Corporate treatment for the ills of academic medicine

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best treated by a combination of psychotherapy and medication.

The FDA’s recent analysis suggests that the risk of emergent suicidality in children and adolescents receiving SSRIs is real — but small. The FDA’s advisors recommended stronger warnings in labeling and better information for patients and caregivers, but they stopped short of recommending contraindications for these drugs. However, many participants in the public hearing seemed convinced that the pharmacologic treatment of pediatric depression should be banned or severely curtailed. That would turn the clock back 25 years, to a time when the only thing we could offer the families of suicide victims was the hope that someday we would have effective treatments. Ideally, the FDA, families, and clinicians will find the right balance between the risk of suicidality and another, greater risk: the risk that lies in doing nothing.

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These are anxious times for academic medical centers, which have reacted to recent developments with measures that were beyond contemplation in a more optimistic past. Confronted by the challenges of managed care, decreases in reimbursement, restrictions on house-staff working hours, heightened scrutiny of clinical research, declining federal support for medical education, and the growth of formidable competitors such as hospital chains and medical practices specializing in high-margin services, academic medical centers can no longer be complacent about their financial health or their reputations as the best places to receive care. Many of these institutions have political clout and access to considerable private wealth, but none can count on a bailout from government or donors if they founder. Nearly all have adopted tighter management practices and worked to eliminate inefficiencies. Many have reorganized, and some, like Stanford University Medical Center and the University of California at San Francisco, and Brigham and Women’s Hospital and Massachusetts General Hospital, have merged with erstwhile rivals. As these institutions attempt to run themselves like other large enterprises, their faculty, affiliated physicians, and many others question whether a preoccupation with costs and revenues will distract them from their traditional missions.

Anyone who believes that academic centers have lost their way by adopting corporate practices must surely have been alarmed by the news of a “partnership” between GE Medical Systems and New York–Presbyterian Hospital, the organization that resulted from the merger of the hospitals of Cornell University and Columbia University. Under the terms of this partnership, New York–Presbyterian will spend a reported $500 million, over 10 years, on products and services from GE, ranging from imaging equipment to change-management programs to training in process-improvement and quality-improvement programs. The agreement tied together a broadly diversified medical products and services business, with revenues of approximately $9 billion at the time, with one of the dominant health care providers in New York City, a 2400-bed hospital system with $2 billion in annual revenue.

Academic medical centers routinely spend millions of dollars on equipment from GE and its competitors, and they engage consultants for everything from operational assistance to informa-
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The drawbacks of obtaining guidance and services from advisers whose interests diverge from those of the client are unfortunate but generally accepted, as long as there is full disclosure of the potential conflicts. Any such conflicts in GE’s role should be known to the hospital, and GE surely recognizes that the success of its relationship with New York–Presbyterian and its ability to form other similar relationships depend on the hospital’s continuing satisfaction with the arrangement.

If GE’s quality- and process-improvement programs enable a hospital to make better use of its operating rooms, eliminate unnecessary duplication of tests, and shorten waiting times in clinics, the hospital and its patients benefit. But any consultant could also help a hospital’s financial performance by pursuing strategies that do not benefit the public. Many academic hospitals could improve their bottom lines by cutting the amount of uncompensated care they provide and eliminating unprofitable services. They might also promote excessive use of high-margin services. For example, to the extent that physicians induce demand, any hospital that owns a scanner — and any physician who earns fees by interpreting scans — can raise revenues by performing scans for less critical or even dubious indications. Similarly, well-reported phenomena such as “DRG creep,” “upcoding,” and “unbundling” can increase health care expenditures without benefiting patients. Such practices may seem innocuous from the individual patient’s point of view, if they merely raise health expenditures generally. But a physician or hospital that takes advantage of reimbursement anomalies can also jeopardize patients’ health. Physicians and hospitals can be reimbursed more if a candidate for the placement of multiple coronary stents has the procedure divided among two or more hospital admissions than if they are placed as part of a single complex procedure. Is it plausible that clinical needs alone explain why so many patients have stents placed as part of multiple admissions?

No institution with a reputation to preserve — whether for-profit or nonprofit, medical center or consulting firm — can risk encouraging or engaging in any practice that might be construed as fraudulent or unethical. Nevertheless, one cannot presume that what is good for the hospital and the consultant is good for society. Does this imply that a successful partnership between GE Medical Systems and New York–Presbyterian Hospital will not serve the public interest and that such arrangements should be discouraged? I believe that would be the wrong conclusion. The problem is not that GE Medical and its competitors are seeking to make hospitals more efficient. The problem is that hospitals are not always rewarded for providing care that is both of the highest quality and appropriate. The task of GE Medical is to help the hospital respond to the incentives it faces. The responsibility of those of us who are concerned about the future of health care is to make sure that the incentives they face are the right ones. It is a responsibility that we cannot delegate.

From the Department of Veterans Affairs Palo Alto Health Care System, Palo Alto, Calif., and Stanford University, Stanford, Calif.

Cardiopulmonary Bypass after 50 Years

L. Henry Edmunds, M.D.

A little more than 50 years ago, a hole inside a human heart was closed, with a machine maintaining life while the surgery was done. Within the next two years, four of eight children survived repair of complicated congenital heart defects in operations involving a similar machine. The heart–lung machine, as it was called, was invented and developed by John and Mary Gibbon (see Figure 1). Simultaneously, Forssmann, Cournand, and Richards developed cardiac catheterization that permitted anatomical and physiological diagnoses of heart disease during life. With the discovery and commercial production of the anticoagulant heparin, these two innovations spawned the modern surgical