UCMC and Trauma Care

What are the origins of emergency care at the UCMC? Why did they open and close their trauma center?

Most of the historical information that follows is sourced from a combination of news stories, interviews, and the first-hand accounts of nurses, doctors, patients, and researchers. It is a mix of hard fact and narrative account, compiled to inform a discussion, not damage or harm the current operations of the hospital. Please contact us (she.uchicago@gmail.com) if you have any questions or suggestions for how to improve this history.

Thanks to years of planning and advocacy, everyone living in Chicago benefits from an advanced EMS system. This public service, while used rarely and only in times of grave need, attempts to distribute its resources to people in all geographic areas of the city. The distribution of ambulance services, and for that matter fire department services, is controlled by many layers of government, all of which utilize geographic measures such as catchment areas and road networks to ensure equal access to this vital public service. Framing the emergency medical transportation in the language of human rights, to be protected and encouraged by a democratic government, helps to draw a distinction to the current provision of health care services in Chicago, particularly in the context of the debate around trauma care. The parallel histories of the emergency network and the trauma system reveal important trends of motive and ideology in the stark disparities seen in health care access, and more generally in quality of life, visible along geographic and racial lines in Chicago today.

Before the emergency network was established in Illinois and Chicago, the only ambulances in Chicago were selectively operated by individual hospitals. The practice of ‘patient dumping,’ illegal since 1986 under EMTALA, was prominent. Before the trauma system and the emergency ambulance system in Chicago were established, ambulances would be dispatched by individual hospital to pick up injured patients in selectively defined service areas. In the case of many Southside patients, hospitals refused to send ambulances out into the city.

If you were unlucky enough to not qualify for an ambulance ride due to skin color or wallet depth, either a police van or an acquaintance with a car would pick you up and drop you at the nearest hospital. Often in the 1960s, hospitals were ‘9 to 5’ health care facilities. If a hospital was not open, patients would be left outside or left untreated in waiting rooms until the next day, when they would be transferred to the public John H. Stroger Hospital, also known as Cook County Hospital. The high number of injured patients showing up every morning at the door of Stroger led to the informal creation of the first trauma center, sequestered on the hospital’s fourth floor. Because private hospitals in the city had no legal obligations to treat anyone, they used their discretion to ignore patients of color or patients who probably could not pay. This unfairly burdened some hospitals in the city with a majority of a certain patient category.

To respond to this problem, the city of Chicago mandated that all hospitals in the city open emergency rooms. To continue its operation as a research hospital in the city, the UCMC was required to open an emergency room. The motive behind this policy was to encouraged all members of the city’s health care system to take part in treating the most vulnerable patients in the city. When new funding entered the scene for trauma care in the 1980s, the UCMC experiment with trauma care began. Along with many other hospitals in the city and across the state of Illinois, the UCMC opened a trauma center. In 1986 they began taking patients but by 1988 had completely pulled out of the system. According to hospital press releases, the UCMC closed its doors due to a flood of patients and a lack of funding. They claim opening a trauma center today would send them down the same path towards millions in losses and a rigid, flooded trauma unit. This is just part of the story.

Trauma care is not always a financial drain, even with a predominantly poor patient mix. Implying that the inclusion of one service into a hospital’s offerings will drain the hospital plays down the complexity of hospital finance. For instance, Christ Advocate, the hospital in Oak Lawn that takes on the burden of patients from the Southwest and Far South portions of the city, has operated its trauma center for the past twenty years. Cutting down on unnecessary procedures, having good connections with outpatients clinics, and reducing the time patients spend in the ICU have all lead to lower costs. Many academic studies point to the feasibility of trauma as an economic option, and indeed the UCMC’s pediatric trauma center is a testament to this: when a hospital wants to do trauma and picks the right people to do it, trauma care can work.

It should be noted that trauma care is an expensive service, and it is expensive for everyone, but many hospitals find that remaining part of the network that serves the most serious injuries of the public is a service worth the cost. The voluntary trauma network in place today allows for the motive of profit to override the motive of public health. The system is no accident: whereas members of the public lobbied for the emergency system and decided to pay for it with their taxes, private hospitals have lobbied for current hospital tax exemption laws that allow them to remain voluntary players in the health systems that they occupy. This is particularly relevant in the state of Illinois, in light of recent legislature concerning hospital taxation (discussed in other sections.)

The hospital should not be ‘tried’ for its past indiscretions, but when administrators present the hospital’s decision making process as solely rational and consciously apolitical, an alternate history does present itself.

What sort of community health services does the UCMC currently offer?

