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FROM THE EDITOR
"No Margin, No Mission" Is Too Simplistic

The modern hospital grew from public nonprofit institutions, such as almshouses, that provided charity care to the ailing poor. It wasn't until the twentieth century that chains of for-profit hospitals made their debut in the U.S. Now, according to the American Hospital Association's 2010 survey data, more than a third of community hospitals in the U.S. are for-profit [1]. The changing face of the American hospital has led to significant questions about what the role of a hospital is and should be. Is a hospital a business, focused on profit margins and the bottom line? Or is it a mission-driven public resource, working to improve the health of a community? And are these two roles as diametrically opposed as they seem at first glance? The response to these questions is often "no margin, no mission"—in other words, if a hospital doesn't make enough money to keep its doors open, its higher purpose is moot—but this is too simplistic a view to take of the inherent tension between hospitals as businesses and hospitals as a form of public service.

In this issue of *Virtual Mentor*, we explore this tension in the context of a changing economic landscape in the U.S. With the advent of health care reform and an increased national focus on hospital costs, the way that both for-profit and nonprofit hospitals operate is changing: they are reevaluating their existing business practices in order to survive and thrive. As the authors of this issue describe, this has far-reaching implications for patient care, hospital organization, physician autonomy, and medical ethics.

Hospitals have important relationships with three key stakeholders: their customers (patients), their employees (hospital staff and, increasingly, physicians), and their shareholders (board members, in the case of private hospitals, and the community, in the case of public hospitals). This month's case commentaries focus on different aspects of these stakeholder relationships. Shivan Mehta, MD, MBA, and David Asch, MD, MBA, explore the case of a physician employed by a hospital, who is unsure about her own autonomy when the CEO publishes physicians' ordering information by cost. Chuck Peck, MD, an expert in physician-hospital joint ventures, provides another point of view in a separate commentary. Susan Dorr Goold, MD, MHSA, MA, examines the ethics of altering the so-called standard of care to spare a patient high hospital fees. In the final case commentary, Richard Thompson, MD, discusses the ethics of giving perks to wealthy patients as a way to garner philanthropic donations from grateful patients. Can the hospital/employed physician relationship work for the benefit of both parties and patients, too? Faith Lagay, PhD, reviews a 2012 journal article by hospital administrator David M. Belde who

believes it can, as long as the relationship is built on "socially directed" ideals shared by the medical profession and health care organizations.

The health care reform debate has led to an increased awareness of the cost of medical care and different ways to address these costs. Neel Shah, MD, gives an overview of how costs have become so high and how Cost of Care's Teaching Value project aims to help health care professionals master the complex cost landscape. In the medical education section, Stefan Timmermans, PhD, and Hyeyoung Oh describe the effects that an increased focus on hospital inpatient costs is having on medical education, given that medical students are trained on the wards. In the state of the art and science section, Devan Kansagara, MD, MCR, Brian Chan, MD, MPH, David Harmon, MD, and Honora Englander, MD, take a hard look at care transitions, an area that has been a focus of health care reform efforts. Cristie M. Cole, JD, reviews the effects of the Affordable Care Act on self-referral to physician-owned hospitals, previously suspected of driving costs up. Self-referral is also covered in this month's excerpt from the *Code of Medical Ethics*.

Accountable care organizations, or ACOs, are hospital or health system collaboratives that explicitly tie health care outcomes and cost reductions to physician reimbursement. ACOs already exist in the U.S., and many people have suggested that they are a perfect way to simultaneously achieve the dual goals of improving health care quality and reducing health care costs. However, as with any new development in hospital management or technology, there are ethical issues that need to be considered. Matt DeCamp, MD, PhD, writes an article in the policy forum section detailing some of the ethical considerations ACOs confront. In a medical narrative, Matthew McNabney, MD, gives guidance to physicians who will need to adapt to work in ACOs.

As the business of medicine continues to evolve in the U.S., and as more and more doctors become hospital employees, it will be increasingly important for physicians and future physicians to fully understand the environments in which they work. It was a pleasure and honor to work on this issue of *Virtual Mentor*, which I hope will serve as a resource as we navigate this changing landscape.

Alessandra Colaianni
MS-3
Johns Hopkins University School of Medicine
Baltimore, Maryland

References

1. American Hospital Association. Fast facts on U.S. hospitals. http://www.aha.org/research/rc/stat-studies/fast-facts.shtml. Accessed January 10, 2013.

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