Hospitals

CARDIAC OVERKILL?

REDUNDANT HEART CARE COMES TO SANTA CRUZ

By Christine Miller

If you or a member of your family were to have a heart attack in this county, you might expect to be taken by ambulance to one of the local hospital emergency rooms, quickly diagnosed and hooked up to intravenous medications, then linked to monitoring gadgets and plugged speedily into the most state-of-the-art cardiac care that modern medicine had to offer.

Most people, especially young people, don't think through the scenario of having a heart attack until cardiovascular disease—the nation's biggest killer—actually strikes a family member, or an older friend. Some of us never think about heart attacks until we have one ourselves. But if you were to try to imagine what it would be like to be on the receiving end of this county's health care delivery system, you might come up with a scenario more or less like the one just described. And until only recently, you would have been dead wrong.

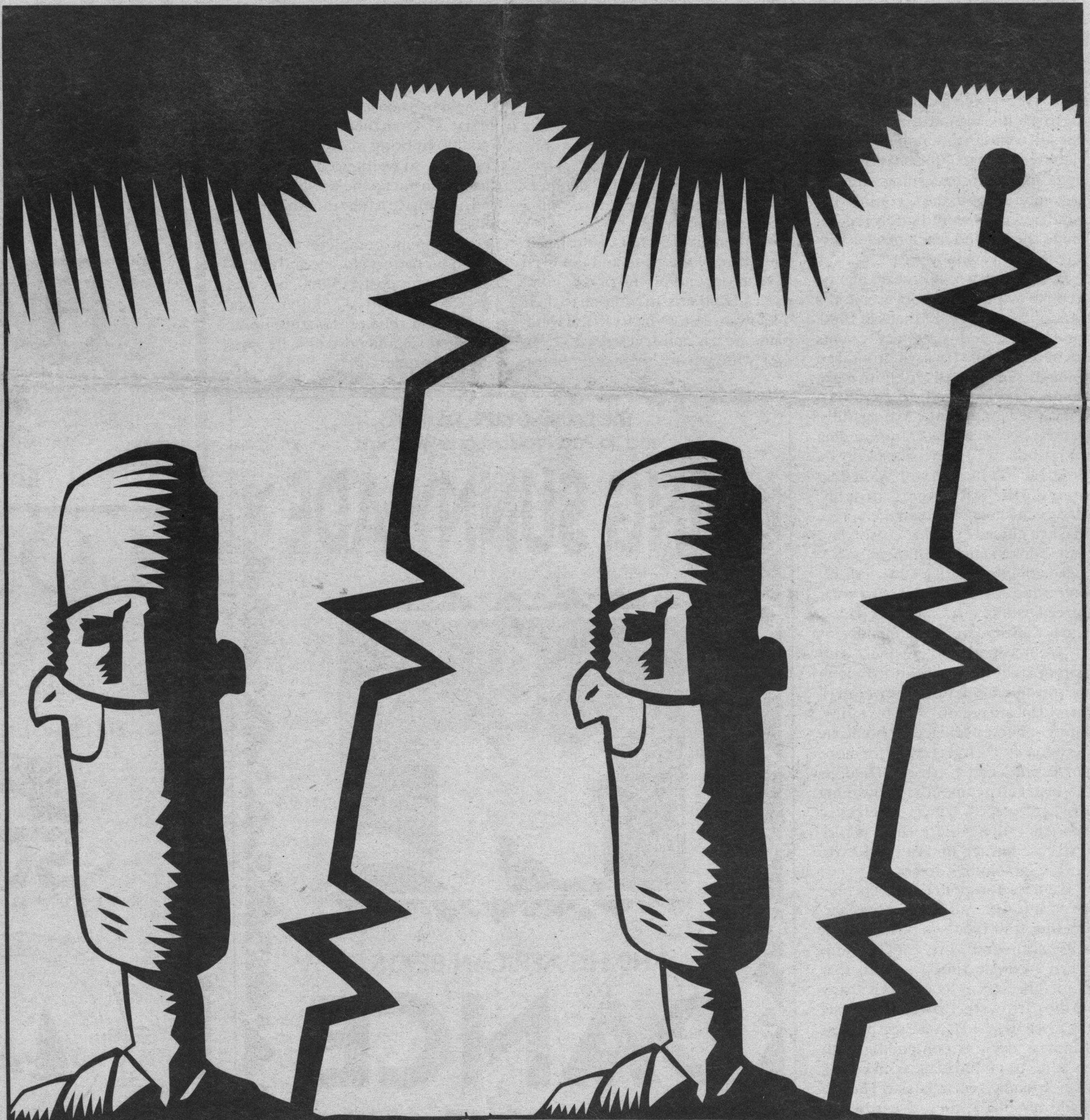
In keeping with a standard of care set 20 years ago, local hospitals have offered coronary care units—specially equipped beds staffed by specially trained nurses. However, until last year no Santa Cruz County hospital provided up-to-date cardiac diagnosis, surgery or coronary care—care that is increasingly commonplace in many smaller communities across California.

