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Is there an auditor in the house?

Toronto's Sunnybrook hospital, confronted with the same perilous cash squeeze that afflicts administrators in the private sector, sees its novel cost-efficiency schemes as the only means of preserving top notch health care

By Ivor Shapiro

It's more than a year since Patricia M. was discharged from the Sunnybrook Health Science Centre in North York, Ont., but head pharmacist Tom Paton remembers her well. Not her name, or her face-matter of fact, he never saw her face. What he remembers is a number, $63,000-the price tag on a single intravenous drug that saved her life. "The AmBisome case," Paton calls it, because that's the name of the drug.

The patient: a 38-year-old bank loans officer. Her symptoms: high fever, breathlessness, inability to walk, growing weakness. Diagnosis: fungal endocarditis-a fungus clogging up a valve in Patricia's heart. Prognosis: certain death. Remedy: valve-replacement surgery, preceded and followed by treatment with an antifungal drug. Doctors tried the standard drain-cleaning agent, Fungizone, but within a week, it was causing massive liver damage. That's when an infection specialist prescribed the next-generation version of the same drug: AmBisome. It promised the same benefits with lower toxicity. But the whopping cost, about $900 a day, compared with $112.05 for Fungizone, set alarm bells ringing in Sunnybrook's pharmacy.

Sunnybrook's annual drug bill of $5.5 million must be shared among more than 17,000 inpatients a year. Now, Tom Paton, the man who holds the purse strings in an industry flirting with bankruptcy, was being asked to spend more than 1% of his budget to save a single life.

The price placed upon a pharmacist's signature isn't often so steep, but every day, Canadian health professionals are making high-stakes trade-offs that differ little, in essence, from those in any beleaguered industry. It's not just the private sector that has been forced into critical downsizing by a flat-line economy. Governments across Canada have caught on to the need to count every dollar. The result: health-care budgets, once deemed untouchable, are feeling the squeeze. Medicine does, of course, have its own issues. It also has its own name for the task of setting priorities. The name, most commonly used in wartime or other emergencies for grouping casualties, is triage.

The triage of dollars begins with governments: Every budget represents a decision about how much will be spent on education, police or health care. Federal and provincial governments spent $46.7 billion on health in 1991, the equivalent of 9.9% of the GDP, up from 8.5% in 1985. Next, they decide how much of the health envelope will go to hospitals-in 1991, they got almost half of government health-care dollars. Governments then divide the cash among individual hospitals, and from there, the triage torch passes to hospital managers.

Among Canadian hospitals with a well-earned reputation for facing down tough choices is Sunnybrook, the University of Toronto's northernmost health-science academy. Health-care analysts Michael Rachlis and Carol Kushner, co-authors of the 1989 bestseller Second Opinion: What's Wrong with Canada's Health Care System and How to Fix It, cite Sunnybrook's president Peter Ellis among a handful of hospital executives who have shown "a strong commitment to quality and efficiency" through innovative programs and a determination to hold physicians accountable for spending. An austere brown-brick complex, Sunnybrook sleeps 1,319 patients, provides work for 300 physicians and 4,300 staff, and costs $260.5 million a year to run.

CEO Ellis is a lean, soft-spoken Yorkshireman, with slightly unruly grey hair. No one was surprised in 1963 when young Ellis, youth group leader and Young Liberals chair, opted to follow his dad into a career in management. Offered trainee positions by both Marks Spencer PLC and United Leeds Hospitals, he chose the latter and spent a decade there before quitting an increasingly bureaucratic National Health Service to join the health-care division of consultants Woods Gordon in Toronto.

Three years later, he took a mid-rank position at Sunnybrook and, by 1987, at age 42, he had the top job. Once installed, Ellis set his sights at Sunnybrook on cost-effectiveness and made war on waste. He considers the modern hospital grossly overstructured, and likes to quote American studies showing that a typical patient sees 50 different professionals during a hospital stay. For the patient, these handoffs mean confusion and frustration. For Ellis, they represent paperwork, frustration and a trumpet call to tear down professional walls.

