Academic Medical Centers At Risk Of Not Being Academic Or Medical

By Chuck Dinerstein, MD, MBA — March 9, 2017

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What doctors long feared, and what alternative medicine proponents have long desired, has come to pass. More academic medical centers, which lay claim to being superior, have been embracing alternative techniques that, unlike actual medicine, have never passed double-blind clinical trials.

In 1999, only 8 academic centers embraced the alternative to evidence-based medicine. Now that is over 70, including everything from vague "wellness" notions to naturopathy.

In the Stat News special report [1], they note that the reason is financial - but real doctors are less happy about things such as "alternative therapies promoted as a way to treat disease."

This is approaching crisis levels. It turns out that 28 of the 91 members of the Association of Academic Medical Centers [2], whose mission is to improve health by:

(1) educating and training the next generation of health professionals;
(2) conducting biomedical, translational, and clinical research; and
(3) providing the highest quality comprehensive primary and advanced specialty care.

are simultaneously members of the Academic Consortium for Integrative Medicine and Health [3] whose vision is “A transformed healthcare system promoting integrative medicine and health for all” the train has already left the station.

Why the rush to embrace the alternative? The first is that it has federal government blessing. Ever since President George H.W. Bush created the Office of Alternative Medicine (later the National Center for Complementary and Alternative Medicine, now the National Center for Complementary
and Integrative Health) and then President Clinton signed the Dietary Supplement Health and Education Act of 1994, the alternative market has been in a Golden Age.

There are at three other interconnected trends contributing to including non-traditional Western medicine in our academic centers:

(1) A move to provide a medical experience rather than a service;

(2) Conceding that medicine does not have all the answers and the beliefs of customers enhance experience with little downside risk and;

(3) An adjunctive role can be repackaged as a revenue source.

Let's discuss those.

1. Healthcare as an experience

“Mayo Clinic sells a $2,900 ‘signature experience,’ which includes consultations with a wellness coach.” [1]

Consider oncology care, to a great part; it is driven by clinical protocols. Recipes for care that are provided equally well as hospital A and hospital B, after all, it is a standard recipe. How can hospital A get more patients (and revenue) than hospital B – by providing a better ‘care experience.’ You could refer to If Disney Ran your Hospital [4] which “focuses on the similarities between Disney and hospitals - both provide an "experience," not just a service. It shows how hospitals can emulate the strategies that earn Disney the trust and loyalty of their guests and employees.”

Or consider patient satisfaction scores, collected by the Centers for Medicare and Medicaid (CMS) and part of the scoring used to incentivize (and penalize) hospitals. There are questions about cleanliness, quiet, courtesy, respect, explanations, getting help – all measures of experience, not outcome. All graded on a 5 point scale. Perhaps that explains all of those “We strive for five” signs we see. If it reminds you of your conversations when purchasing a car, it should, it is about rating and shaping the experience of healthcare, not necessarily its outcomes. In the same way that physicians have morphed into providers, patients have become customers. (As a physician, there is no greater responsibility and privilege to care for a patient, it’s just not the same for a customer)

2. Western medicine does not have all the answers

“The old way of combating chronic disease hasn’t worked,” Cosgrove [Cleveland Clinic’s CEO] wrote in a column posted on the hospital’s website, “We have heard from our patients that they want more than conventional medicine can offer.” [1]

Everything I learned in medical school has changed, sometimes to the point of being untrue. I was trained to put a tube into a patient’s nose and ultimately into their stomach – to decompress the
bowel after abdominal surgery. Three days with a very uncomfortable tube. Today we have found it to be unnecessary. But it is a far cry from this type of practical, tested change, to the belief that the customer is always right or that crowd-sourced beliefs are, by their nature, correct. And this is the first of the unintended consequences that perturb the physician commentators in the Stat article. ‘[If a hospital is offering] treatment that’s based on fantasy, it undermines the credibility of the institution.” Steven Salzberg Ph,D Professor Biomedical Engineering, Johns Hopkins

As Linda Lee, MD the director of Johns Hopkins Integrative Medicine and Digestive Center is quoted in the Stat article, “Yes, as scientists, we want to be rigid. But me, as a physician, I want to find what’s best for a patient. Who am I to say that’s hogwash?” [2] Well we can at the very least consider the clinical guidelines offered by the Society for Integrative Oncology [5], a group that includes representatives of Sloan-Kettering, MD Anderson, Columbia and University of California, San Francisco.