Santa Cruz heart attack patients who needed high-tech cardiac diagnosis or surgery would be shipped, by ambulance, to Santa Clara or San Mateo counties. For many heart attack sufferers, Santa Cruz hospitals functioned more like small-town sorting and shipping departments than real centers of diagnosis and treatment.

Last year, 274 patients had to make this costly and often dangerous ambulance trip over Highway 17. Occasionally, the heart attack sufferer was too sick to be moved. If the patient's condition was unstable—if their heart could not beat rhythmically, or with enough force to maintain an adequate blood pressure—the long ambulance ride might have been too risky an ordeal. Patients have had to stay in Santa Cruz for several days before making the journey to another hospital for definitive care, diagnosis or surgery.

But over the last year, our small-town referral system has begun to change. AMI/Community Hospital of Santa Cruz performed its first modern diagnostic procedures last summer, followed in October by a coronary bypass operation on a 52-year-old Santa Cruz postman. To date, more than 40 coronary bypasses have been successfully completed, plus a number of heart valve replacements. Locally available surgery is keeping Santa Cruzans from having to be exported out of county, sometimes hours from home and family.

The team of surgeons and nurses performing these operations is unique in that they belong to a group that does most of its surgery at Seton Hospital in San Mateo. While one surgeon is stationed permanently in Santa Cruz, the others rotate between their busier San Mateo practice and their Santa Cruz "satellite."



MOTT JORDAN

Rotating teams like the Seton team are not entirely new to medicine, but they are the exception rather than the rule. For a growing community like Santa Cruz, such an arrangement may solve our long-standing void in cardiac care. But as part of a larger picture of poorly planned and uncoordinated expansion of medical services in this community, cardiac surgery may be contributing to new problems as fast as it solves old ones.

Dominican Hospital, the largest area hospital and direct competitor to AMI/Community, is about to open a cardiac diagnosis and surgery program of its own. This second program will effectively duplicate the services provided by Community. Vocal critics at both the state and local level question the efficacy of building two centers so close together in a county previously served by none.

Consumer watchdog organization Mid-Coast Health Planning Agency adamantly opposes twin centers. David Wright, director, cites an

"insufficient number of heart operations performed annually" on Santa Cruz residents to justify two centers. Says Wright, "Two centers may make some money for the hospitals, but may not be good for the community." Wright has fought a five-year battle in and out of court to prevent the duplication of facilities that now appears inevitable.

Many local physicians echo similar views. Says one doctor on staff at both Dominican and Santa Cruz Community hospitals, "It's an irresponsible move at a time when the health care community in general has been trying to become more cost-conscious."

The problem of duplicated services is itself twofold: Since the installation costs of a multi-million-dollar center can only be recovered by raising hospital fees across the board, local patients will ultimately have to foot the bill for these services—twice. Worse, duplication means that the number of heart surgery cases will be split between two hospitals with each center doing only half of the total. At first glance this doesn't look like a problem, but the implications of two teams performing half as much surgery may spell disaster for patients.

A Phoenix, Arizona, study conducted in 1985 showed not only a rise in the cost of the average operation (from $19,000 to $27,000), at centers with smaller annual case loads, but also an increase in the number of patients who either died during surgery or suffered post-surgical complications. In the Arizona study, a doubling of the number of cardiac surgery programs was associated with a 35 percent increase in the number of surgery-related deaths.

Besides increased costs for patients, increases in these so-called mortality/morbidity statistics are what critics find most disturbing about the prospect of duplicated services here in Santa Cruz. The trend toward more complications in low volume hospitals turns out to be true for other kinds of surgery as well. Points out one Stanford-trained cardiac surgeon, "It's almost a maxim of surgery that small case loads mean big trouble." The conventional explanation for higher mortality/morbidity statistics, says David Wright, "is that operating teams doing fewer cases become 'rusty,' less able to deal with surprise problems during an operation. They get out of practice."