Why, for example, should it take a typical patient two hours to get a chest X-ray-waiting in bed for a porter, in a wheelchair for a radiographer, in a corridor for another porter? X-ray machines are cheap enough, says Ellis, to locate them near wards, and to train ward staff to use them. "We're going to have to organize our work better," he says.

Ellis's language reflects the new marriage of empathy and economy in an industry not previously given to looking too closely at the bottom line. He speaks of patients as "customers," of cancer treatment as a "niche," of health care as "a knowledge-based industry." The modern hospital, he says again and again, must be "efficient and effective." What follows is a portrait of one such hospital, and of the people who seek, against lengthening odds, to keep its services intact.

From Peter Ellis's softly lit spacious office, it's a short walk east along a wide terrazzo corridor, past the main lobby, and two floors up to the pharmacy department headquarters, where Tom Paton pondered the fate of dying endocarditis patient Patricia M. that well-remembered day in 1991.

A cautious 44-year-old who could be your friendly neighbourhood pharmacist, down to his meticulously trimmed mustache, Paton sat with two doctors and reviewed Patricia's highly unusual case history. In emergency surgery back in 1979, she had received her first valve implant-a porcine valve, meaning the implant had regulated the blood flow inside a pig for a while before being called up to the majors as doorkeeper between two chambers of Patricia's heart. Now, the valve was decaying-an inevitability abetted by the fungal growth.

Big problem: open-heart surgery would result in lost blood, and Patricia, a Jehovah's Witness, would not authorize a blood transfusion. With the antifungal drug Fungizone lowering her red-blood cell count every day, she'd not be able to survive the blood loss during surgery. AmBisome was Patricia's only hope, the doctors said. It was, they said, a unique set of circumstances.

"Unique." Paton seized on the word. It was one thing to spend money once, another to set a precedent. "This is not the time to decide about cost," he told the physicians, "when we are, in effect, standing at your patient's bedside." He would buy the AmBisome, this once-but that didn't mean it was now an approved drug at Sunnybrook.

The annual guide to approved drugs, a pocket-size paperback known as the formulary, is the chief weapon in any hospital's war on drug costs. Before a drug is placed on Sunnybrook's formulary, it must be approved by the hospital's Pharmacy and Therapeutics (P) Committee, which gives the nod to a new drug only when its benefits demonstrably justify its expense.

One drug that is not on the formulary, not yet anyway, is a revolutionary anti-infection agent named Neupogen, which, unlike antibiotics, prevents infection by stimulating the bone marrow to produce infection-fighting white blood cells. In theory, this difference could mean life over death for some

cancer patients-those whose chemotherapy has to be reduced or halted because its toxins have damaged the bone marrow. According to the drug's advocates, Neupogen should be administered together with each dose of "chemo" if the patient is at high risk for infection.

Sunnybrook cancer specialists have no fundamental argument with the drug's proven effectiveness in preventing infection. They point out, however, that there are no studies to show that the extra "chemo" would mean more lives saved. Meanwhile, a course of Neupogen costs $1,500, and to use it with, say, three courses of chemotherapy for just 100 of the hospital's 1,270 expected cancer inpatients this year, could mean spending close to $500,000. For now, they restrict the Neupogen-chemo whammy to the few cancers that have high-cure rates-mainly testicular tumours and Hodgkin's disease. It's just a pleasing coincidence that because patients in this group are usually outpatients, the Neupogen bill is their own problem, or their drug plans'-not the hospital's.

Everyone recognizes it's plausible that Neupogen could save the lives of some chemotherapy patients. Tom Paton says that if he had more financial room to manoeuvre, he would want to give the cancer people a little more latitude. "If I had the money available," he says, "I could say in those iffy cases, 'I think we should try this.' And maybe it would help." Neil Shear, who chairs the P Committee, agrees. "If it were a dollar-fifty a dose," he says, "it would be an easy decision."

