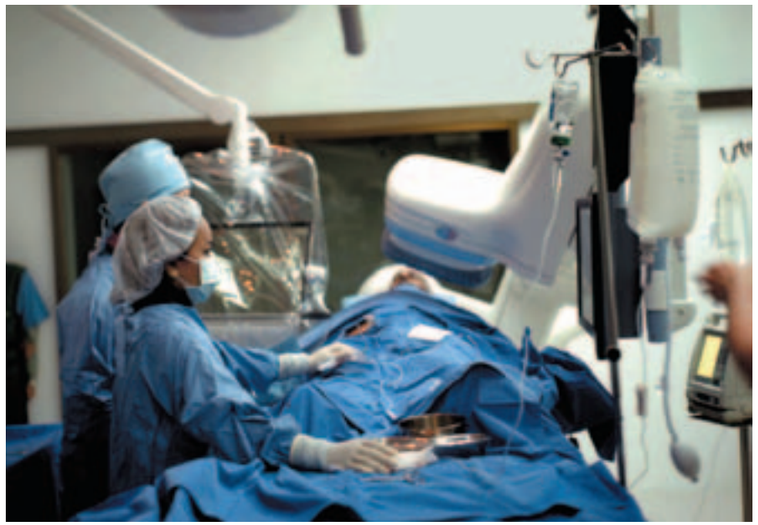
Medical Meccas

Hospitals around the world are drawing new patients with topnotch doctors, high-tech equipment and low costs. These 10 are leaders in their fields.



IT'S NOT JUST DOCTORS: Bumrungrad hospital in Bangkok is redolent of a five-star hotel

1 Beyond the Beaches

Bumrungrad International hospital in Bangkok is a magnet for medical tourists.

BY JOE COCHRANE

IT'S NOT A STRETCH TO CALL JAMIE JOHNSON AN ACCIDENtal tourist in Thailand. While touring with a Christian singing group last month, Johnson, a diabetic from the United States, developed an infection in her ankle that shut down her kidneys. She was evacuated by airplane from Malaysia to Bumrungrad International hospital in Bangkok —a facility she had never heard of in a country she had never been to and in a city she had associated with sex shows in beer bars. "My husband back

PHOTOGRAPHS BY AGNES DHERBEYS—COSMOS FOR NEWSWEEK

roles is helping less developed countries treat and manage endemic conditions like malaria, leprosy and tuberculosis. The hospital's Malaria Centre has a cutting-edge research facility, which can bring the latest equipment to bear on clinical samples sent in from remote areas. Over the years the hospital has expanded its focus to how infectious diseases spread through communities—an area that's become particularly timely with the rise of bird flu and other global illnesses. Since 1999 the hospital, in collaboration with clinics in Europe, has provided an early-warning system for outbreaks of smallpox, cholera and botulism. It may be a far cry from its roots as a floating hospital, but change has been part of its ethos from the start. ■

8 Swapping Body Parts

A doctor's boldness has made the Hôpital Edouard-Herriot a center for transplantology.

BY FLORENCE VILLEMINOT

DR. JEAN-MICHEL DUBERNARD IS not afraid of notoriety. When he co-led the world's first face transplant, on Frenchwoman Isabelle Dinoire in November 2005, he was derided for being an opportunist preoccupied with making headlines at his patient's expense. But after a year, Dinoire is doing well, and Dubernard is making no apologies. "I'm 65 years old and at the end of my career," he says. "Looking back, I'm proud of what I've done."

Dubernard's boldness has propelled the Urology and Transplant Surgery Department at the Hôpital Edouard-Herriot in Lyon, France, to world-class status. The French doctor, who also holds a seat in the National Assembly, trained abroad in the 1960s with Dr. Joseph Murray, a Nobel laureate, at Harvard. Methods and techniques he had learned during his American apprenticeship—like finding ways to improve the functioning of transplanted organs and avoid their rejection—were key to the development of his transplant practice in France. His unit has perfected techniques for transplanting the pancreas and other organs that are now widely copied. He led the first team to complete a successful transplant of the hand in 1998, and the first to transplant two hands at once, in 2000. His success now attracts a steady flow of foreign patients; his team carries out about 120 kidney transplants a year. Dubernard has also made teaching a priority. "I want to train foreign doctors so that they can practice in their home countries," he says.

