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Commentary

The Rise of Corporate Medicine and its Melding, Conflicts and Influence on the Art and Science of Medicine, using Pancreatic Cancer (CaP) as the Model

Avram M Cooperman[1]*, David Grossman[2], Mazen Iskandar[3], Justin Steele[1] and Michael Wayne DO[1]

[1]The Pancreas and Biliary Center and Advanced Minimally Invasive Surgical Center of NY, New York, USA

[2]Department of Surgery, Aventura Hospital, Aventura, Florida, USA

[3] Department of Surgery, Mt Sinai Hospital, New York, USA

***Corresponding Author:** Avram M Cooperman, The Pancreas and Biliary Center and Advanced Minimally Invasive Surgical Center of NY, New York, USA.

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Introduction

The onset of a new year finds the USA closer to a single payer medical system than ever before. Policies of medicare -medicaid influence and determine the quality, economics and standards of medical care. The Quality Payment Program (QPP) outlined in a 1653 page document amplifies the merit based Medicare-Medicaid payment system, which evidently has not lessened the interests of corporate health and Big Pharma.

Traditional and Corporate Medicine

Medical practice has changed significantly in the past decade, for the better and worse. Formerly, medicine involved as much art as science. The "art" emphasized close personal care, "babysitting" seriously ill patients, and consultants as needed.

Today care is less personalized, provided by hospital employed physicians (hospitalists) and is much about the bottom line. Evidence based analyses of outcomes replace many antiquated customs and "how I do it" practices. By acquiring multiple facilities, and offering consumers competitive health insurance rates, corporate health becomes both provider and insurer. Growth has created a larger base for corporate health expansion. By clever negotiations, controlling costs, renegotiating fee schedules, and expanding residency programs, profit margins are reset . Like the big fish who consume smaller fish, corporate acquisitions include hospital staff, physicians, and valuable real estate, much of which is profitably sold for converted residential dwellings. These patterns have reoriented physician practices, from privately owned and managed to hospital based employed physicians. The era of individual and small group medical practice is waning. Private practice costs for real estate, staffing, office management, billing and insurance are defrayed. The stresses of individual care are reduced and leisure family time is increased. Financial incentives are attractive, at least for initial contracts. Hospital based physicians, frequently work 3 twelve hour shifts per week and are then "off call" This minimizes individual patient contact and responsibilities and transfers care to a "committee" of specialists. This further abbreviates patient visits, but allows for more timely and detailed daily electronic progress notes and accurate billing codes. The patient's care is then transferred to the next shift physician. This is far different from intense in hospital personal care rendered by physicians familiar with the patient before hospitalization. who assumed "ownership" and were seemingly always available. Presently many patients feel "rented", rather than owned. The disappointments are most often sensed by elderly patients who were familiar with personal medicine. For most millennial's who have not needed intense, omnipresent individual care there are no comparisons.

Corporate medicine attracts patients, in part, by expanding services and specialty clinics headed by newly trained specialists who are less costly, less experienced and easier to manage than established experts. Advertisements extolling favorable patient experiences are common, by mailings, newspaper and television ads, as well as billboards and ads in public transportation.

Will Corporate Medicine Scrutinize Outcomes of Treatment?

It is one thing to apply a business approach to hospital expenses, accounts receivable and investing in new programs but it is equally if not more important to scrutinize outcomes of treatment and morbidity. When the best of available treatment is dismal it is difficult to justify its continued use and an open minded approach to new and alternative approaches is necessary. Three diseases with abysmal outcomes that warrant a changing are glioblastoma, some lung cancers, and Cancer of the Pancreas (CaP). For illustration CaP will be used to highlight some issues of treatment and outcomes.

Cancer of the Pancreas

A long experience with pancreatic cancer has confirmed that actual long term survivors are few, independent of prognostic factors (lymph node status, size and grade of tumor) and of hospital size and status (university or community). Quality care is more about dedicated, knowledgeable, inquisitive, open minded, experienced physicians working together to insure no lapses and few errors in care and less about a hospital name and size.

Cancer of the Pancreas (CaP) is a high risk, low reward illness which utilizes multiple hospital resources and has dismal outcomes. This is one of several illnesses whose treatment should be influenced or reconsidered by corporate scrutiny. Addressing the century old mantra that surgery remains the first and best approach for CaP, particularly since 80+% are unresectable at presentation and survival is uniformly poor even when resectable, might be a starting point. Corporations unlike surgeons are less influenced and impressed by traditions and more by outcomes. Reprogramming the "reasoning center" of many physicians would be a good start, and lowering "knowledge shields" which block factual data is a good second step.

In an upcoming Surgical Clinics of North America convincing data is presented that actual 5, 10 and 20 year survival for CaP is possible and more likely when surgery follows not precedes systemic (neoadjuvant) therapy. Perhaps neoadjuvant therapy should be the preferred initial treatment for all CaP patients. This is the preferred treatment method at MD Anderson, and is supported by their impressive actual survival statistics.

Support for neoadjuvant therapy is based on the fact that; CaP is a systemic disease that has metastasized long before the tumor is detected; metastases noted after surgery are present in 80% of resected patients, often evident within 3 months of surgery; and in CaP, unanticipated metastasizes are present beyond the resection margin even when margins are negative.

Our hope for corporate medicine is much more than better fiscal and hospital management. Rather it emphasizes the longer view that requires a new mindset open to different and better treatment for high risk-poor outcome disease. An open minded analyses and willingness to change and abandon ineffective therapy is long overdue.

This must include an emphasis on prevention of illness by lifestyle change to prevent and treat causes of illness rather than symptoms. Prevention through lifestyle IS the simplest way to prevent most chronic illness (cardiovascular disease, cancer, obesity, and metabolic syndrome) which account for 3/4 of the deaths in the USA. Preventing illness is not counter to the interests of the health care and drug industry as there will always; be sufficient numbers of acutely ill, noncompliant patients who will require hospitalization and interventional therapy.

Suggested Readings

1. Avram M Cooperman. "The Pancreas Revisited". *Surgical Clinics of North America* 98.1 (2018).
2. AM Cooperman., *et al*. "Prevention and Early Detection of Pancreatic Cancer". *Surgical Clinics of North America* 98.1 (2018): 1-12.
3. AM Cooperman., *et al*. "Cancer of the Pancreas, Actual 5,10 and 20 year survival: The Fortunate and Lucky Few". *Surgical Clinics of North America* 98.1 (2018): 73-85.
4. T Vreeland and MHG Katz. "Timing of Pancreatic resection and Outcomes: Is there a Difference". *Surgical Clinics of North America* 98.1 (2018): 57-71.
5. RA Wolff. "Adjuvant or Neoadjuvant Therapy in the Treatment in Pancreatic Malignancies: Where Are We?" *Surgical Clinics of North America* 98.1 (2018): 95-111.

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