The $63,000 spent on Patricia M.'s AmBisome could have bought six courses of Neupogen for each of seven selected cancer patients with a high risk of infection. But how many of those seven, if any, could it have saved? For how many years? With what quality of life? How do you perform a cost-effectiveness analysis with such imponderables?

To judge cost-effectiveness you require, after all, some knowledge of the likely outcomes of your option. And for a surprising number of treatments, there are no hard data on outcomes. Then, what? You weigh the all-too-concrete needs of your visible patient (AmBisome for Patricia, dying before your eyes) against the possible benefits for invisible patients (Neupogen for seven anonymous chemotherapy patients). And if you have a good shot at helping the visible one, damn it, you want to help her.

From Pharmacy on E3, through Cardiology, and two floors up to Ward C5: Neurosurgery. Here, every morning at around 8 a.m., with the early rush of medications and vital-signs over, Joanne Banfield, RN, nursing unit director, turns to one of the most complex tasks in her daily routine: juggling patients.

Last night, all 36 beds on C5 were occupied. The Intensive Care Unit (ICU) wants to send two recovering post-surgical patients down; two on their way up to the operating room make it a straight swap. Two discharges today, and just one elective patient coming in, "elective" meaning he's survived the waiting list, should leave one bed empty.

But wait: two neurosurgery patients are in borrowed beds in other units. Plus, one bed is supposed to be reserved for diagnostic patients, who come in for tests and are discharged within 48 hours, with another bed reserved for Emergency admissions.

Most days, the C5 math means delaying an elective admission, or keeping a post-op patient a day longer in the ICU, unless a spare bed can somehow be found elsewhere in the hospital.

The task would be somewhat simpler if every patient on C5 needed to be in hospital. Instead, up to 12 of the 36 beds on C5, and 10% to 12% of all acute-care beds in Sunnybrook, are occupied by "alternative level of care" patients who should be in a rehab centre, chronic-care centre or nursing home. Having recovered from anything from a broken hip to a brain injury, they can't take care of themselves, and their communities don't offer adequate home-care support. Nursing homes are full, or won't take patients who require intensive nursing because their government per diems don't cover the added expense. So, they stay in hospital as "bed blockers," a massive drain on hospital resources. Three-quarters of Sunnybrook's revenue comes from provincial government grants. The remainder includes extended-care board and lodging, private and semi-private accommodation fees, provincial insurance payments for outpatient services, and $750,000 from profit-making activities such as parking fees and the proceeds of two first-rate banquet venues. The Ontario grants include a base amount and various add-ons to compensate for growth in numbers of inpatients and for the intensity of resources required by certain case types: When the hospital agreed to take on 100 extra open-heart operations last year, the Ministry of Health added $1 million to the base budget.

A key element in Sunnybrook's negotiations for such add-ons is the average cost of care for each type of patient, as calculated by the hospital itself. By the dawn of the '90s, most leading Canadian hospitals were installing U.S.-designed patient-costing software adapted to use a Canadian list of 602 diagnostic categories called Case Mix Groups (CMGs). Sunnybrook MDs classify every inpatient into a CMG, and the costing system uses the resulting data to draft protocols predicting, for each group, days spent in hospital, nursing costs, lab tests and drug use.

The system also provides Sunnybrook's clinical unit managers with printouts that compare various physicians' treatment costs for similar patients. Meetings to discuss the printouts provide a rare peer-pressure incentive for doctors to examine the costs of care head-on. MDs are not, strictly speaking, Sunnybrook employees: Many have their salaries paid by the university, and their service fees are billed to the provincial health plan. Yet, it is MDs who make the calls that cost money: drugs, tests and treatments. Now, MDs are beginning to be held accountable for cost control.

Five years ago, director of finance Dan Germain was manager of cost accounting at General Electric Canada Inc., and the essence of patient costing is familiar territory. "We had 3,000 different lighting products at GE," Germain says. "We knew exactly what each one was going to cost-how much for glass, how much for filaments. This is exactly like that. We have to know what resources we're using for each product."

