Commentary on Brown

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I endorse Lawrence D. Brown's thesis that "misplaced concreteness" is a fallacy that "lay[s] at the doorstep of a particular type of organization problems that are properly ascribed to . . . the historical, cultural, and political forces that produce public policy." I also agree that academic medical centers (AMCs) exemplify the fallacy. Brown writes, "That AMCs should summon a stronger voice for policies of social protection is hard to deny . . . [but] their preoccupation with a core curative mission powerfully discourages such policies." In what follows, I augment his analysis by summarizing some of what I have learned from studying and writing about AMCs and helping to govern and administer one of them (Fox 1980, 1986a, 1986b, 1996, 2001, 2015).

What Brown calls the "core curative mission" of AMCs emerged in the late nineteenth and early twentieth centuries, initially in Germany, the United Kingdom, and Canada. American physicians who had worked in university laboratories and teaching hospitals in these countries introduced the mission to the United States beginning in the 1890s. AMCs were initially funded mainly by private charity and philanthropic foundations. John D. Rockefeller endowed the most influential of these foundations. In the second decade of the twentieth century, state governments began to provide capital and operating funds to AMCs.

A British innovation in conceptualizing the work of AMCs began to influence the organization of health care in the United States during the 1920s. As the First World War ended, Lord Bertrand Dawson—who had been in charge of medical care on the Western Front—wrote articles and an

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official report distinguishing primary from secondary care. Dawson proposed to reorganize health services by creating, in geographic regions, hierarchies of providers of primary and secondary care linked, at the summit, to teaching hospitals and their medical staffs. Patients would flow up these hierarchies to, and knowledge and trained professionals downward from, what came to be called AMCs.

I summarize the history of AMCs in three words: piety, platitudes, and pork. Beliefs and behavior associated with these words, on which there is a substantial literature, are the story of AMCs during the past century. First, piety: AMCs and their funders have assumed that progress in biomedical research and the application of findings from it to patient care are the principal sources of improvements in the health of populations. By the 1940s, however, doubts were emerging about this assumption. An increasing number of participants in the work of AMCs recognized that scientific progress was only one of a cluster of determinants of population health. But, as Brown and others describe, AMCs operated in an environment in which the culture of the health professions, public policy, and the economy offered strong incentives to increase the size and scope of AMCs.

In response to these incentives, leaders and employees of AMCs devised platitudes—a vocabulary ungrounded in strong evidence—to assert and justify the core missions of AMCs. From the mid-1940s through the 1970s, these platitudes attracted powerful support for AMCs among public and foundation officials, journalists, business executives, and leaders of labor unions. The persistence of piety and the effectiveness of platitudes in the context of scientific advance and growing demand for care and professional education yielded growing revenue (I apologize for calling it pork) for AMCs. The institutions and their employees simultaneously did good and did well.

Brown argues that AMCs would "fare better on the whole under a more stable system of public funding" than they do now "under the nerve-racking carte blanche . . . to which they have become . . . accustomed." He concludes that "AMCs are unlikely anytime soon to escape the ambivalence and ambiguity that have come to complicate their lives." Alas.

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