Transcript: Why *The Pitt* is our fave new drama

Dan: Hey there. I've got a new favorite TV show: "The Pitt." I signed up for HBO -- Max, whatever --thats what my editor says I'm supposed to call it. The show takes place in a Pittsburgh emergency room, and the first season follows the staff through a single, jam-packed day, hour by hour. It's riveting. Noah Wyle, who got famous playing a young doctor on the show ER in the 1990s, stars here as the senior doc on duty. And people who work in emergency rooms say it gets a lot of things right, including medical details that fly past most of us in scenes like this…

Doctor 1: Bring me up to speed?

Doctor 2: Intubated for agonal respirations. GCS five, probably anticoagulated.

Doctor 1: With what?

Doctor 3: First time here. There's no medical records.

Doctor 1: Call for FFP.

Doctor 2: No, we got four factors…

Dan: And yeah, I basically did not catch any of that. But when I played it for an actual ER doctor, Alex Janke, he kept smiling and nodding along. In any case, those were not the kinds of scenes I called Alex Janke to talk about. Because what drew me to the Pitt -- for professional purposes at least -- are scenes that show the bigger-picture forces -- the financial forces -- that MAKE this day, and every day, so difficult for the people who work in big-city ERs, and for the people who show up needing care. Forces that make ERs more crowded, and more chaotic. Less safe, and more expensive. I called Alex Janke because on top of working shifts at ERs, he does research on those forces as a professor at the University of Michigan.

Alex Janke: I care a lot about. Emergency medicine. Like I think that what we do is really, really special. And I also think that if you want to understand the problems in the world, you should come to the emergency department, 'cause that's where people go when they have problems.

Dan: Problems like gun violence, homelessness, sex trafficking,drug addiction, and a likely hate crime bring patients to The Pitt throughout the season. The Pitt

also looks at questions that Alex studies: Why do people have to wait so long to get seen at ERs? How badly can those long wait-times affect our health? So, we watched some scenes that address those questions together and Alex was like...

Alex Janke: I've gotta find the people that made this show. This is so crazy. They, they've gotta have some docs working for them.

Dan: There's a whole team. There's a whole team.

Dan: Alex Janke thinks the producers picked the right team… because, he says: This is too real. So here comes a debrief. Basically free of spoilers -- in terms of the MEDICAL drama. And I'll tell you right now: The financial problems? Those storylines do not get wrapped up on The Pitt, or in real life. But the show does help us understand them, and what they cost all of us-- doctors, patients, everybody-- in money, in our health, and in our emotional well-being.

This is An Arm and a Leg, a show about why health care costs so freaking much, and what we can maybe do about it. I'm Dan Weissmann. I'm a reporter, and I like a challenge. So the job we've chosen on this show is to take one of the most enraging, terrifying, depressing parts of American life, and bring you something entertaining, empowering, and useful.

The folks who made "The Pitt" made a super-canny choice: The show follows a single day in this ER -- and it happens to be the first day for a crew of new residents and interns. So while we watch them get shown around, we get a tour. First stop, the waiting room. It's PACKED. A second-year resident explains how patients register, get a quick assessment...

Doctor: And then they come back to waiting room till bed opens up

Doctor 2: For how long?

Doctor: Eight hours if they're lucky. A lot of times 12.

Doctor 3: Ah, is it always this busy?

Doctor: Uh, no. It gets a lot busier.

Dan: Here's Alex's take on that snapshot.

Alex Janke: I think this is entirely real. And we can really expect this to be true going into the future that, uh, you know, eight hour waits, 12 hour waits, very high rates of left without being seen are just gonna keep happening all over the country. And it's not gonna be every day that you walk in the door. but it's gonna keep happening.

Dan: Why?

Alex Janke: That's a great question.

Dan: Alex has a couple of answers. One is about demographics: We've got more folks now who are old, with complex medical issues than ever before, and that's only gonna get more true for a long time to come. The other basically gets dramatized in the next couple scenes we watch. First, Noah Wyle's character, the senior MD on this shift, Dr. Michael Rabinovich -- everybody calls him Doctor Robby – gives the newbies his briefing. Here's the first thing he tells them.

Robby: As you can see, our house is always packed and our department is mostly clogged up with borders. Those are admitted patients waiting for a room upstairs sometimes for days.

Dan: OK, that went by quick, but Dr Robby basically just described WHY people wait eight hours, twelve hours, why this ER and its waiting room is so full. I'll let Alex explain.

