Mr. Chairman and Members of the Subcommittee:

My name is Theodore Knatt. I am an orthopedic surgeon practicing in Baton Rouge, LA. I am also Chairman and cofounder of Greater Baton Rouge Surgical Hospital, a physician owned hospital that serves the minority population in our part of Baton Rouge.

I appreciate the opportunity to participate in this hearing on health disparities and HR 3014, the Health Equity and Accountability Act of 2007. I commend Representative Hilda Solis and the 110 other Members of Congress who have cosponsored this bill for their efforts to draw attention to this nationwide problem and propose solutions to this complex issue. Health disparities are pervasive in our society, and it is the obligation of all health providers to find ways to reduce them.

This is an effort that will require support from government at every level, active participation from all members of the health care community, and also the efforts of those who currently suffer the consequences of health disparities. If our society creates improved access to medical services, then those in need will have to take advantage of those opportunities. As a physician, I am all too familiar with the problem of patient compliance with the treatment regimen prescribed by their physicians. It is a frustrating part of every doctor's work. All too often we see patients fail to heed the advice and counsel we have provided to them. There is no question that we have to break down artificial barriers to good medical care, but we must also find ways to encourage patients and families to take advantage of what we can offer.

HR 3014 proposes ambitious steps to eliminate health disparities. As a practicing physician I am not in a position to predict whether all of them will make a difference. I only know that my daily job is to see that my patients have access to the care they need, when they need it. I cannot eliminate every cause of health disparities, but I can do my best to make sure that my efforts help my patients overcome these barriers to good health.

I do not need an introduction to the problem of health disparities. It is a daily part of my life as a physician treating minority and low income patients. It was part of my life growing up in New Iberia, LA, and one of the important factors that made me decide to become a physician. While I can't provide any national solutions, I can discuss what my colleagues and I do every day to try to improve the quality of our patients' health and to increase their access to medical and surgical

services. We are addressing health disparities one patient at a time. While the federal government can play an important role in helping reduce health disparities, unless you can find a way to get that minority, rural or low income patient directly connected to a sympathetic health care provider, these barriers to good health will be with us for a long time.

Louisiana unfortunately is a textbook case of the problems that lead to health disparities. Many of our citizens are poor and others lack health insurance. Regardless of race, poverty is a key factor in the adequacy of healthcare that an individual receives. It's not just the inability to pay that causes this. Many people, even though poor, are too proud to take "charity" and wait until the last possible moment before seeking medical help.

Race and ethnic background play a role also. It is no secret that many African Americans do not trust establishment medicine. That is a major reason we built our hospital, as I will explain shortly. The cultural history of our Hispanic citizens and Native Americans also affect how they respond to mainstream medical care. Too often, patient and physician are talking past each other.

Physical barriers, like rivers and lakes, also keep people from getting medical services. Now, that may be hard for the Members of the Subcommittee to understand, since you live and work in a city with excellent public transportation and numerous bridges across the Potomac. In our state, however, there is no public transportation in many areas and water is a significant barrier, particularly if one has to travel many miles to find a way across. I hope as the Subcommittee considers ways to address health disparities, all of you will make a point to see first hand where the people who experience health disparities actually live.

Even if transportation is not an issue, custom and culture play an important role in the way people view mainstream medicine. As a physician trained in the latest orthopedic techniques, I know what modern medicine can do to help people in need. But unless we pay attention to the individual's cultural background, those medical miracles might as well be locked in a closet.

Another issue, particularly in Louisiana since Hurricane Katrina, is the availability of medical care. Hospitals were destroyed in the storm, and many have not been rebuilt. Physician practices were disrupted, and doctors have moved away because their patients moved away. Some areas simply do not have a hospital and no one seems eager to come build one.

I think that HR 3014 tries to address many of these issues and I know that all of you want to make progress in reducing health disparities in this country. I understand that legislation is the tool that you have to solve problems facing our society. But that is your job, not mine, so perhaps the most useful thing I can do today is tell you about our hospital in Baton Rouge, why it was built and how we use that facility to reduce barriers to care, one patient at a time.

Our hospital, Greater Baton Rouge Surgical Hospital, is predominantly owned by African American physicians. We are fortunate to share ownership with United Surgical Partners International, Inc. They bring management and financial expertise to our hospital. Most importantly, because they provide essential hospital management, the physicians, investors and non investors, are free to practice medicine and provide care that would not otherwise be available to our community. Because we are also invested in this hospital, we are motivated to make sure that it is a safe, efficient and economical place to deliver medical and surgical care. Also, because we own the hospital and have a say in its governance, we directly control how care is delivered and can make administrative decisions needed for the best patient care. I am proud to say that the National Medical Association has honored our facility with a National Merit Award.

