
Dr. Kildare Clarke

'South Africa is right here in New York'

Dr. Kildare Clarke is Associate Director of the Emergency Room at Kings County Hospital in Brooklyn, New York.

EIR: Is there serious harm to patient care because patients have to wait many hours to be seen?

Dr. Clarke: We try to deal with that by putting an experienced emergency physician to screen all of the patients when they first arrive. For example, we saw a patient complaining of lower abdominal pain. It turned out that the patient had had a myocardial infarction [heart attack]. We have a rule that any patient who is over 40 and has any abdominal pain is to be seen at once. Sometimes the patient who complains relatively little is the most seriously ill.

EIR: Why aren't there enough beds to take in your patients upstairs?

Dr. Clarke: It's a crazy thing. Between medicine and surgery, there are 488 beds. The Department of Medicine has reduced its number of beds over the past two years. The chairman said there were not enough medical residents [physicians training in their specialty] to staff them. (The department was not able to secure enough residents through the matching program in which this and other programs participate and compete for residents.) At the same time, his position is that after his beds are filled, he can't admit. His census is indeed close to 100%.

Now with the chairman of surgery it's a different problem. He says, "I won't take medical patients onto the surgical service." Why? "1) It will decrease the number of residents on my service, since this number is based on the number of surgical beds I have. 2) I can't bring in elective patients who provide residents with a sufficient number of operations to qualify for their Surgery Boards if these beds are taken by non-surgical patients." But although residency training is, indeed, important, it is being allowed to take precedence over patient care.

With a patient in a hospital bed, i.e. with optimal care, the patient will recover and go home sooner. Therefore the current system is short-sighted and creates havoc in the emergency room. For instance, today we have 14 patients admit-

ted to medicine, but stationed here [in the emergency room], while there are 33 unused surgical beds—i.e., in terms of patient care, no one should tell me there's shortage of staff, because there are nurses on the floor, all ready to care of them. We can extrapolate that, if there were surgical patients there to fill these beds, they would get care.

EIR: What are the illnesses of the 14 medical patients whom you are caring for?

Dr. Clarke: They include coronaries, hypertensive encephalopathy, tuberculosis, pneumonia, and AIDS.

The other down side, though not a major issue, is that for every patient who stays in the emergency room—whether it's for one day or for ten days, for example, a tuberculosis patient who has been here for seven days—the total bill is for one visit to the emergency room, i.e. \$105, instead of 7 times \$850 per day [for a hospital bed].

It's a fight between department chairmen. Our executive director is undermined by the chairmen who sit at Downstate in [the Departments of] Medicine and Surgery. [Downstate Medical Center Hospital is the private hospital which is affiliated with Kings County Hospital—ed.] They make major decisions affecting the welfare of the patients in our emergency room. I've been fighting this for ten years. These chairmen are more interested in their ego and power base than in the care of the patient. Because these patients don't put money in their pockets, there's no need for them to hold the hand of the family or of their patients in order to get paid. This shows why socialized health care is an absolute. The clear-cut interests of individual people is getting precedence over the public at large.

EIR: Whom can you appeal to?

Dr. Clarke: Due to Koch's legacy in the HHC [Health and Hospitals Corp.], they're more interested in their affiliation than in patient care. Look at the affiliation situation and the affiliation contract. Back when the city hospitals were under the Department of Hospitals, they were basically staffed by foreign medical graduates, in those days, Indians and blacks. The medical schools said, "You don't provide enough good care for the poor. Give us the money and we'll provide your patients with better care." Over the ensuing years, these contracts became lucrative. The hospital gives money to the private physicians to "run the hospital." The school will say, "I need 20-30% off the top as my overhead." Using the remaining 70%, it will provide staff for the hospital. But this staff is employed by the medical school and reports to them, not to the head of HHC.

Translated into different terms, the same doctors whom HHC, if independent of the affiliation contract, could have gone out and gotten for \$100,000 per year by hiring directly, the medical schools will pay \$140,000 per year via the affiliation, and these doctors will have no allegiance to HHC, but instead to the private medical school. We can extrapolate



Rescue workers unload an accident victim for treatment. In this situation, everyone should get the same level of care—but not everyone does.

HHC gets only 30% of its total money, which it pays out as actual services performed.

EIR: You mean that these doctors serve only part-time and yet they get paid as full-time?