Dubernard is now working to promote "transplantology," as the practice is called, to the status of a medical discipline in its own right. He wants to combine two of France's top transplant centers in Lyon and Nantes to produce the unquestioned world leader in the field. "We don't do this for money or success," he says. Whatever the reason, his patients have many new reasons to be grateful. ■

INVASIVE PROCEDURES

Less Is More ... And Better

FROM HARVARD MEDICAL SCHOOL

BY DONALD M. BERWICK, M.D.

The modern hospital is the cathedral of our time—gleaming, mystical, intimidating, even majestic. It seems to contain miracles and, sometimes, it does; bioscientific breakthroughs have changed the course of illness, curing cases of leukemia, fixing hearts, transplanting organs. It is easy to be in awe. We want whatever the magic of health care can give us—the more, the better.

So it comes as a surprise to most people that the facts often suggest otherwise, as researchers at Dartmouth Medical School—led by Profs. John Wennberg and Elliott Fisher—have been showing for years in the so-called Dartmouth Atlas project. They sort the United States into 307 geographically defined "hospital service areas," and study how often Medicare patients in those areas get specific medical and surgical procedures.

For many procedures, the variation is stunning. Compared with the lowest-use areas, people in the highest-use areas get 10 times as many prostate operations, six times as many back surgeries, seven times as many coronary angioplasties and 10 times as many hospital days if they have heart failure. It all raises an obvious question: if medical technology is being used so differently, who's right?

A lot of the variation depends not on clear-cut scientific evidence that one treatment is better than another, but on the beliefs of specialists in the area and the supply of doctors and hospital beds. The use of specialist visits varies by 660 percent, and what best predicts the rate is the number of specialists per capita. The more doctors, the more doctor visits. The more hospital beds, the more days spent in the hospital.

Are you lucky if you live in a high-use region? Not necessarily. Landmark studies by Fisher showed that high use did not mean better quality of care and outcomes. In fact, for many measures, quality and outcomes were best in the low-use areas and worst in the high-use areas. The less, the better.

Fisher and Wennberg suggest that the rates of use of health-care procedures and treatments should, indeed, vary a lot, but not according to where you live. Rather, variation should reflect the preferences of patients ("Would you rather wait a bit to see if your back pain gets better, Mr. Smith, or try surgery now?") instead of the local habits of doctors or, worse, the local supply of specialists. When patients are actually invited to participate in decisions about their care—"shared decision-making"—both costs and rates of use of expensive, invasive procedures tend to fall, and outcomes and satisfaction improve. The Dartmouth team calls this "preference-sensitive care," and it thinks health care driven by necessity rather than supply could be both more responsive to our needs and, overall, far less costly.

A shortlist of "high variation" surgical procedures in the Dartmouth Atlas includes gallbladder removal; coronary-artery bypass and coronary angioplasty (in people with minimal symptoms); hip replacement; carotid-artery surgery; radical breast surgery (instead of lumpectomy) for localized breast cancer, and prostate removal for benign enlargement of the gland. If you or a loved one is scheduled for one of these, you might pause and ask some questions. Do you understand the alternatives to surgery? Would a period of "watchful waiting" help? Is the decision to operate based on your own assessment of your options? Or does it reflect mainly the local habits of the medical-care system? Surgery may be the right choice, but that ought to depend on the patient's preferences as well as the scientific facts.

BERWICK is clinical professor of pediatrics at Children's Hospital and Harvard Medical School, and CEO of the Institute for Healthcare Improvement.

