Witness

Date

Time