Dr. Clarke: That's right. The private institutions clamor to have it set up so that the procedures are rewarding which are highly technical. They get to be done at the private hospital and not the city hospital. For example, Kings County Hospital, which is one of the biggest municipal hospital centers, has an unusual adult emergency room with a total of 400 to 600 per day. Yet our cardiac catheterization laboratory has been dismantled, and all catheterizations are done at Downstate. The people who mostly need these procedures aren't getting it. These poor have such eating habits and social situations as to render them more prone to the disease processes [that cause coronary disease]. You must pay for [catheterization] to get it, unless you are an especially interesting case.

The cardio-thoracic surgery department, which was part of the Kings County Hospital when I came up through my residency, is now at Downstate Medical Center. So if you come in here with a gunshot wound to the chest, then, although the trauma surgeons here are very well trained, one would expect in so large an institution there would be a cardio-thoracic surgeon available to you, yet it's not so. They're all at Downstate, although Downstate really doesn't need them as much.

Although we don't have a full affiliation with Downstate, except in psychiatry and radiology, we have a loose arrangement. The director of a department at Downstate is really a department director at Kings County Hospital.

Take radiology. For each x-ray taken at the Kings County Hospital facility, the Department of Radiology Corp. at Downstate Medical Center gets paid. This is HHC's money

allotted for x-rays.

EIR: So they get the money, because their radiologists read the x-rays?

Dr. Clarke: Yes. The city is in budget shortfall. It is my contention, and I can prove it, that even if we deal with the affiliation as it currently exists, if we would use the beds in the [HHC] corporation, in a more productive way, we could double the quality of care at no more cost to the corporation and, at the same time, have money left over to put in the program and help the mayor to balance his budget. If I were head of HHC, I'd tell the mayor I could give him back \$250 million of the \$2.5 billion and run the corporation better and improve the care 100%, if I didn't have to give contracts to the medical schools without accountability. Why should I pay you when I train your residents for you? You use our patients, who you take care of for your research material. We are giving you the privilege to learn on our patients.

If there were socialized medicine, greed would not be such a factor, with patients being pawns.

EIR: Well, what happens if a patient comes to your emergency room with a cardio-thoracic emergency?

Dr. Clarke: At best you'll get a cardio-thoracic fellow to operate, not an attending [physician]. This is why I'm so outraged. We can't play with people's lives in that fashion. Last year I wrote to Koch about this. Despite all my outcry, their solution was, I should quit if I felt that I was being forced to violate my Hippocratic Oath. I, in turn, suggested *he* quit.

EIR: Does the city provide you with the technology you need?

Dr. Clarke: I must give credit where it's due. After I went public on it, the administration acted very well. They gave me almost every piece of equipment I wanted within reason. Yes, I'd like to have a three-dimensional echocardiographic machine, but, to be realistic, when a fellow in cardiology can bring such a machine down to the emergency room, you can't expect everything. A patient shouldn't be in an emergency room to have every bit of diagnostic work. They've been as helpful and receptive as they can. It's just one crisis after another.

EIR: Do you have a loyal staff here?

Dr. Clarke: Yes, we have a loyal staff. Some emergency doctors have been here for eight years. But a subgroup is transitory. They're between residency and a new fellowship or work in practice in another state. A substantial fraction are "Board prepared" in emergency medicine, mostly through length of practice here. They include surgeons, psychiatrists, rehabilitation medicine physicians, radiation, and oncology medicine specialists. What's so great about our emergency room, is that there are so many specialties.

EIR: Do you have enough staff here?

Dr. Clarke: If we don't have to keep patients here for two to three days, then we don't have a shortage. Emergency medicine as a specialty is a study where you put two pieces of a puzzle together: The essence is recognition, identification, stabilization, and admission or discharge. It's not to carry out long-term treatment. You need not overstaff, just have a pool of staff to be ready for an emergency like Avianca. [Dr. Clarke is referring to the large number of casualties in the recent crash of a Colombian passenger jet on Long Island—ed.]

The average emergency room physician is a type of person who likes to get things done. He will draw blood while he starts an intravenous infusion. Therefore you don't need a separate phlebotomist.

EIR: What do you feel you gained by the threat to resign en masse?

Dr. Clarke: The public and the mayor's staff and the HHC recognize that there is a health care crisis where lives are in danger. You should be better off going to a hospital than staying home. But we still see admitted patients staying in the emergency room for days. That's not a victory won.