We built our hospital to meet the medical and surgical needs of the African American community where we practiced. Although we continue to work at other hospitals, we wanted to create an environment of trust for our patients and give them a sense that they were human beings, not numbers. One of the major barriers that keep African Americans from seeking medical care is the simple fact that they do not trust establishment hospitals or health care providers who have no sense of their cultural history, preferences or biases. My colleagues and I knew that we could establish trust if we built our own hospital. We have succeeded in building that trust. Many of our patients come long distances to seek care at our facility because they trust us.

Greater Baton Rouge Surgical Hospital has been open for three years. We have 10 inpatient beds, four operating rooms and one procedure room. Our physicians perform more than 3,000 procedures annually. Interestingly, non investing physicians refer more patients that the investors do. They have confidence that their patients will be treated with dignity. We are in the process of expanding our physical plant because of the patient demand, and primary care

physicians will be joining with us to work in our clinics so we can expand the array of services we provide. Currently we offer general surgery, gynecology, ophthalmology, spine and hand surgery, and sports medicine. We accept all patients, regardless of their health insurance or economic status. Approximately 85 percent of our patients are African American. More than 30 percent are on Medicare. About 10 percent are Medicaid, and many of these are children. That number would be even higher if we offered obstetrics. The balance may or may not have health insurance. We don't care. Everyone is seen. Many of our patients do have good health insurance and could choose almost any hospital in Baton Rouge. However, they come to us. It is the trust factor that I mentioned earlier.

We have a facility designed to address emergencies that may arise in the course of patient care or to stabilize patients who come to our hospital, but need medical services that we do not provide. We maintain a transfer arrangement with another hospital and the local EMS personnel handle these transfers to insure that the patient is provided the highest level of safety possible while being moved from one hospital to another. In the three years we have been open, we have not had to transfer an admitted patient because of an emergency that was beyond our capacity to address. Our nurses are ACLS certified, one of many steps we take to maintain high quality at our facility.

One of the great frustrations we experienced before building this hospital was the fact that we could not provide the kind of medical and surgical care that we thought our patients needed. All too often, minority patients have multiple medical problems. In addition to needing a hip or knee replacement or repair, they are also obese, diabetic and have cardiovascular complications. Too many surgeons and too many hospitals do not want to treat these patients, so they are told that they are not appropriate for surgery and sent home, where they deteriorate further. We knew that we could help these patients with an organized approach that addressed their medical complexities so that they could become good candidates for surgery.

Since building our hospital, we have been able to reverse this situation. We have established a close knit group of physicians from many disciplines who work with us to help our patients improve their overall health status. For example, I often see patients in my office who need orthopedic surgery, perhaps knee or hip replacement because of a lifetime of hard work standing

in a serving line at a cafeteria. The patient is also overweight, hypertensive and has uncontrolled diabetes. Like it or not, this is the reality of much minority medicine.

I know that this patient is not a good candidate for surgery at this time, but instead of sending him or her away, I develop a plan to improve their health status so that they can eventually get the orthopedic procedure they need. Through this network of health care providers I mentioned, I can get the diabetes under control, get the hypertension managed properly, and with good nutritional counseling, put the patient on the path to a healthier diet and healthier weight. When this has been done, I can then operate on the patient safely and with a good outcome. This takes time and costs money, but the end result for the patient is certainly worth the effort. In an effort to be as economical as possible, we do not admit these patients for weeks while addressing their medical complexities. This is the most expensive way to meet the patient's needs and exposes them to needless risk of infection or other complication like blood clots from extended hospitalization. To the greatest extent possible, my colleagues and I work to keep these patients out of the hospital, until the day comes for their surgery.

We do not cherry pick our patients, as has been suggested of physician owned hospitals. We work to improve the health of our patients to prepare them to be good candidates for surgery. Are my patients healthier than some in the community hospital? Absolutely, and it is because my colleagues and I have worked hard to get them to that point.

Even if we cannot achieve the health goals for our patients, we will still provide care. I frequently operate on ASA level 4 patients, the most complex cases, at our physician owned hospital. Because of the skill of our staff, we are able to achieve good outcomes.

We built our hospital to address the health problems of Baton Rouge's African American population some of which were not being met at other facilities. In some cases, there is simply the lack of trust this population has with the medical establishment. Other cultural issues play a role, as well. Certainly, if we could train more African American physicians, this would help overcome at least part of this problem. I am sure that among Hispanic and Native American populations similar problems of trust and culture exist that could in part be addressed if we trained more physicians and other health providers from those groups. However, as we all know, the rates of entry into the physician ranks by these populations are very low and have remained

so for many years. I know that HR 3014 proposes ways to deal with these shortages. That may be one of the most important parts of this legislation.

However, health disparities are not just a function of race or ethnic background. Economics plays an important role as well. That is why we accept all patients regardless of ability to pay. I am proud to say that we don't use a collection agency to harass those individuals who can't pay their bills. I believe that even with the number of uninsured people in this country, if all hospitals worked together to address these economic hardships financial barriers to care would begin to fall across the country.