Prior to 1986, state-level planning agencies set standards using a similar logic. The state required a minimum of 250 cardiac surgery cases per year before it would grant a license to a hospital to offer heart surgery. Hospitals wishing to expand into cardiac diagnosis and surgery used to have to *prove* to the state that the community needed the program.

But with Deukmejian came a certain level of deregulation. This loosening of controls effectively decentralized costly high-tech hospital services (like neo-natal centers and cardiac surgery) that had previously required state authorization. In the process, licensing restrictions on hospitals were lifted and high-tech health care entered the free market.

During the early 1980s, with regulation still in effect, AMI/Community Hospital sought to convince the state of this county's need for a cardiac surgery program. "Their estimated number of cases in fact overlapped the figures being used by Salinas Valley Hospital, which was applying for a heart center of its own," says Wright. Each hospital used the same county-wide statistics, and neither painted a realistic picture of what case loads would look like with two fully operational centers. Obviously each hospital would do only a portion of the total number of cases.

Both hospitals were granted the go-ahead to open centers. Dominican simply waited in the wings with its plans until two years later when state restrictions were lifted. Today the redundancy of surgical service resembles the metaphor of a Jesse Jackson write-in campaign: with more hospitals performing heart surgery, cases, like votes, get split; in the end multiple heart centers, like multiple Democratic candidates, weaken each other. Studies like the Arizona survey predicted a rise in cost, complications and deaths with more centers doing surgery. Of serious concern is whether AMI/Community or Dominican in direct competition with one another, can provide the community with an optimal program.

"Lacking effective public input, the decision (to install cardiac surgery) was strictly a corporate one," says former mayor Jane Weed. Weed served on the board of Mid-Coast Health Systems Agency during the hospitals' decision making period. She criticizes the fact that "a mechanism for public opinion to affect hospital planning simply does not exist."

Agency director David Wright is even more emphatic: "These decisions were made behind closed doors in a smoke-filled room." The public and even his own agency, a legal entity, "were actively excluded from the decision to build these centers." Wright claims that whether for profit or nonprofit, hospitals in a free market system behave the same: "To them it's all marketing."

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Both Weed and Wright stress the fact that community needs are often not represented by hospital boards. "Neither board ever asked if the children of this county were properly immunized," says Weed, "or how many women are getting adequate prenatal care." Wright agrees, adding, "the boards are often conservative."

Even Dominican Vice President Bob Semas admits that although local residents serve on it, his hospital's board of directors tends to be "conservative and self-perpetuating."

AMI/Community also has a board but part of its decision to build may have been made even further from public scrutiny or participation. As a single institution in a 113-hospital international corporate chain, AMI's decisions necessarily reflect the larger needs of its parent corporation as well. Regarding the competitive economic situation faced by hospitals in general, Jane Weed says: "Let's face it, there just isn't any profit in it for hospitals to make sure that children get vaccinated."

Today, less than a year behind Community, Dominican Hospital is on the verge of opening its own heart center for business. Dominican expects to do its first diagnostic procedures and surgery this summer. Unlike AMI/Community, Dominican will not be relying on surgeons who rotate from a high-volume center outside the county. Instead, one full-time surgeon and his assistant will run this second program.

Given the enormous capital outlay required to install cardiac diagnosis and surgery ($5 million-$6 million), why have both Santa Cruz hospitals proceeded at the risk of "flooding" the cardiac surgery market?

One possible explanation for the rush to build has to do with revenues from parts of the cardiac program other than surgery. Although surgical case loads may be less than robust, both hospitals expect to see a profit from diagnostic and nonsurgical procedures such as cardiac catheterization and, especially, angioplasty.

Angioplasty is a nonsurgical treatment of coronary artery disease that reopens blocked arteries with a tiny inflatable balloon. The balloon, built into the end of a long thin tube, is passed up to the heart from an artery in the leg with the patient fully conscious. Once at the blocked segment of coronary artery, the balloon is carefully inflated, widening the area and reopening the artery. The result is a return of blood flow to the deprived area of heart muscle, preventing and sometimes even reversing a heart attack that is in progress. The procedure is virtually painless and leaves only a tiny scar. Moreover, patients can usually return home the following day, which reduces hospital costs dramatically.

It is precisely its lower cost that has hoisted angioplasty so quickly onto hospital board meeting agendas. Angioplasty is cheaper than surgery so insurance companies prefer it. And since angioplasty is quicker and cheaper, hospitals can make money on it. Medi-care, a national health insurance for the elderly, has set a precedent of high reimbursements to hospitals for angioplasty—$16,000 in some cases. With such high levels of reimbursement, insurance companies effectively create a climate that makes angioplasty an attractive procedure for hospitals to offer. Some companies have simultaneously begun denying payments for other types of coronary bypass surgery, thus securing the profitability of angioplasty for hospitals and doctors alike.