9 A Master of Microsurgery

[redacted] literally specializes in putting the smile back on patients' faces.

BY JOANNA CHEN

ALTHOUGH THE WEST BANK TOWN of Jenin is known for its hardened militants and their battles with Israel, Palestinian teenager Ahmed Fakhouri got his wounds in a more conventional way: a near-fatal car accident. A shard from the windshield broke off during a collision and sliced the left side of his face, severing major arteries and paralyzing his facial muscles on one side. "I felt like my life was over," Fakhouri recalled recently. "I hid from people, even my family, because I didn't want them to see me."

THE SURGEON: Dr. Eyal Gur treats patients whose facial nerves have been damaged

Fakhouri wound up on the operating table of Dr. Eyal Gur, a plastic surgeon and head of the Microsurgery Unit at the Sourasky Medical Center in Tel Aviv. Sourasky is one of the leading centers for treatment of patients suffering paralysis of the face as a result of neurological disorders, which often leave the corners of the mouth frozen. After complicated surgery, Fakhouri regained enough control over his facial muscles to do something he hadn't done since the accident: crack a smile.

As a surgeon, Gur navigates some of the toughest of surgical terrain—the human face has more nerve endings and muscles than any other animal's. First, he transplants a sensory nerve from the patient's calf to the non-paralyzed side of the face, connecting it like an extension cord to an active motor nerve. He waits, typically for nine months, while the new nerve grows along a conduit and reaches the paralyzed side of the face. Then he

FROM LEFT TO RIGHT: ILLUSTRATION BY JAMES STEINBERG FOR NEWSWEEK
PHOTOGRAPH BY ALEXANDRA BOULAT—VII FOR NEWSWEEK

takes a muscle from the patient's inner thigh and attaches it to the intricate web of facial arteries and veins. Nerve fibers reach the implanted muscle within six months, at which time the patient can grin. "It's a celebration when the child comes to the clinic and smiles for the first time," says Gur. "This is why I do what I do." ■

10 Care at Life's End

Terminal patients and their families get what they need at Mount Sinai Medical Center.

BY DAVID NOONAN

SOMEBODY IS GOING TO HAVE TO INvent a new word to describe the kinds of cases that Dr. Diane Meier deals with as head of the palliative-care program at New York's Mount Sinai Medical Center—"complicated" just doesn't get the job done. A typical patient: a 93-year-old woman, newly diagnosed with pancreatic cancer, unable to eat and in need of round-the-clock pain medication, who was the sole caregiver for her demented 90-year-old sister. Meier and her 14-person staff at Mount Sinai will treat about 1,000 such patients this year, each one a daunting tangle of medical, psychological, social and spiritual issues. For the majority, death is nigh—it could be hours, it could be months, but there is no other prognosis. They are exactly the sort of patients who often get lost in today's cure-driven, hyperspecialized health-care system.

CARED FOR: Angel Cruz, a palliative-care patient in New York, with his wife and daughter

But determined people like Meier are transforming the way U.S. hospitals care for the most seriously ill patients. Palliative medicine, a holistic team approach to advanced illness, focuses on controlling symptoms (especially pain), setting realistic treatment goals and improving communication among all the parties involved in a case. When it's done right, patients suffer less, families have more control and hospital costs are reduced even as the quality of care improves. The field, with its roots in the hospice movement, is booming. Between 2000 and 2004, the number of hospital-based palliative-care programs in the country jumped from 632 to 1,102, which is 27 percent of all hospitals.

After pain control, communication is the most important job of the palliative-care team. Most of the benefits—from avoiding unnecessary procedures to arranging for very sick patients to go home—depend on it. "Communication sounds easy, but it requires a tremendous amount of training and skill," says Meier. "And it is incredibly time-consuming. You can't rush a patient and a family through these conversations, or you might as well not have started them." The word for that—caring—works just fine. ■

Read our tips for treating pain at xtra.Newsweek.com

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