

demonstrating appropriate clinical outcomes and taking on significant financial risk. It's hard to imagine how these expectations could be met in the absence of a fully integrated system of providers in which doctors, nurses, hospitals, public health professionals, nursing homes, pharmacists, home health agencies, etc. join forces to manage *cost-effectively* the care of individuals and to deal *systematically* with the known health needs of a region or population.

As possible points of departure for developing such truly accountable care systems, Shortell and Casalino suggest several current organizational arrangements including multispecialty group practices, hospital staff organizations, physician-hospital organizations, independent practice organizations, and health plan-provider organizations or networks. I'm concerned that none of these existing organizational arrangements is likely to be sufficiently scalable to meet the real challenges. What has more potential of doing so, in my view, are well-organized academic health centers.

Indeed, many academic health centers are uniquely poised to develop the kind of integrated health care systems that we need. Many already have organized faculty practice plans, a network of affiliated hospitals, community physician referral bases, a relatively robust IT infrastructure, a tradition of innovation, loyal patients, and the trust and respect of their communities. Modern information technologies could be used to stitch together the network of hospitals, doctors, home health agencies, pharmacies, and other community resources needed both to provide for the health and health care needs of a large population and to monitor the system's fiscal performance and to identify opportunities for improvement. Given their existing capabilities—and their avowed mission to serve the public interest—academic health centers, either individually or preferably in partnership with others, should lead the way toward solving what is arguably the most urgent health problem facing our county.

However we do it, if we want our health care system to fly in the twenty-first century, we've got to stop trying to repair a hodgepodge arrangement that is hopelessly antiquated and get on with the hard work of replacing it with a real system that can actually do the job. Now that Congress has provided CMS with substantial resources to fund more appropriate ways to structure and finance health care services, I believe academic health centers—as engines of innovation—should seize the opportunity to demonstrate what true health care reform might look like.

References

1. Shortell SM, Casalino LP. Health care reform requires accountable care systems. *JAMA* 2008; 300: 95–7.

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Memento Mori

The first one caught me by surprise.

I was doing my initial thoracentesis,
a task less daunting than the word implies.
A cheerful woman gasped from fluid in her chest,
a pleural effusion caused by rampant cancer.
There was no effusiveness in the somber needle
I guided carefully through her chest wall.
"I'm going to die now," she calmly said,
and, with nothing further, laid back dead.

It was the moment doctors dread;
full frontal with the enemy ahead
And I midwife to the highest drama.
This was no time for contemplation.
Coding, CPR, intracardiac adrenaline;
we were quick and forceful, but for naught.
Relatives were notified, and in intense detail
we probed each second, searching for a clue or cause.
None came, and nothing from a later autopsy.
We had no solution, no solace, and no one to blame.

While preachers celebrate the rising soul,
and mystics sense transfiguration, and
loved ones clasp one another, casting
hope against the loneliness of death,
we found no answer in her body,
no meaning in the metaphysics,
and nothing in ourselves to talk about.

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