Heart Hospitals: For Better or Worse
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My last Editor’s Page dealt with physician self-referral in cardiology, a situation which raises potential conflict of interest issues that are both real and perceived. Heart hospitals are a relatively new type of medical facility on the healthcare landscape, and they typically involve partial ownership by physicians. As with physician self-referral, heart hospitals offer a number of attractive benefits to healthcare delivery but also raise concerns about possible conflict of interest and adverse effects upon community hospitals. In a sense, heart hospitals not only embody many of the issues of self-referral, but also larger issues involving the role of cardiovascular services within the universe of medical care.

The term “heart hospital” has been used to describe a variety of facilities ranging from stand-alone institutions to “hospitals within hospitals.” Some are affiliated with general hospital systems, whereas some are financially independent and partner with for-profit entities. The specialty hospitals that have attracted the greatest attention and concern share the characteristics described by a report of the U.S. General Accounting Office (GAO) (1). These hospitals are stand-alone facilities usually devoted to the narrow spectrum of diseases of one organ system, and they nearly always encompass partial physician ownership. Most specialty hospitals are devoted to cardiovascular diseases, orthopedics, or surgery—services that usually generate surplus revenues (read profits) for general hospitals. According to the GAO survey, 70% of facilities have physician ownership amounting to an average ownership of 50% of the hospital, although the average share for any individual physician was about 2%. Nearly all specialty hospitals were at least partially owned by group practices. Not surprisingly, the combination of physician ownership and profitable services raises the specter of potential self-referral and conflict of interest.

Although comprising <2% of acute-care hospitals nationwide, specialty hospitals have burst upon the medical scene with rapid growth. Thus, the number of specialty hospitals tripled between 1990 and 2003 to a total of 90 facilities, with 20 in the planning stage (1). Seventeen of these hospitals were cardiac, with five more on the drawing board. A search of the term “heart hospital” on Google yields more than 10 pages of listings. In fact, the increased number and potential impact of heart and other specialty hospitals was sufficiently great that the Medicare Modernization Act of 2003 placed an 18-month moratorium upon the exemption that these facilities were granted from the Stark Medicare Physician Self-Referral Law.

The concept of specialty hospitals is certainly not new. Hospitals devoted to pediatrics, women’s health, and psychiatry have existed for many years. However, these facilities are usually not physician owned and they are generally directed at specific patient populations rather than diseases. The recent growth of heart and other specialty hospitals has been facilitated by several factors (2). The improvement in medical procedures and anesthesia has enabled care delivery to be streamlined. Health plans have been less selective in contracting. Many general hospitals have been operating near full census. From a financial standpoint, profits have been available from reimbursement, as has capital from for-profit firms such as MedCath. It is of interest that heart and other specialty hospitals have nearly always been located in areas with weak or absent Certificate of Need rules, which contain large medical groups with which to affiliate.

The proponents of heart hospitals cite a number of advantages for these institutions. Their focus upon disease of one organ system and the anticipated increased volume of these disorders treated should result in greater quality of care. Staff, management, and equipment dedicated to a specific set of disorders should result in greater efficiency of care. Thus, one would expect heart hospitals to reduce costs and increase the number of patients a physician can care for, an important consideration with an impending shortage of cardiologists. The greater physician input into and control of heart hospitals is seen as a great advantage to effective and efficient operations. Finally, the above efficiency along with the perceived convenience of smaller heart hospitals should result in greater patient satisfaction.

Despite these advantages, the proliferation of heart and specialty hospitals has produced a chorus of concerns. To begin with, heart hospitals carry the potential for an excess capacity of beds and services with the financial impact which that implies. Excess capacity along with the potential incentives of self-referral could result in overutilization. The division of patients between more institutions could lead to decreased volumes and quality at all facilities. Finally, duties at specialty hospitals may make specialists unavailable to cover emergencies at general hospitals.

Those opposed to heart hospitals point out that they could have a substantial negative financial impact upon general hospitals. Cardiovascular procedures are profitable and subsidize money-losing but necessary community hos-
hospitals, Casalino et al. (2) have identified the debate. Focused factories? Physician-self-referral, or to adjust payment to re
cision and patient selection, then it would seem justiﬁable to take
any adverse action against them. Rather reimbursement
might be adjusted to reﬂect the costs incurred by general
hospitals in providing nonremunerative but necessary ser-
VICES such as burn units. Conversely, if specialty hospitals
adversely affect general hospitals owing to unfair competi-
tion and patient selection, then it would seem justiﬁed to
include specialty hospitals in the provision of the Stark
medicare, Physician Self-Referral Law, which prohibits
self-referral, or to adjust payment to reﬂect care mix. Of
signiﬁcance, the concerns regarding specialty hospitals have
again focused attention on why some medical services are
much more remunerative than others. Major revision of the
current Medicare relative value system might, of course,
have more profound consequences upon cardiovascular
medicine than heart hospitals ever could.
And so, as the movement toward heart hospitals gathers
momentum, both the concerns and the debate about pos-
sible adverse effects continue. General hospitals worry that
procedures which generate ﬁnancial surpluses will be lost
and unavailable to fund important nonremunerative services
such as burn units, trauma care, and social services. In
addition, they are concerned that physician ownership may
bias decision making and lead to the referral of only
low-severity, well-funded patients to heart hospitals. Pro-
onents of specialty hospitals counter that such concerns
belie a basic mistrust of doctors, and that physicians will
always make the best decision regardless of self-interest (4).
The data are not available to resolve the issues. Neverthe-
less, it seems to me that physicians are somewhat naïve to
believe that they can dismiss concerns regarding the obvious
potential for conﬂict of interest that heart hospitals present
by merely saying “trust me.” The recommendation of the
Task Force on New Niche Medical Facilities of the Amer-
ican Hospital Association to eliminate the whole hospital
exemption to the Stark Law for specialty hospitals is
evidence of this naiveté. If physician ownership is too small
and potential dividends too inconsequential to inﬂuence
decision making, perhaps physicians should consider donat-
ing these ﬁnancial gains to some worthwhile cause. In this
way they could preserve the important aspect of physician
input and control of the facility as investors while defusing
any issue of self-referral.
Finally, as cardiologists, we must realize that the percep-
tion of conﬂict of interest is often as signiﬁcant as its
existence. We should act aggressively to remove any per-
ception of conﬂict of interest in our decision making, or
someone may take that action for us.

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