<table>
<thead>
<tr>
<th>Modality</th>
<th>Examples</th>
<th>Advantages</th>
<th>Limitations</th>
<th>Quality of evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mind Body</td>
<td>meditation, hypnosis, relaxation techniques, yoga, cognitive- behavioral therapy, biofeedback, and guided imagery</td>
<td>Safe good evidence</td>
<td>Time consuming</td>
<td>Low</td>
</tr>
<tr>
<td>Touch therapy</td>
<td>Reiki, massage</td>
<td>Safe, available</td>
<td>None</td>
<td>Low</td>
</tr>
<tr>
<td>Physical activity</td>
<td>Exercise</td>
<td>Good evidence safe</td>
<td>None</td>
<td>Moderate</td>
</tr>
<tr>
<td>Energy therapy</td>
<td></td>
<td>Safe</td>
<td>No good evidence</td>
<td>Low</td>
</tr>
<tr>
<td>Acupuncture</td>
<td></td>
<td>Good</td>
<td>Skills not readily available</td>
<td>High</td>
</tr>
<tr>
<td>Diet and Nutritional supplements</td>
<td>Chinese herbal supplements, homeopathy</td>
<td>Interests the most patients</td>
<td>Potential adverse effects</td>
<td>Moderate</td>
</tr>
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Let me return to the clinical guidelines (and compliment them for their candor):

- Of 31,044 adults surveyed, 75% used some form of Complementary
Alternative Medicine (CAM). Exclusion of prayer reduces the figure to 50%.
- there is little evidence to date showing that any CAM therapies can suppress or cure cancer in the clinical setting.

So why pursue these modality? As the guidelines go on to state unconventional therapy is used most often as a complement rather than replacement of mainstay treatment. Those abandoning conventional therapy due so out of anger, lack of control, a belief in a cure, social associations and mysticism. They offer two reasons. First, in the words of the Institute of Medicine’s report “Cancer Care for the Whole Patient.”

“cancer care today often provides state-of-the-science biomedical treatment, but fails to address the psychological and social (psychosocial) problems associated with the illness. These problems—including anxiety, depression or other emotional problems—cause additional suffering, weaken adherence to prescribed treatments, and threaten patients’ return to health”

Second, while their benefits may be evanescent, they do no harm. As Dr. Richard Land, Chair of Preventative Medicine at Cleveland Clinic states, “If it doesn’t work, I don’t know that you’ve lost anything. If it does, you do get to a better place.” [1]

3. An adjunctive role can be repackaged as a revenue source

These are adjunctive modalities and in our current healthcare system that means that they are, in general, not covered services. So there are no co-pays, or deductibles, or insurance authorizations – very little administrative overhead. They are paid for the old fashioned way, cash, check or credit card. And as my finance professor loudly proclaimed, “Cash is king.” No figures are available, in fact, I doubt that few individuals within these medical centers are aware of the revenue but CAM is tapping into what Stat describes as a $37 billion a year market. In a world of diminishing payments and increasing responsibilities for the medical care that insurers and CMS pay for, the cash flow from CAM is huge. No wonder administrators’ judgment may override faculty's concerns.

Let me end with one last quote from the guidelines:

Patients who seek such therapies should be informed that their benefits vary from individual to individual, the mechanism of action is not fully understood, and these therapies do not have antitumor effects. Patients should also take financial implications into consideration.

It’s a variation on letting the buyer beware. Shouldn’t our premier academic medical centers hold themselves to a higher standard?

[2] Scientists are not rigid, they simply want reproducible proof. And what is the role of a physician other than to have the experience and training to make reasoned judgments?

[3] Strength of evidence is broken down as follows:

<table>
<thead>
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<tbody>
<tr>
<td>High</td>
<td>RCTs without important limitations or overwhelming evidence from observational studies</td>
</tr>
<tr>
<td>Moderate</td>
<td>Randomized Controlled Studies (Inconsistent results, methodological flaws, indirect or imprecise) or exceptionally strong evidence from observational studies</td>
</tr>
<tr>
<td>Low or very low</td>
<td>Observational studies or case series</td>
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