Except that patients, especially acute-care patients, are a bit less predictable than light bulbs. Case in point: Patricia M. Her CMG was number 198: "acute and subacute endocarditis." Predicted cost of protocol treatment: $11,250, including $1,962 for drugs.

So much for protocols: Patricia's care cost $95,927. But then, the protocols were never meant to dictate an individual patient's care. It's a matter of averages-of keeping average costs within budget. As every hospital employee in Canada now knows, there is no longer enough money to pay for all the care that every patient, and every doctor, wants.

Since the late '80s, the headlines have been blurring into a mush: 300 beds closed across New Brunswick, 1,000 in Calgary and Edmonton, 595 in Toronto....Montreal seniors wear diapers: no nurses for bathroom trips.... British Columbia calls for 25% cut in beds. Regional boards in Saskatchewan trim hospital costs....Newfoundland closes hospitals, shrinks others in full-scale assault on budget deficit....Ontario's social contract squeezes hospital expenditures. With the federal government gradually pulling out of health-care funding, the word is out that hospitalization is a hideously expensive and often unnecessary way to deliver health care. Quebec and Ontario are trumpeting plans to refocus spending on disease prevention, and community care is the word of the day.

Yet, few cities-Victoria and Winnipeg being important exceptions- provide enough homemakers, nurses and on-call physicians to provide hospital-quality care in the community. Analyst Michael Rachlis, MD, comments with obvious frustration: "The easy part, in a recession, is to cut expenditures on

hospitals, doctors, labs and so on. The hard part is to reallocate the funds to community services and health promotion."

In this regard, Rachlis, a scathing critic of what he considers an overdoctored, overhospitalized culture, finds ironic common cause with hospital managers. No one wants patients staying a day longer in hospital than necessary. The bottom line for hospital managers has never been clearer: See them, treat them and get them out of here.

From Ward C5, one floor up and 60 metres west: B6, the Medical Day Treatment Centre, site of a rare and precious win-win story. Ambulatory care, they call it. When low-intensity nursing costs run between $375 and $677 per bed per day, there's a compelling logic to doing without the beds. Today, surgeons can use lasers or tiny balloons to do same-day jobs that used to require scalpels, hours of operating room time and days of inpatient recovery. But at Sunnybrook, the most conspicuous ambulatory- care savings have so far been realized not in high-tech surgery but in the more mundane world of what was, until early 1992, Ward B6.

Two years ago, Ann Butler, a 51-year-old unemployed shipping clerk who suffers from psoriasis sores on her face, torso and legs, would have been admitted to B6 and treated to daily applications of a sticky white paste. Not that she needed nurses checking on her hourly, or bringing her medications; not that she needed, God knows, the hospital meals.

But there's no one sleeping on B6 anymore. Every morning, Butler takes two buses and a subway train to Sunnybrook from her home in Rexdale, removes her clothes, gets her skin toned up by UVB lights, and has the paste applied. Then she puts on pyjamas, sits around reading and watching TV, eats a sandwich, has a bath-and goes home. "The travelling's a hassle," Butler says, "but at night I sleep in my own bed."

Converting the 36-bed ward to day treatment cost Sunnybrook just $350,000 in capital outlay and saves $1.2 million in annual operating costs. This swing to day treatment is part of a nation-wide trend: During the five years ending in 1990, inpatient admissions per 100,000 Canadians dropped to 13,086 from 13,812. Day surgery as a percentage of all surgery rose to 36.9 in 1989 from 31.2 in 1985.

But not all cost problems have win-win solutions. A large part of successful hospital management resides in deciding what kind of hospital to be, and not to be. Since the late '70s, Sunnybrook has been transforming itself from a general-purpose teaching hospital to one with strategic specialties. It began with a regional trauma centre, treating accident victims brought in by ambulance or helicopter. A cancer program was added soon afterward.