Angioplasty has become so popular in the last few years that it will make money for hospitals even if new surgery programs do not.

But money-maker or not, angioplasty falls short of a panacea. The possibility of ruptures and blocks of the coronary arteries during the balloon-inflation requires that surgeons be in the hospital on stand-by to rush a patient into the operating room, just in case the balloon procedure fails. In other words, for hospitals to be able to provide money-making angioplasty, they will need heart surgeons on the premises.

"Angioplasty is definitely the horse leading this parade," says watchdog organization director David Wright of the duplication of cardiac facilities. And no one is denying the charge.

Until Community opened its heart program, all of Santa Cruz's several hundred yearly angioplasties were also shipped to other counties. From the point of view of the hospitals, these cases represented revenue lost. "Angioplasty is definitely part of the reason for installing cardiac surgery," acknowledges A.J. Lindemann, chief operating officer at Community Hospital.

Now Dominican will also be slicing a piece of the pie.

And the problem of redundant services is not unique to Santa Cruz. Nationwide, 400 new cardiac catheterization labs opened in 1987—a 44 percent increase in the number of labs from the year before. In Los Angeles County, 80 hospitals are currently planning heart surgery programs. "The proliferation of cardiac programs is so extreme it has created a backlash movement," says hospital growth consultant Phillip Ronning. Even the state legislature is alarmed. Last month, the California Senate subcommittee on health unanimously passed a bill to reinstate licensing quotas. Ronning is convinced that money-making angioplasty procedures "are what's driving the growth." Ronning says, "the market is large, and because it is high-tech and the insurance companies are paying, it is also glamorous—everybody wants a piece of the action."

But the question that continues to plague area residents—the consumers and potential recipients of these services—is whether or not two centers, less than two miles from one another, are really justified.

In defense of cardiac surgery in Santa Cruz, Dr. Alex Zapolanski, heart surgeon and co-director of the Community program, cited some frightening statistics: "36 percent of those who were treated for first heart attacks died," said Zapolanski; "85 percent of those deaths occurred in the first 24 hours." Prior to cardiac surgery in Santa Cruz, many of these acutely ill patients could not have been helped. Zapolanski believes they will have a better chance with improved local facilities.

Incoming Dominican surgeon Dr. Lee Griffith agrees that there is a need for surgery in this community. Answering the criticism regarding too few cases and the possibility of increased mortality and morbidity, Dr. Griffith says: "Cardiac surgery has changed so much, even in the last few years, that studies [such as the Arizona study] don't necessarily mean anything. Today many of the less ill people are being treated with angioplasty, so we end up actually operating on sicker and older people. Studies that have been done over the last several years have not been standardized to reflect the way in which surgery itself has changed."

Griffith believes his team will be able to maintain high-quality care performing as few as 50 operations a year—a caseload he says he is sure he'll see—even as the second doc on the block. Unlike the San Mateo-based Community surgeons, Griffith plans to make Santa Cruz his permanent home, and ultimately to retire here.

Whatever the hospitals' motives for installing cardiac surgery programs in this community, the days of shipping heart attack victims out of the county appear to be over. And while Dominican Hospital may have a longer commitment to the area with twice Community's annual revenue, Community has the backing of the nation's third largest corporate chain. With both programs so well rooted economically, only time will tell whether or not the apparently profit-minded decisions to build twin centers will actually benefit the public that had so little say in their making. •

PLANNING STANDOFF

Last Friday, in an unprecedented effort to block the Dominican center from opening, AMI/Community Hospital filed an appeal with the county planning department. In it Community alleges that the Dominican center will adversely affect the county and has requested that the planning department stop the Dominican center. "Our community cannot support duplicate services," states Ann Klein, Executive Director of AMI/Community; "If Dominican is allowed to proceed, medical costs for these services will go up at both hospitals, and quality of care will go down."

In a response issued Monday, Sister Julie Hyer, Executive Director of Dominican Hospital, stressed that authority to block or approve cardiac services resides with state, not county officials. Hyer's statement points out that the Office of State Health Planning and Development has already approved her hospital's request to provide cardiac services and that the amended use permit appealed by AMI/Community pertains only to county works such as utilities, sewage and parking.

Planning department official Bob Legget says a decision on the appeal is likely to be reached in the next three to six weeks. However, until this legal snafu is overcome, Dominican's program is effectively forestalled.

—Christine Miller