EDITORIAL

Economic Pressure in Hospitals

Profound Disagreement over Priorities Between Doctors and Managers

Johannes Köbberling

Editorial to accompany the article: "The commercialization of patient-related decision making in hospitals—a qualitative study of the perceptions of doctors and chief executive officers" by

Karl-Heinz Wehkamp, Heinz Naegler in this issue of *Deutsches Ärzteblatt International*

Managers and doctors have very different perceptions of the medical and economic processes in hospitals. Those familiar with the health care system will not be hugely surprised by this finding of the survey by Wehkamp and Naegler (1). While the managers/chief executive officers categorically deny that they exert any influence on medical decision making, the doctors describe their decisions as being affected by management policy on an almost daily basis.

The managers' viewpoint

Let us start by looking at the managers' viewpoint. They are under pressure to achieve a high enough return to secure the future of the institution. Managers in private hospitals also have to maximize the profit margin.

Without exception the managers insist they exert no influence over medical decisions, for they too are fully aware that such influence would break the law. Probably the majority of managers will genuinely avoid influencing doctors' decisions on the treatment process in individual cases. Their profit strategy concentrates on optimization of organizational processes, and they assume that their operational guidelines do not affect medical decision making.

Although this perception is understandable from their standpoint, it is a narrow view that largely ignores the real problems. If they plan according to the economic interests of their hospitals, they will be failing to take account of the needs of the population and creating structures that in many cases clearly restrict doctors' freedom of decision. For example, increasing facilities for cardiac catheterization on grounds of competition will lead to widening of the indications although there was no medical need for such a move.

The doctors' viewpoint

The doctors, who sometimes have absolutely no involvement in the shaping of hospital structures, complain almost without exception that many operational guidelines affect their medical decisions directly or indirectly. They state, some more explicitly than others, that they are virtually forced to accept influence on their choice of treatment, or that they have bowed to economic constraints of their own accord. They view this influence as virtually a characteristic feature of their work. The influence exerts itself, for instance, in decisions regarding the opening or closure of departments, purchasing of materials and medications, and particularly in connection with staffing policy. Because of the

study's methods, most of the doctors' criticisms refer to individual cases and are often formulated imprecisely. However, the authors (1) list some concrete examples of cases where influence was exerted.

Some of the doctors who were interviewed expressed the opinion that basic principles of medical ethics were transgressed on a routine basis. Several of the responses indicated that doctors not only feel that their decision-making freedom is under threat, but have also taken part in ethically dubious decisions. In my view they should ask themselves whether they have not sometimes violated the basic ethical standards of their profession, especially if decisions are taken with their own interests in mind. The medical conscience is in danger of becoming blunted.

Ways out of the dilemma

General dissatisfaction on one side, widespread repression of the problems on the other—this state of affairs cannot be allowed to continue. Increasing the funds available for the health care system, a frequently voiced demand, would not change a thing. More money in the system would certainly not reduce the profit motivation; in fact, it would merely intensify the sensitive aspects of the problem.

"Cheaper" does not automatically mean "worse." The necessary and adequate level of care can be excellently achieved with the existing means. This might require restrictions in comfort and luxury here and there. The opulence displayed in some hospitals, assuredly due in part to the pressure of competition, emphatically does not lead to improved treatment results.

What is missing is a shared comprehension of how the available funds should be used, what priorities should be set, and how medicine should be conducted. Managers often lack the knowledge and understanding of how rationalization can take place without cutting necessary services. For example, they should regularly be informed by doctors where profitable overdiagnosis and overtreatment not only yield no medical benefit, but may in some circumstances even cause harm.

There is no alternative to intensified cooperation between doctors and managers when it comes to important basic decisions. Doctors must not just complain but concern themselves with economic principles and get actively involved in shaping how hospitals are run. Managers must talk to doctors and work together with them to create consistently patient-oriented hospital structures. A legal framework stipulating that doctors should be represented in management and authorized to take decisions

Former Head of Internal Medicine, St. Antonius Hospitals, Wuppertal: Prof. Köbberling

would probably be helpful, because in light of the pressure on managers to maximize profit not much faith should be invested in voluntary solutions. Politicians should no longer be allowed to ignore this problem.

It is indisputable that in the confrontational culture still prevalent in many hospitals, for some doctors open broaching of the problems would be connected with economic risks. Nevertheless, it is an ethical imperative to speak out when decisions taken by nonphysicians put patients in danger. The old principle "*salus aegroti lex suprema*" (the wellbeing of the patient is the supreme law) must not be relativized. This applies to all those involved in the health care system.

Conflict of interest statement

The author declares that no conflict of interest exists.

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Corresponding author

Prof. Dr. Johannes Köbberling
(Former head of Internal Medicine at Kliniken St. Antonius Wuppertal)
Am Freudenberg 85, 42119 Wuppertal, Germany
johannes@koebberling.de

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CLINICAL SNAPSHOT

Seizure or Syncope?

A 26-year-old man collapsed in his home. His mother found him with “twitching limbs” and then “unconscious,” and initiated chest compressions. On arrival of the emergency medical team, he was awake and oriented, with normal vital signs and blood sugar. There was no evidence of a tongue bite or urinary incontinence. An ECG taken in the emergency room revealed right bundle

12-channel ECG after an ajmaline test (speed 25 mm/sec, amplitude 10 mm/mV).

branch block in the V1 and V2 leads, with mild ST segment elevation. After an ajmaline challenge (1 mg/kg of ajmaline given intravenously over 10 minutes), typical saddle-shaped ST segment elevation emerged more clearly (*Figure*), establishing the diagnosis of Brugada syndrome. This is an ion channel disease comporting an elevated risk of sudden cardiac death. The patient declined the prophylactic implantation of an AICD for personal reasons (among them the need for frequent battery changes), and outpatient cardiological follow-up was recommended. In retrospect, the episode that brought him to the hospital was most likely a rhythmogenic syncope that at first resembled an epileptic seizure. As this case shows, syncope must be included in the differential diagnosis of epileptic seizures, and vice versa.

Dr. med. Olaf Krause, DIAKOVERE Henriettenstift Hannover, Zentrum für Medizin im Alter und Medizinische Hochschule Hannover, Institut für Allgemeinmedizin, krause.olaf@mh-hannover.de

Elisa Walle, Prof. Dr. med. Wolfram Terres, Allgemeines Krankenhaus Celle, Klinik für Kardiologie

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