During the '80s, the hospital designated three more strategic programs: cardiovascular disease, extended care and psychiatry. Conversely, Sunnybrook is not in the business of transplanting organs, curing liver disease or delivering babies.

Savvy program choices make sound niche marketing: Cultivating a name for specialist achievement helps attract research grants and capital funding. And cancer, geriatrics and trauma are, Ellis freely admits, sexy areas that currently evoke special attention from the media, governments and corporate foundations. "But you also have to have an eye on the horizon," says Ellis. "We went after the cancer clinic an outpatient treatment centre adjacent to the hospital in 1979 when no one else wanted it....We said, 'There's a niche. Lets get into it.'" As for tomorrow's niches, Ellis's money is on heart and circulation, one of the single greatest causes of potential years of life lost.

Few health-care analysts question the need for hospitals to specialize. That way, resources are not spread too thinly. And, in theory, hospitals will complement each other's programs.

In theory, no one will fall between the cracks.

Four floors down and a few steps east in two congested rooms of the C2 corridor, another, trickier, riskier juggling act is now playing, six days a week, 12 hours a day. At centre stage is an amiable gentle-mannered nephrologist named Carl Saiphoo.

When diseased kidneys shut down, people die of blood poisoning unless they can find some other means of filtering wastes out of their bodies. The only permanent solution is a kidney transplant, but while waiting for an organ, kidney-failure patients must be hooked up to dialysis equipment, usually for four hours, three times a week. Sunnybrook owns 10 fully active machines that can accommodate 60 outpatients a week, but Carl Saiphoo squeezes in an extra six people, using ancient backup machines and gaps in the schedule. Squeeze is the word Saiphoo uses, and squeeze is the word that comes to mind when you walk into the hemodialysis rooms, where men and women slouch on jammed-in recliners, watching TV or staring listlessly.

Saiphoo has lost count of the calls from physicians fruitlessly seeking a place on his roster for their patients. He can only presume that each one found a place somewhere else, although all Ontario hospitals are short of dialysis space. "I don't know what happens to every patient that someone calls me about," Saiphoo confesses.

Scarce resources; tough choices. MDs can no longer afford to concern themselves solely with saving lives while leaving it to drone administrators to sort out utilization issues. As philosopher Eric Meslin points out, doctors still answer to their patients on the matter of health and welfare, but as managers of resources, those same doctors must answer to the boss on the matter of dollars and cents. Meslin, associate director of the Clinical Ethics Centre at Sunnybrook, says most doctors are reluctant to admit the obvious: that trade-offs must sometimes be made. Rather, MDs prefer to take shelter in phrases such as "medical discretion" or "clinical judgment." Meslin says cryptically: "No one in this institution would admit that a patient was denied care on the basis of cost."

But nephrologist Saiphoo comes close when the talk turns from finding dialysis space to ordering radiological tests. "Before, I didn't know what anything cost. Now, I say, 'What's the cheapest way to get the diagnosis?' For example, an arteriogram is the cheapest way to discover problems with the arteries leading to the kidneys. It's a definitive test, but it's invasive and has some risks....In the old days, the preferred way was to call for an IVP, renogram and renal scan first. Today, I often go straight to the arteriogram. I'm still getting the results I want, but I'm not being as careful-as cautious, rather-as before."

But it's the psychological games that worry cardiologist Ron Baigrie, who was Patricia M.'s attending physician. Baigrie says: "When you're in a system, and you know what the game is, a game whose rules you didn't choose, it's relatively easy to convince yourself that it's okay. Is it okay that a patient waits almost two months to have a cardiac catheterization? Is it okay that a patient waits six or eight or 12 weeks to have cardiac surgery? If I were to say to you that it's totally unacceptable, that's going to make the rest of my day kinda difficult, isn't it?"

