ACADEMIC MEDICINE AND THE URBAN HEALTH AGENDA

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After decades of relative neglect, the involvement of New York City's academic medical institutions and the urban health agenda is beginning to improve. These institutions have always served as a major source of care for the urban poor and have been a major urban employer as well. However, in the past, our medical centers often were like ivory towers with moats around them, with limited additional interaction with the surrounding—often poor—communities. This recent enhancement of involvement of academe in urban health seems not to be driven primarily by altruism or a concern for the urban poor, but may be seen as a reaction to the pressures of the academic and clinical marketplace. These pressures include the local penetration of managed care, including Medicaid managed care; academic medical centers, feeling threatened, are now competing for patients never competed for before. We are very interested in building up our patient base in any way we can. A second factor is the influence of regulatory agencies and professional organizations such as the Residency Review Committee, the American Board of Internal Medicine, and the Liaison Committee for Accreditation of Medical Schools, which are consistently increasing their requirements for primary care educational experiences.

ACCESS TO CARE

Two changes now under way influence access to care. One is the focus on primary care, which is understandable and substantive. Market and academic forces are changing our focus from the training of specialists to the training of more primary care doctors and from tertiary care to primary care. These important changes have significant clinical and educational benefits as our students are increasingly exposed to more high-quality primary care and enhanced opportunities to become

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familiar with the health care challenges of the urban poor. The second aspect of access relates to community-based programs. There are many more community-based programs sponsored by academic medical centers than there were 10 years ago.

For instance, at Mount Sinai, we have a school-based program. Every school in District Four has not just a nurse handing out acetaminophen, but a board-certified pediatrician; for the high schools, there is a specialist in adolescent medicine. Another community-oriented program that I believe has helped to build strong bridges to the urban poor is in adolescent health. This is not on our campus, but in a large satellite in East Harlem, several blocks away. It is very successful and strongly supported by a variety of agencies. I see a substantial and growing interest in our faculty, students, and trustees in a much more meaningful presence in the community.

In this context, it is important to realize that academic medical centers define their communities in different ways. One of our communities is East Harlem, another is in the upper East Side, and still a third is in Boro Park in Brooklyn. These are different communities with different needs, traditions, and orientations. New York's communities are better represented on the board of trustees of every academic institution now than they were 10 years ago.

I also see the linkage with the community in other areas. For example, we recently dedicated a housing project, Project Linkage, a major sheltered housing facility in East Harlem established by a partnership of our medical center with a number of federal and local agencies.

QUALITY OF CARE

Academic quality-of-care programs developing in New York's medical centers will prove to be very relevant to an improvement in our understanding of the urban health issues. Several years ago, as we were planning to develop an academic quality-of-care program at Mount Sinai, I conducted an informal survey across the country and found two types of such programs. The first type may be located in a basement or in a quonset hut on the campus, where often one will find a group of outstanding scholars who work very hard writing grants to foundations and conducting research on large national databases. Analysis of the clinical programs in hospitals may fail to reveal evidence of the impact of specific quality-of-care initiatives in the institution based on the work being done in the quonset hut. There is a disconnection between the local academic efforts and clinical efforts.

The second type of quality program is an entirely different story. Instead of

having a title such as professor, the individual running the group is a vice president. The staff are based in the administrative suite and often can be found conducting length-of-stay reduction programs.

Based on this limited survey, it seemed to me that we needed a different type of program, one that had two characteristics. The first was that the program include both clinical and academic responsibilities; the second was that the research was local. With these considerations in mind, at Mount Sinai we were fortunate to recruit Dr. Mark Chassin, former Commissioner of Health in New York, to be professor and chair of a new Department of Health Policy. Importantly, Dr. Chassin has two titles. He is professor and chair of the Department of Health Policy, and he has built a strong Department of Health Service; at the same time, he also serves as senior vice president for quality at the Mount Sinai Hospital and Health System. He has, therefore, a dual responsibility and two budget streams, one from the medical school and one from the clinical enterprise. The databases he uses are local, and his laboratory is Mount Sinai and East Harlem, not the national Medicare database. The Department of Health Policy has developed effective initiatives in breast cancer, prostate cancer, vaccinations, and geriatrics. The theme is that market changes are driving academic medicine toward a better, real interaction with urban health problems, and it is recognized that, in the long run, quality is going to be important in the marketplace. The concept is to integrate the academic work and the local quality initiatives in the hospital.

INSTITUTIONAL COOPERATION

We are entering an era of cooperation. I have been in my current position for 10 years; when I came to New York City, the president of a major medical center taught me that the most important recruiting tools in New York were bridge and tunnel tokens. Previously, New York's institutions seemed to focus on recruiting from each other; for the city as a whole, that was not productive in the long run. Some local errors occurred because of the lack of cooperation. For example, several years ago, when the National Institutes of Health announced the Women's Health Initiative, several large grants became available. Efforts were made to convince the institutions in New York to cooperate, but in their arrogance, each thought they would win one of these big grants; why share it with anybody else? What happened? New York did not get one. New York City, with about 4 million women and people of every socioeconomic state, language, ethnic background, disease, and age, did not win one of these grants because we could not figure out how to cooperate. There was not enough resolve among the leadership of the city's institutions to make it happen.

We are now seeing less such competition and more cooperation across institu-

tions. What are the forces that facilitate cooperation? In part, we see more cooperation across institutions because of mergers. Investigators and clinicians in formerly competing facilities now find that they are in one institution; this fosters cooperation in a hurry. Substantial cooperation also has been fostered by the Biomedical Research Council, based at the New York Academy of Medicine, which has been developed with New York State funding and has been very effective. Cooperation across institutions has also been fostered by the Academic Medicine Development Corporation, established by the Greater New York Hospital Association, which is starting a major multi-institutional educational and clinical breast cancer research program throughout the city.

In addition, an important, cooperative, multi-institutional initiative in urban morbidity has recently been fostered by the business community. I applaud the New York City Partnership, which has effectively brought together a group of individuals from academic medicine to work with them and to see how they can help us. This has yielded an initiative in emerging infections and in the development of antibiotic resistance in New York, and other initiatives are being planned.

All these symptoms of cooperation were not present 10 years ago. The combination of the market forces driving academic medicine into the community and the assistance of the business community have fostered a spirit of cooperation that gives us some sense of optimism for the future. However, the involvement of academe in New York City in the urban health agenda, though improving, is still far from robust. As the academic and clinical market pressures mount, more progress can be expected, especially if meaningful partnerships develop with the business community and cooperation grows between traditional rival institutions.