The medical board of the hospital consists of its departmental chairmen. They're the executive committee. Who will you complain to when an acting chief of staff is a chairman at Downstate? We ask for a medical director who is loyal to Kings County Hospital and not to Downstate, and we ask for a chief of service to be employed by Kings County Hospital and not by Downstate. It is not that we're anti-intellectual. We are clinicians. Our mission is to deliver health care, not to do research. The researchers belong to the university. I took on the issue a long time ago for patient care. The other doctors picked up on it. Patient care is my only issue.

EIR: What is the cause of the increased patient load in the emergency room? Is crack a major factor?

Dr. Clarke: I haven't seen crack abuse as causing a great problem here. The acute crack cases come in here and clear up in eight hours. I used to see a lot more drug overdose cases. The overdose cases I see now are mostly caused by physicians prescribing tranquilizers.

Crack, however, is indirectly the cause of a great deal of surgical trauma when people get shot over crack.

EIR: What about AIDS?

Dr. Clarke: Yes, AIDS has caused an increase but no more than tuberculosis.

EIR: Isn't that also due to AIDS?

Dr. Clarke: Not just because of AIDS. The causes also include poor nutrition and homelessness. I treat tuberculosis here. For example, if a person complains of cough lasting

more than two weeks and even if their x-ray is negative, I'll treat them for TB. Do I have proof? No. The skin test may be negative. I give rifampin and INH, not triple therapy [using three medications simultaneously—ed]. These people do well.

EIR: Why do you have to treat them? Can't they be followed up elsewhere?

Dr. Clarke: They will have a six-month wait in the outpatient department.

EIR: What about a city program for TB?

Dr. Clarke: I have them come back to me, because too many people get lost in the shuffle. It's not just the older population. We've relaxed our standards with TB, we've made a mistake thinking it's gone.

EIR: What about pelvic inflammatory disease in women [a major cause of sterility and ectopic pregnancies]?

Dr. Clarke: All of the sexually transmitted diseases have increased tremendously. There you can absolutely talk about crack. Though I can't prove it, I think crack is aphrodisiac. Also, they may be having a lot of sex to pay for drugs. People talk of STD as syphilis and gonorrhea, but chlamydia is also a major cause. We have seen a reasonable increase in secondary syphilis [the second stage of the disease, which is characterized by a rash—ed]. Doctors must know how to tell chicken pox from secondary syphilis. This area is a melting pot. People from the Caribbean who haven't had chicken pox quickly pick it up in New York, so it's easy to overlook secondary syphilis in these people.

EIR: Why can't this diagnosis be made by a doctor in the community?

Dr. Clarke: There are very few doctors the poor can go to. If you're a doctor practicing in a poor neighborhood, you have to consider the safety factor, because you deal with belligerent patients. Can you afford the office? Your patients, even if they are working, lack health insurance. Medicare doesn't reimburse you enough or soon enough.

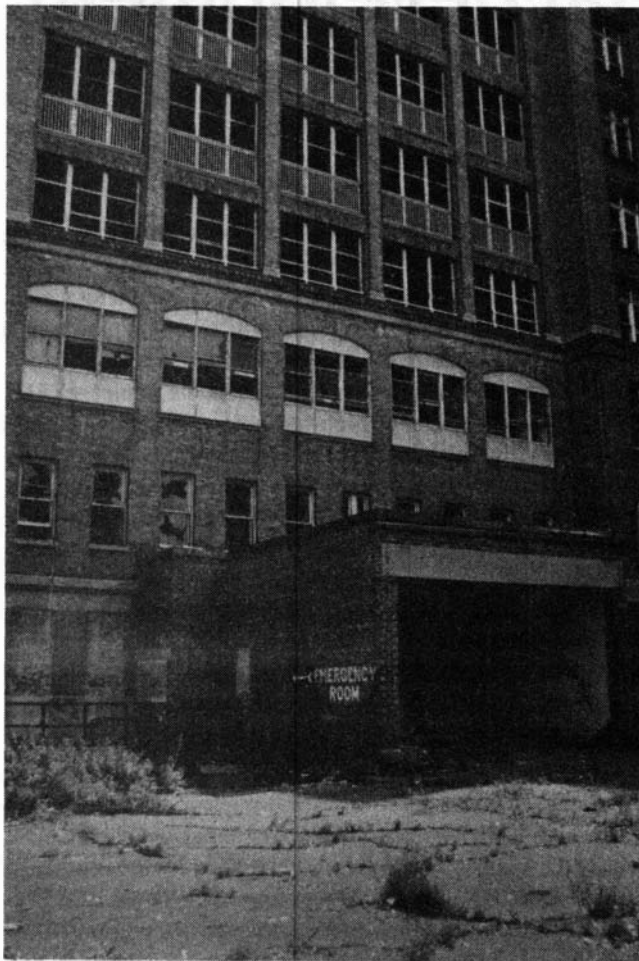
Also, you don't have private doctors because they lack hospital privileges. The medical schools can withhold privileges from doctors. With litigation costs so high, the doctors are fearful to practice in a community where they don't have the backup [of a hospital where they can admit patients.] As a result you have the flight syndrome among doctors in the community. So there are not enough doctors in the community.