According to their audited financials released in 2012, the UCMC claims to offer around $252 million dollars in community benefits. Unpacking what is counted in this often touted community benefit total reveals some ambiguities, however. Legal definitions on what constitutes “community benefit” are unclear. Federal standards differ from state standards. In Illinois, recent court cases (Provena v. Illinois) have attempted to establish an acceptable definition for what constitutes community benefits and to what degree a non-profit is obliged to provide such benefits. The decision reached in this court case, while ambiguous, requires that calculated community benefits do not include covering Medicare/Medicaid gaps, erasure of bad debt, or unprofitable activities that primarily benefit the institution. As an institution receiving state property tax benefits valued at around $58.6 million as of 2009, the UCMC has an obligation to provide at least this amount per year in “charity care” under the state’s definition.

However, a new law enacted in 2013 and lobbied for by private hospitals in the state erases this definition. According to the new law, hospitals CAN count Medicare cost overruns as charity care and if they do not provide enough charity care in a given year, they can merely cut a check to a public entity to make up the difference. This legislation was championed by Hyde Park’s own Rep. Barbara Currie, making it hard to imagine the UCMC was passive in the legislative process. Furthermore, the University recently hired a new Executive Director of Strategic Communications, whose most recent job was working in public affairs at Provena Hospital, the same hospital that had their non-profit tax status revoked by the state and fought tooth and nail to ensure that the system of tax exemptions remained unchanged. Both of these events can only be seen as coincidences without further evidence, but their timing in light of the trauma center campaign and a shift in rhetoric towards accountability by many commenting on the campaign publicly could be read as relevant to some internal awareness within the hospital about the need to bolster the image of its potentially dubious charity care policies.

The University of Chicago Medicine’s devotion to providing true charity care for those who cannot pay at all is much less than advertised- only $20 million per year according to their IRS990s. The other $230 million included in this Medicare-inflated total comes from many different sources, including $48 million in unfunded research and $90 million covering cost overruns with Medicare patients. Hospital representatives often point that they take the most Medicare patients in the state and indeed this is true. What they fail to mention, however, is the direct institutional benefit accrued from these intakes. By taking in so many Medicare patients, the hospital receives a greater share of federal research and education dollars. In fact, given current formulas for calculating education costs, it is likely (but admittedly not certain) that the hospital likely turns a profit on each resident it trains. Treating Medicare patients is important and a good public service, but by not fully disclosing how the institution benefits and hiding true costs behind shrouded pricing structures, it is unclear if this massive sum is a charitable one at all.

The often touted Urban Health Initiative sucks up only a couple million dollars a year from the hospital’s 1.3 billion dollars of revenue intake. An exploration of the excellent intentions and superb doctors working on the UHI could take another document, but its lack of resources means that its position as a key initiative of the hospital should be minimized.

The current loopholes in the legal framework for non-profit hospitals give discretion to the institutions that benefit most from their exploitation. The UCMC is not solely responsible for the failed health landscape of Chicago’s Southside, or the flaws in the for-profit medical system as a whole, but its continued collusion in refusing to advocate for change and its resistance to outside community pressure do indicate that windows to act have been presented but ignored by hospital administrators. The current FAQ from the UCMC depicts it as a financially precarious institution drowning in the problems of the Southside. They are right in saying that they alone cannot (and should not) address the economic, social, geographic, racial and medical disparities of the Southside via charity. But that does not mean that what they are doing is currently enough.

Because these laws give leeway to hospitals as to how they dole out their community benefits, they get to define who is in their ‘community.’ By defining their community as the world of medical research, and the city as a whole, the hospital’s planning can ignore the localized problems in their backyard. A comparison of resources in the current emergency room at the hospital compared to the devotion to treating rare diseases merely express the hospital’s devotion to a certain patient group: those who have rare diseases and unique cases. Indeed, these cases should be treated, but it cannot be pretended that all people suffer from these diseases the same way.

There is an impression in hospital press releases, and more broadly in charitable giving and government funding streams, that there is nothing new or prestige-building about treating broken bones and bleeding hearts. Complex neurological disorders, genetic aberrations, and expensive cancer treatments garner much more research money than trauma. The socioeconomics of such patterns should not be casually ignored. Trauma is a leading cause of death in America, and THE leading cause of death for black men aged 1 to 44. Sadly, many who will live long enough to develop such complicated diseases that can be treated at the UCMC are the patients who have money and live past the age of 44, and these patients are less and less frequently not living on the Southside.