Alex Janke: The emergency department is not full because folks with the sniffles came in when they could have gone to an urgent care. That is not the reason that the ER is crowded. Those patients are so easy, we see 'em out in triage. I love seeing those patients 'cause that's somebody that I can get in and out. I can take really good care of that patient sometimes just from the waiting room. The ER is full because there are folks that need to be in the hospital or folks that need to be in skilled nursing facilities or in rehab and we can't get them to that next step.

Dan: So those patients become "boarders" -- get stuck: they can't get moved to the next step, but of course they can't go home either.

Alex Janke: And so they wait in the ER and that creates crowding all around all the other patients.

Dan: The “boarders” fill up the ER beds. So everybody else piles up in the waiting room. Things get super-crowded. That sucks for those of us who show up as patients -- a lot of us wait a super-long time. And that crowding -- and the chaos that comes with it -- creates burnout for people who work in ERs.

Alex Janke: The thing that burns you out is feeling like you're not able to do a good job or you're not in control of your working environment. And this is the reason. It is because it is crowded. Like an old lady comes in with belly pain. I can't take care of that patient in the waiting room that I need that lady back in the department. I wanna get a CAT scan on that lady. I need some time with her. And it's just, it's, it's dangerous and unpleasant all around.

Dan: Because you, because you don't have space to see her. You don't have a bed, you don't have capacity to see her. And so she's in danger.

Alex Janke: Absolutely. Without a doubt. And, you know, there's a deep, there's a deep literature on this, crowding impacts the quality of care along every possible dimension. It makes you more likely to screw up. I'm an ER doctor. My whole job is to not screw up. I'm like playing this game and the game is to not miss something really bad. And the faster you make me go with fewer resources, your ER doctor's just a little more likely to screw up and not handle that correctly. I have gray hairs from a couple of cases.

Dan: He tells me about one of them. A woman who came in with a rash. When he finally examined her, twelve hours later, it turned out that rash was from flesh-eating bacteria. Those twelve hours meant that bacteria did a lot of damage. Alex says that woman spent a long time in the ICU, and took months to fully recover.

Alex Janke: I mean, those are the, you know, that's one of the cases I know about, like how many patients have I been on shift and I don't even know what happened, 'cause there's so much chaos going on that I don't have insight into what might have missed or what we might not have done very well?

Dan: So the ER doesn’t work because it’s too crowded. And it’s crowded because of “boarders” -- patients waiting for beds elsewhere. And in the next scene, we get Dr. Robbie's perspective on WHY that’s happening. That’s when a hospital administrator, Gloria, shows up to give him a hard time. She says, WE NEED TO TALK ABOUT YOUR NUMBERS. Meaning, patient satisfaction numbers.

Gloria: Do you know how likely patients are to recommend this hospital?

Robby: Um, this is an emergency department, not a Taco Bell.

Gloria: 11%.

Robby: Well, if you want people to be happier, don't make 'em wait for 12 hours.

Gloria: There's a nursing shortage across the country.

Robby: Most of our patients are boarders who are waiting for a bed upstairs.

Gloria: We don't have the beds.

Robby: That's bullshit. The beds are up there. You just don't want to hire the staff. You need to care for 'em.

Dan: Alex has one little problem with this scene. He's like, these conversations definitely happen, but not on shift, on the ER floor. But you know, OK it's a TV show, and the whole premise is that we're on the floor the whole time. And Alex has a second problem. Dr. Robby maybe does too good a job keeping his cool.

Alex Janke: You know, Dr. Robby is rushing from one dying patient to another, and someone shows up in a suit and says, you know, your patients aren't very satisfied with your care. I think he handles it like an angel. If it were me, I think I would lose my job that day.

Dan: Otherwise, Alex is like: This is dead on.

Alex Janke: There's so much going on here. This is wild. It's so wild.

Dan: And he unpacks it. Yes, there's a nursing shortage. Yes, there's an actual shortage of hospital beds. And to a degree, these shortages are … business decisions.

Alex Janke: There's some real truth, there's a real hook to the idea that the emergency department waiting room and the emergency department beds as a place to keep folks waiting for a bed upstairs in the hospital — it is an optimization problem.

Dan: An optimization problem. That's what Alex says people who study hospital administration have called this situation. The question is, what are you optimizing for? If you're a hospital administrator, Alex says, you're trying to optimize ... your budget. You're asking yourself: How do you get the most return for what you spend? You don't do it by paying nurses to staff beds with no patients in them. Nobody's paying you for empty beds.

Alex Janke: I mean, we want our hospital beds full. we've gotta pay these enormous costs for inputs, like, uh, nurses and, every single hour of nursing care that you pay for, you wanna make sure that, uh, it's getting used. Every hospital bed day that you have staffed, you better fill up that bed.