Let's say you're a surgeon. You've trained but didn't pass your Boards. The chairman of Downstate Department of Surgery will not let you in. Similarly if you're an internist, but the chairman doesn't like you because you disagreed with him. He controls hospitals. You can't take on this establishment without tons of money. Even if you win, you ask your-

self, "is it worth it?" unless you're a fighter. Because who will be benefited? It's for the benefit of your patients. You won't benefit, they'll make your life difficult. Have you heard of the Peer Review Organization point system? So I get these patients here, because the department chairmen keep the local doctors from practicing out there, because they can't get hospital privileges. I ask HHC not to let them make life difficult for our doctors and patients. Affiliation leads to the degradation of patients.

Our nation is making a terrible mistake leading to catastrophe. Without adequate health care, no country can survive. We see our health eroding rapidly because we don't see that the wealth of a country depends on the health of its inhabitants.

EIR: Recently there was an article in the *New England Journal of Medicine* showing a life expectancy of 51 among black



In New York's notoriously depressed South Bronx, this onetime emergency room was replaced by a small "community clinic." Says Dr. Clarke, "We see our health eroding rapidly because we don't see that the wealth of a country depends on the health of its inhabitants."

males in Harlem. In such a case, you hardly get any social return from the cost of a person's upbringing and education. **Dr. Clarke:** Take five people out of Harlem, send them to medical school, investing thousands of dollars, what's your return? Virtually zero. We, as a country, use every degrading adjective to describe our own situation when it is seen in a Third World country. One of the best articles on this is in today's [Feb. 15] *Newsday*. This article says that the conditions of the poor in New York are just like the poor in Johannesburg. South Africa is right here in New York. Soweto is just like our poor communities.

We have four kinds of medicine here: 1) whites, 2) blacks, 3) rich, 4) poor. Don't see this as a racist statement. With the poor there are the sub-categories, black and white. Poor white treatment is very different from poor black. Rich blacks do not get the same treatment as rich white, theirs is also much inferior. The most ironic thing happened here once. The CEO of Maimonides Hospital had just sent a memorandum on who not to accept as a patient at the hospital. He was seriously injured in an accident, but, when he was brought to his own hospital, they turned him away. He was sent away and died here.

The only way we'll get a foothold on health care will be if everyone is given the same level of care. We must go to socialized medicine. This doesn't exclude a private medical sector. If you want a free facelift, that's okay if you have the money.

EIR: Do all of the medical schools have private hospitals at the same time they are affiliated to city hospitals?

Dr. Clarke: Here are some examples: Einstein Medical School and Jacobi Hospital; Mount Sinai Medical School and Elmhurst General Hospital; New York Medical College and Metropolitan Hospital; Columbia University Medical School and Harlem Hospital; New York University Medical School and Bellevue Hospital.

Here is a case in point of how the system works. New York University is affiliated with Bellevue. A prisoner [being treated] at Bellevue needed radiation treatment for cancer, which is available at NYU, but not at Bellevue. NYU said they would not treat him, so he was sent here. This exemplifies also how they get money from the HHC.

Montefiore, a private hospital, cares for Rikers Island prisoners under a contract. Montefiore insisted on the city having the medical facility at Rikers rebuilt. The city paid Montefiore doctors to work there, but they never complained about the squalid conditions at Rikers. None of these patients end up being cared for at Montefiore. They don't want any handcuffed patients at such a pristine place. So they end up at Kings County Hospital! Yet it's a \$36 million contract. Even if we paid \$10 million in salaries for the Montefiore doctors, it's still \$26 million we save the city by treating them at Kings County Hospital. Why pay another hospital for this?