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Dana-Farber CEO on Mass General split: Boston needed a dedicated cancer hospital

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By Tara Bannow Oct. 10, 2023

Dana Farber CEO Laurie Glimcher at the Boston Globe Media offices in Boston on Tuesday. *Pat Greenhouse/Globe Staff*

One of the first items on Laurie Glimcher's agenda after becoming CEO of the renowned Dana-Farber Cancer Institute was to build a freestanding cancer hospital in Boston.

The most obvious partner would be Mass General Brigham, the large, not-for-profit system that operates the Boston hospital where Dana-Farber's doctors currently treat cancer patients. But after seven years of negotiations with MGB's top brass — including about 30 meetings in the past 10 months alone — she said it became clear that they weren't interested.

"It would have been easier if MGB would have said, 'Yes, we can do that with you,'" Glimcher told The Boston Globe's editorial board on Tuesday. "That would have been the easiest path. But they refused over and over and over again."

Instead, Dana-Farber is partnering with Beth Israel Deaconess Medical Center to open its proposed cancer hospital for adults.

At the heart of this drama is a purported disagreement over where cancer care is best provided. Glimcher strongly refuted the assertion by MGB's CEO, Anne Klibanski, that this is best done in a general, acute-care hospital. She said research has shown the country's 11 dedicated cancer hospitals have better outcomes.

"All we do is cancer," Glimcher said. "When you do cancer, you see things that others might miss."

Dana-Farber is one of at least six cancer centers that announced plans to build new cancer-specific hospitals this year alone. While there's little appetite to build general hospitals, this boom is fueled in part by the rise of targeted precision therapies like CAR-T, which are mostly delivered inpatient. Glimcher said Dana-Farber's hospital will cost almost $1.6 billion, far more than other cancer centers in development.

Research backs Glimcher's statement. Patients treated at freestanding cancer hospitals had a 10% lower mortality rate compared to those treated at community hospitals, after adjusting for case mix, according to a 2015 JAMA Oncology study. The study looked at the country's 11 cancer-specific hospitals that are exempt from Medicare's typical hospital reimbursement system and compared them to almost 5,000 community hospitals.

The reason is because in a cancer hospital, all of the providers focus only on cancer, said Kevin Tabb, CEO of Beth Israel Lahey Health, told the Globe's editorial board. The cardiologists and nephrologists, for example, all specialize in treating cancer patients.

"This is a model that exists and is proven," Tabb said. "It just doesn't exist here in New England. What's fair and available for the citizens of New York, what's fair and available for the citizens of Houston or San Francisco needs to be available right here for our people in New England."

Targeted immunotherapies have created "a paradigm shift in the way we treat symptoms," Craig Bunnell, Dana-Farber's chief medical officer, told the editorial board. Patients on these drugs have different symptoms from those caused by chemotherapy, and they could die if those symptoms are managed the same way, he said.

Daniel Boffa, Yale School of Medicine's thoracic surgery division chief, said in an interview he doesn't think cancer patients will always have better outcomes in cancer-specific hospitals. There are advantages to both models, he said.

On one hand, because a freestanding cancer hospital focuses all its resources on cancer care, there won't be distractions like transplants or trauma taking precedence, Boffa said. On the other, cancer patients can have health issues unrelated to cancer, such as a blood clot in the lungs, an infectious disease, or a gastrointestinal problem.

"There are a lot of issues that are not obviously linked to cancer and cancer treatment that it would be impossible to account for in a cancer-specific hospital," Boffa said. "I do think there is an advantage to having someone with experience managing these issues in a cancer population be involved, but most clinicians who have experience managing these in a cancer population practice in an acute-care hospital."

Of course, it's worth noting that some people suspect the real reason MGB turned Dana-Farber down is because a new hospital would have competed with its existing inpatient oncology program.

In a meeting last month with the Globe editorial board, Klibanski, MGB's CEO, described being blindsided by Dana-Farber's announcement, noting that the parties were in the process of negotiating an extension to their contract. Glimcher called that a "false narrative."

"They absolutely, 100% said, 'We're not going to build a dedicated cancer hospital,'" Glimcher said.

Despite the high price tag of building the hospital, Glimcher and Tabb told the editorial board that the new hospital will lower the overall cost of treating cancer. Glimcher said MGB arguably has the highest rates for services in the state, while Beth Israel's prices for surgeries, imaging, and radiation are 30% lower.

Tabb said the two organizations enlisted independent economic analyses that found the new hospital will lower costs. State regulators will have access to that data, he said.

"We don't see a way of moving this forward without that being true," Tabb said.

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