Dan: So, now you've got a new equation to balance. Here's how Alex describes the question:

Alex Janke: How do you maximize your patient bed days —that's how you get paid — without ever having to turn away business?

Dan: OK, let's unpack that: You want to maximize patient bed days. The number of beds that actually have patients in them, beds you're getting paid for, on any given day. But you've limited the supply of beds upstairs. You don't want to pay for something you might not be able to sell. And yet: You don't want to turn away business.You've got a patient who needs a hospital room -- a potential paying customer --you don't wanna tell 'em, hey we don't have room for you on our cardiac ward. You gotta go somewhere else. So, how do you make room for patients -- for customers -- when there's more demand?

Alex Janke: Well, one way to do that is to queue those patients, put them in a in a slot so that they're ready to fill up that bed as soon as that bed becomes available. Where does that happen? The emergency department.

Dan: So this is why Alex is so enthusiastic about this scene: It dramatizes this whole analysis -- and Dr. Robby's perspective-- the boarders who crowd up the ER and the waiting room: They're the results of the hospital's financial strategy. No wonder Dr. Robby's mad.

Coming up: How doctors get caught in the processes that end up with awful bills for patients.

This episode of An Arm and a Leg is produced in partnership with KFF Health News. That's a nonprofit newsroom covering health issues in America. Their reporters win all kinds of awards every year. We are honored to work with them.

We're gonna skip ahead to episode six of The Pitt. No spoilers here. This scene stands alone, and it's all business. Robby stops by a computer terminal where one of the newbies is charting-- writing up her notes after seeing a patient. Listen for a key term right up top: Medical Decision Making. A little later we'll hear Robby use its initials: MDM.

Dr. Robby: Four-year-old with a fever. Your medical decision making says otitis media.

Dr. Javadi: Yeah, she had an ear infection.

Robby: Did you also consider and rule out meningitis, mastoiditis, malignant otitis external?

Dr. Javadi: I did.

Dr. Robby: Then you should document your cognitive work in the MDM.

Dr. Javadi: You want me to pad my chart?

Dr. Robby: No. I want you to show your work. Billing is the side effect of that.

Dan: "Billing is a 'side effect' of adding details" to the chart. When I watched that scene with Alex, he was like, Yup: charting is where our work turns into medical bills.

Alex Janke: So when we bill for care, we bill an insurer for care, we bill the chart, right?

Dan: The billing department translates the work described in the chart into 5-digit codes, and each one has a price tag. MDM, medical decision-making, contributes to codes for "evaluation and management" like 99281 or 99285.

Alex Janke: And if you bill for 99285, you get a whole bunch of money. And if you bill for, uh, 99281, then you get a little bit of money.

Dan: The only difference is that last number. It reflects a scale -- 1 to 5 -- how much work went into this visit. Was this straightforward? That's a one. Was it high-level? Really complex? That could be a five. Researchers have found that "upcoding" -- like billing a level four for something that's really probably a two

-- is one reason why, as a country, we spend more on ER bills every year. I tell Alex: In one of the very first episodes of this podcast, we heard from a listener who had brought his son to the local ER -- only place open at night -- for what turned out to be ...and ear infection. The hospital coded the visit a "4" out of five. Pretty expensive. Our listener said, if that's a four, *what is it when you bring your leg in a bag?* Alex was like, Yeah.

Alex Janke: There's this fight between like physician groups on the one hand, and insurers on the other hand about like how hard our job is and how much they should pay us, and the only one who consistently loses in that fight is the patient.

Dan: Yeah. Well said. Well said.

Alex Janke: You're absolutely right. It's definitely true in emergency medicine. And you know, like I, I've written on this topic our patients are more medically complex than they have ever been. The complexity of the evaluation management that happens in the emergency department is higher than it has ever been. But that's no excuse for, you know, leaving the patient with an absurd bill that's out of proportion to what she did for them. This is one of the ways in which you're like, put in all of these like little situations where like you're in a lose-lose situation.

Dan: Lose-lose situation. Alex tells me a story. He was working in triage one day, and a guy came in with a bug bite.

Alex Janke: …and his buddy had convinced him that he might have like a really bad problem. He was like, this is a black widow spider bite. And it was a crazy day and I'm just like floating around at triage, slinging orders. And, he like stopped me in the hallway as he was like thinking about leaving. And he was like, do I really need to be seen for this? Do I really need to be seen for this? And I'm like, well, you have been seen. I am a doctor. And, and he walked out the door and I had this moment where I was like, do I go write a note on this guy? If I write a note, then we'll bill him.

Dan: And Alex says he knew: That guy didn't have insurance. Whatever that bill was, he could get stuck paying for it.