Access to health care can be limited by distance from facilities. In Louisiana, we have parishes that have few, if any, hospitals. Ever since Katrina, few people seem to want to build hospitals in many of those areas. That is why I drive 90 miles to New Iberia to provide care. I also work in a parish largely populated by low income whites, whose poverty prevents them from getting the medical care they need. My colleagues at our hospital perform similar outreach, travelling to outlying areas to bring modern medicine to areas where this is in short supply. Our hospital operates satellite clinics to extend our reach to other areas where there is a need for our services.

My fellow physician investors built the Surgical Hospital to improve access to care for African Americans who were not receiving what they needed. Our role in the community and surrounding areas has expanded and will continue to do so. I can assure the Subcommittee, however, that if we had not been able to build this hospital we never would have accomplished what we have.

As this Subcommittee knows, access to medical services also depends on the availability of facilities where that care can be provided. Health disparities increased in Louisiana after Hurricane Katrina because many hospitals were damaged or destroyed. Rebuilding our capacity has not been easy especially if physicians are involved in the effort. For example, St. Bernard Parish was heavily damaged by Katrina and remains in a very poor state. The two hospitals were destroyed and have not been replaced. Local physicians wanted to build a hospital with the support of a management company. However, other hospitals outside of the Parish objected. That pressure, combined with the uncertainty created by the debate over physician ownership in Congress, ultimately caused the physicians to abandon the effort. There is still no hospital in the

Parish. It seems clear that health disparities are not only related to poverty or race, but also to community hospital greed and national political activity. For those members of Congress who are actively opposing physician ownership of hospitals like ours, I don't know who you think you are helping. Certainly not the residents of St. Bernard Parish who must travel long distances to get hospital care.

Greater Baton Rouge Surgical Hospital is not alone among physician owned hospitals in trying to reduce disparities in health care in this country. Doctors Hospital at Renaissance in McAllen, TX, serves a greatly underserved Hispanic population. Most of the physician owners are also Hispanic, which helps reduce the cultural and language barriers that can prevent people from seeking and receiving timely medical care. St. Joseph's Hospital in inner city Houston, serves underserved African Americans and Hispanics. Local physicians, working with a corporate partner, kept the hospital open so these people could have convenient access to care. A similar effort is underway at another Houston hospital, with physician leadership and investment.

In Honolulu, Asian physicians have purchased two hospitals that were going to close. Their effort will mean that the local Hawaiian and Asian populations will continue to have easily accessible, culturally appropriate health care.

Local physicians worked with the town of Troy, Alabama, to rescue the only hospital in the town. Their willingness to risk their own capital was the difference between success and failure.

The Kansas Medical Society works through county medical societies to try to get medical services to people who are uninsured. Physician owned hospitals, including the best orthopedic facility in the state, are teaming with the county societies to make their services available to these underserved individuals.

Native Americans are among the most poorly served patients in our nation. Poverty, cultural issues, geographically remote reservations and a myriad of health problems combine to create one of the most difficult health situations in this country. An over extended Indian Health Service cannot meet all of these needs. However, physician owned hospitals particularly in Western states like Colorado, Montana and South Dakota provide important services to all ages at reservations in several states.

The many programs outlined in HR 3014 are just one measure of the immensity of the health disparities problem in this nation. As physicians, we try to reduce them one patient at a time. However, I can assure this subcommittee that my colleagues and I could not accomplish what we do if we had not built our hospital in Baton Rouge. The success of our facility for patients, and the success of other physician owned hospitals across the country, should be applauded and encouraged. Any step, however small, that reduces health disparities and improves care for patients should be nurtured. Instead, I see too many Members of Congress apparently determined to stop what my colleagues and I have been able to do, by outlawing physician ownership of hospitals. I just don't understand it. I invite you to come to my part of Baton Rouge. You will quickly understand why health care innovation is so essential if we are to improve health outcomes in this community and why building our hospital was a turning point in improving care for African Americans in our area.

In conclusion, Mr. Chairman, thank you for having this hearing and shining light on a major problem in our health care system. Thanks to all of the Members of the Subcommittee for their interest in learning more and working on solutions. Those of us in the trenches trying to battle these barriers ask only that you and your colleagues work on a bipartisan basis to provide some solutions involving the entire healthcare community. Our experience, and the experience of others, shows that there is a role that the physician owned hospital can play in this effort. I hope you recognize this as well and will silence our critics whose primary aim in life seems to be their financial health and control of the system, not the health of their patients. If HR 3014 is passed by Congress, I urge you to make sure that physician owned facilities can participate equally with other hospitals.

I would be happy to try to answer any questions the Subcommittee members may have.