Baigrie was chief of cardiology for seven years until he stepped down last year. Asked if his quitting had anything to do with the pressures of dealing with hospital bureaucrats and money issues, he declines to answer but allows, "I have some very strong feelings about that area." Then, he pauses, and adds: "Not necessarily negative feelings."

In the end, though, doctors have little choice about getting involved in the rationing process. As Peter Ellis tells it, "We said to them, 'Do you want to be a Greek chorus that stands on the edge and complains, or do you want to be part of the process?' One doctor told me he went away and consulted his rabbi. The rabbi said, 'Well, if it wasn't you who made these decisions, who would it be? And which is better for your patients- that you make the decisions, or someone else does?'"

Right now, the most kosher method of triage remains the waiting list: Each candidate for an undersupplied service is informed that there's a delay of so many weeks or months, and asked to take a number. In the case of some dramatically undersupplied procedures, such as open-heart surgery in Ontario, a network of hospitals co-operates to ensure that emergency cases are treated fast, even if it means flying the patient to another city. But short of emergency, it's the waiting list for everyone.

And the lists are cumulative. As cardiologist Baigrie explains, a patient with angina might wait several weeks to see a cardiologist; and then several weeks more for a coronary angiogram to check out the damage; and then a couple of months more for surgery. "There's got to be the occasional person out there who dies in the interim," Baigrie says, "but that person might die during surgery or after surgery. I can't say people are dying purely because they're on the waiting lists."

A modern Canadian hospital, Baigrie says, is a bit like a busy airport: "You save money by not building more landing strips; you just tell the pilots to stack up a bit higher."

But what if the pilots are running low on fuel? Carl Saiphoo's severe end-stage kidney patients, for example, have no time to wait, and nowhere to land.

From the steel grey doors of C2, a few yards east and one flight down: oak doors with elegant trim mark the corporate financial offices, where finite millions are split up into myriad deserving envelopes. Michael Young, Sunnybrook's CFO, a serious-mannered 34-year-old CA who cut his management teeth on corporate bankruptcies and receiverships, avers that he doesn't make those choices himself: the entire staff shares in the deed. Each fall, the hospital's Management Committee predicts the following year's revenue, and then allocates budget targets to each department. For the 1993-94 budget, projected cuts totalled $8,375,000. Administrative departments were asked to find cuts up to 5%-two points higher than for patient-care units.

Department heads then consulted staff to implement the cuts. An employee in environmental services suggested that offices outside patient- care areas could be cleaned weekly instead of daily: The hospital will install pest-proof bins for perishable garbage, and save $128,000. Unionized staff in the plant department-a $7-million operation that maintains buildings, non-medical equipment, electrical supply, air conditioning and 38 hectares of land-avoided layoffs by volunteering to perform minor renovations that would previously have been contracted out. But at the end of the day, many of the cuts-whether termed bed closures or efficiency enhancers-were

realized by cutting jobs. Last January, Sunnybrook issued layoff notices to 88 mainly low-skilled employees to garner savings of $3.4 million.

The hardest choices were on the capital side. With $6.1 million available in capital funding for this year, and $3.5 million committed to lease payments, Michael Young had just $2.6 million to allocate. Capital requests from the various departments totalled $10.8 million, including $3.4 million for items designated critical. The Anesthesia Department wanted five EKG monitors at $25,000 each to replace aging breakdown-prone equipment; the Capital Equipment Committee decided the monitors could be repaired once more. Radiology asked for an extra ultrasound machine, at $227,000; long waiting lists and the promise of outpatient fees provided a good case, but given the capital crunch, the committee felt the need was not critical.

As of this writing, the staff face a second round of trimming- additional cuts of $7.5 million courtesy of Ontario's social contract legislation.

Eric Meslin, the bioethicist, says that four or five years ago, medical ethics was preoccupied with bedside decisions: Should this respirator be turned off? Should this brutally handicapped premature baby be incubated? Today, ethicists worry more about the process of resource allocation. "Canada is not at the precipice faced by the United States," Meslin says. "We have 30 years behind us in which we have developed both strategies and an ethic of universal health care." But now, says Meslin, the principle of universality is being replaced by a question: "How much is everyone entitled to?"