Alex Janke: I don't know what that bill looks like. I don't have insight into that. I don't know how the place that I work at operates on that end. I'm almost never involved in it at all.

Dan: What'd you do?

Alex Janke: Nah, I didn't write a note.

Dan: I said to Alex: Geez, some hospitals have folks who help people in these situations, who go: "Hey, let's see if we can sign you up for Medicaid. Or a super-subsidized Obamacare plan. Or maybe you qualify for charity care here." But of course not every hospital has those folks. Alex was like, oh yeah, for sure.

Alex Janke: One of the places where I currently work, our registration staff know like a ton of stuff about insurance and patients will like ask me, and I'm like, oh, no, no, no. This is the person you gotta talk to. They actually know how to enroll whether it's Medicaid or something else. Yeah.

Dan: It's great that there's somebody , and you know, who the somebody is, for them to talk to, 'cause that is not everybody's experience.

Alex Janke: Yeah. And also, I've worked at other places where you look around in the department and no one knows. And like, that's always a bummer. Like there was a little while where I was handing out a phone number 'cause I didn't like really know what I was supposed to be doing. And so I would, I would give people this phone number. I'd be like, what you're telling me makes it sound like you qualify for Medicaid. But like, I don't really know anything about Medicaid. This is the website, this is the phone number. It's so bad.

Dan: Alex says he hopes people who don't work in ER's watch The Pitt.

Alex Janke: This show is good for people like me because it like humanizes us in a lot of ways and the show definitely makes us out —at least the first two episodes — they make us out in lots of heroic ways, and I think that's great. And I think lots of emergency physicians are heroes. Lots of us are not heroes. You know, we're just people.

Dan: He thinks it'll help people like him -- in his role as a researcher and advocates -- make a case for policies that'll help ERs. And he's not mad about seeing the business questions get dramatized.

Alex Janke: We need to have those conversations way out in the open with bright lights and that's the only way that they won't ultimately have the patient be the only one who loses in the exchange. So, yeah.

Dan: As if we know a little bit more about the whole, about the game that we're in the middle of. Yeah.

Alex Janke: Exactly. Yeah.

Dan: But as happy as he is that The Pitt is out there -- having watched the first two episodes so we could have this conversation-- he's not inclined to watch more of it.

Alex Janke: I think a lot of people, a lot of, like my friends, we don't, we don't have to watch it. I just go to work. It's so spot on, so often, it feels like you're at work. I'm like, well, I do this. I'll tell you, I'm watching Abbott Elementary.

Dan: The network sitcom about a Philadelphia grade school.

Alex Janke: It's pretty good. It's pretty good. There's some strong dialogue, there's some really strong characters.

Dan: Teacher friends of mine love that show. And it's another, I mean, it's interesting 'cause that's another show about people who, part of their job is it like they're in the path of suffering that other people are headed for and doing their best.

Alex Janke: I sometimes say this to residents, but like you can go give as much as you want in the job of emergency medicine. You can give everything to the people who come in the door. It's the same thing with teachers, right? If you're a teacher, you can just keep giving. They'll never stop asking for more, and a lot of 'em do. It seems like a hard gig to me and considerably less remunerative than my job, so…

Dan: I will let my teacher friends know Alex said that. Meanwhile, about fifteen hours after we release this episode, HBO -- I mean, Max -- will release the last episode of The Pitt. For now. The show has been renewed for a second season, starting January 2026. Producers said recently that season two is gonna take place over a Fourth of July weekend… which, a study from Pew Research shows, means the busiest days of the year, by far, for emergency rooms.

We'll be back with a new episode in a few weeks. Till then, take care of yourself.

This episode of An Arm and a Leg was produced by me, Dan Weissmann, with help from Emily Pisacreta and Claire Davenport, edited by Ellen Weiss. Adam Raymonda is our audio wizard. Our music is by Dave Weiner and Blue Dot Sessions. Bea Bosco is our consulting director of operations. Lynne Johnson is our operations manager. An Arm and a Leg is produced in partnership with KFF Health News. That's a national newsroom producing in-depth journalism about health issues in America – and a core program at KFF: an independent source of health policy research, polling, and journalism. Zach Dyer is senior audio producer at KFF Health News. He's editorial liaison to this show. An Arm and a Leg is Distributed by KUOW-- Seattle's NPR station. And thanks to the Institute for Nonprofit News for serving as our fiscal sponsor. They allow us to accept tax-exempt donations. You can learn more about INN at INN.org. Finally, thank you to everybody who supports this show financially. You can join in any time at arm and a leg show, dot com, slash: support. Thanks! And thanks for listening.