Trauma has been around for a short time, and there is still a lot to be researched in this field. To say that the hospital cannot be groundbreaking by advocating for trauma is inaccurate. The costs of having inadequate services for the community for the UCMC are grave. The hospital’s current mission towards research rather than care is made more difficult by the lack of trust in the hospital created when patients fear they cannot go to his institution for the all-important emergency room ‘safety net.’ Indeed, by refusing to take up a cutting edge and exciting field such as trauma care, those deciding where to place resources in the hospital are deferring attention and potential prestige, and negatively impacting the work of individuals who engage with Southside communities.

What about the current Emergency Room at the hospital?

The current ER at the UCMC is inadequately suited to deal with need. As many students and faculty have testified, wait times are usually measured in hours, not minutes. The amount of patients who need care outweighs the resources devoted to them. This problem also makes other hospitals citywide pick up a larger share of the patient load. When the ER at the UCMC is full, it goes on bypass, meaning ambulances are diverted to other hospitals in the city. The University of Chicago is on bypass nearly every day of the year, averaging 30 times per month with an average bypass time of 6 hours and 18 minutes for each event. The UCMC is on bypass 24% of the time its ER is open. The Chicago hospital on bypass second most frequently after the UCMC’s 24%, is Northwestern, which goes on bypass 1% of the time. While the UCMC cannot solely fix the problems of lack of healthcare access on the South Side, it is currently providing ER services at a level far below that of other peer hospitals in the city.

One of the largest and most advertised community health programs at the UCMC, the Urban Health Initiative (UHI), has drawn criticism from community members and doctors alike. The UHI aims to institute community-based health care by referring patients seeking emergency care for minor health problems at the UCMC to clinics within their own neighborhoods. These clinics would ideally be staffed with highly skilled doctors who had the resources necessary to treat a variety of patients available to them.

The concept of community based care is a good one and is incredibly important and as mentioned above, is supported by great doctors who are laying down an important community health network. However, the current UHI has fallen short in providing care to the communities that need it. Much of the work of the UHI occurs in the emergency room: when a patient comes in to the hospital seeking care, they are told to do follow up appointments at community health clinics in their neighborhoods, sometimes without being fully treated at the ER.

What are conditions like in these clinics? Despite a few dedicated physicians, these clinics regularly underperform. Different doctors often cycle in and out and patients are faced with the same crowding that they would see at the ER. This ultimately discourages many patients from receiving care, or encourages them to return to the ER, where the cycle continues. An editorial in the Journal of the American Medical Association leveled a similar, harsh critique of the UHI: it effectively forces poor or uninsured patients off the hospital campus and relegates them to community clinics underequipped to deal with their problems. This policy of the UCMC has been likened to modern day patient dumping. The ideas behind the UHI are important, but the weak devotion to such ideas by financiers in the hospital has merely shifted around the disparities they purport to address.

Why should the UCMC be responsible when this is a systemic problem? Isn’t it too expensive, why do they deserve the burden?

The current system of healthcare in the United States is unsound. Both Republican and Democratic doctors in Chicago support revising our current healthcare system to lower costs and better compensate doctors for the services they provide. The current legal framework surrounding health care tax exemptions is also ambiguous and broken. Medical school is unbelievably expensive and doctors rightfully expect to be compensated for the intense amount of work they do. Given the current system, however, grave healthcare inequalities exist.

The systems that led to health care inequalities will continue to remain broken until the institutions benefiting from them are held accountable and are not allowed to continually renew them. Given current legal and political realities, the UCMC is able to select which “community” benefits from its taxpayer-subsidized activities, largely funded by its non-profit tax exemptions. While Southsiders raise their voices and say that the UCMC is in their community, and that their healthcare needs are equal to the healthcare needs of patients with rare diseases, the UCMC has continued to enact policy that deprioritizes its neighbors.

To address the final and most common opposition this campaign has faced: many believe trauma care is too expensive and the hospital will be forced to take money out of their pocket to pay for it. While this is true, the groups advocating for trauma on the Southside have been actively working with politicians to bring trauma funds to the Southside. They have been cooperating and working with other hospitals, attempting to foster some collaboration to address this problem. However, a key stumbling block has been the hospital’s refusal to cooperate to access funding: when dangled before them, they refuse it. Rather than fight with us to fix a problem, they express a fundamental desire to not do trauma. Like a game of whack-a-mole, no matter which little resistance is targeted, a new one always springs up. This, at the very least, hints at some underlying structural problems that express themselves in a refusal to communicate and an even greater reluctance to act.

Note: These paragraphs attempt to counter the hospital’s arguments in their academic/data-driven parlance. Many students and outsiders who might read this also hear this language best. However, this is just one way to address a complex, emotionally charged issue. For other takes, please see this website or contact she.uchicago@gmail.com.