From the Sunnybrook estate, it's a 30-minute car journey to the Mississauga penthouse condominium where Patricia M., "the AmBisome patient," is now living healthily. She is vaguely aware that her treatment cost Sunnybrook a small fortune, and the high price on her life does, occasionally, give her pause. "Where do you draw the line?" she asks. "It's a tough decision, and I think doctors have to make it. They're the ones who know what the consequences will be; they're the ones who have to answer to the public." Was her AmBisome worth the $63,000? She smiles tolerantly at the dumb question, and works through an answer. "I think so. I've probably paid more than that in taxes, the 20-odd years I've worked in this country....I think it might not have been worth it had it not been successful. But here I am, as normal and healthy as I can be."

Back in the CEO's office on C1, Peter Ellis has little time to spare to ponder the value of life. He has a business to save, and just about all its fat has, he says, already been trimmed. "Tweaking the edges ain't gonna work no more," he offers with a clumsy twang. If the hospital is to become "efficient

and effective," he says, archaic traditions of professional domain-guarding must be destroyed.

"The needs of our customers just don't fit into those neat vertical spires," Ellis says. He wants to restructure the hospital into multidisciplinary patient-focused units (PFUs), each containing 60 to 90 beds or the ambulatory equivalent. It has not been easy to sell this idea to staff. Ellis wants to bring all cardiovascular (CV) patients, for instance, into one PFU, instead of separate wards for CV surgery and cardiology. But the two fall on opposite sides of a high clinical wall: surgery and medicine. Who would head the unit?

Never mind, Ellis responds, let's tear down the surgery"medicine wall too, grouping the new units into giant multidisciplinary teams. But how will surgeons feel about being accountable to Robert Lester, the newly appointed physician-vice-president of the neutrally named Team One, who happens to be a dermatologist? The same goes for internists reporting to Team Two vice-president Barry McLellan, whose specialty is the surgical domain of trauma. And meanwhile, Radiology people, cranky about being singled out as an area of waste, warn darkly of safety issues and quality problems if X-rays are taken by sundry PFU staff.

"There's a lot of anger within Sunnybrook," Ellis concedes. "The important thing is to manage the transition. You've just got to keep talking about the benefits of the change, and move on."

But sometimes, at the end of a long day, as he cuts through C wing toward his private parking space, while nurses all around and above are writing and reading reports in the nightly ritual of changing the guard, Peter Ellis pauses for a while and swings west into Emergency, to sit there and take in the scene.

This is the hospital's front line, where, each night, doctors and nurses hope not too many people will die here tonight, and hope, too, that not many will need to stay. "You rely on the innate human values of the people," says Ellis, "at times when those individuals know there are no beds in the hospital and they've got 15 people on stretchers. I've heard staff say to the patient's mother or father or sister, you know, that `We think you should take so-and-so home, call us in the morning if there are any problems, call your general practitioner, come back.' And you can see the family are worried, and staff probably are feeling the same. But when you balance everything, you know that probably it's the lesser of two evils.

"And the same thing happens at the other end. You know that there's a lot of pressure to discharge people earlier and earlier, and you know there

often isn't a family member to stay home and look after so-and-so, and so the family member says, `Please don't discharge so-and-so today, can't you wait until she can walk on her own?' But there are 15 patients down in the emergency deparment who desperately need that bed."

Ellis is not a poetic man, but there's something about the way he describes the scene that deserves repeating here.

"You know, the place is full to the gills, and every stretcher is occupied, and there are more people queuing up to the door. And everyone's anxious. Sick people are anxious anyway, and they're even more anxious because the place is crowded and they have to wait for service. And you just have to see the staff somehow, in the main, serenely existing in this environment, and maintaining a demeanor that is so human, so amazing.

"You just sit down there," the CEO says, "and you know, it makes you proud."

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