Kenneth Ouriel, MD

From the Cleveland Clinic to Abu Dhabi, Dr. Ouriel discusses his new role, differences in device regulation, and the exciting pace at which medicine changes in the UAE.

You recently became the CEO at Sheikh Khalifa Medical City in Abu Dhabi, UAE. What can you tell us about your new role? Before coming to Abu Dhabi, I was Chairman of Surgery at the Cleveland Clinic, the largest surgical unit in the world, with 350 surgeons and a half-billion dollar budget. The Cleveland Clinic had decided to begin taking on more global projects and was awarded the management contract with Sheikh Khalifa Medical City (SKMC), a large hospital and group of smaller hospitals and clinics in Abu Dhabi. The Cleveland Clinic's CEO, Toby Cosgrove, MD, asked me to serve as the CEO of that group. My personal commitment is a minimum of 2 years. I am joined by five other members of the Cleveland Clinic: the chief procurement officer, the chief medical officer, the chief information officer, the chief of human resources, and the chief operating officer.

There are two projects here. The flagship hospital in Abu Dhabi—the capitol of the UAE—is SKMC, a 700-bed hospital system with 10 primary health centers, a blood bank, a psychiatric hospital, and a rehabilitation facility. The other project, Cleveland Clinic Abu Dhabi, will be a brand new hospital built on an island just off of Abu Dhabi. It will open in late 2010.

Will you retain your position at the Cleveland Clinic? Yes. I am not Chairman of Surgery anymore, but I am still an employee of the Cleveland Clinic, rather than an employee of SKMC.

How is the regulatory environment different in the UAE compared to the US? It is much less formal. We do not have an FDA here, and there is no "device approval." If we want something, we can buy it. The government expects us to be very responsible; we would not use something that was not manufactured in a reasonable way. We only buy things that are approved for use in other countries, but there is no formal mechanism here that we have to go through.

The US FDA offers a level of protection and a very formal regulatory environment. The overall process in the US is a very good one, and it is better than having no process at all. Although each of us has had our frustrations with the FDA and CMS, overall, it is beneficial. A regulatory process is necessary—and the UAE will no doubt have a more formal process at some point.

What is the product pipeline like in Abu Dhabi? Devices and pharmaceuticals are regulated by The Health Authority of Abu Dhabi, which is basically the FDA and CMS combined, is composed of very intelligent individuals from Europe and the US. We do a lot of our purchasing through this government agency.

How is the approval process different there? In some cases, we have leveraged the approval process of other countries: the UK, US, and Western Europe, in particular. We have a formulary for pharmaceuticals; no drug would appear on the formulary that was not approved somewhere else. There is no device formulary, however, but The Health Authority of Abu Dhabi will look at a device and ask, "Is this reasonable? Is this something that has been approved for use in other countries?" I think it is reasonable to have device formularies at hospitals, as long as they are run by the clinicians who use the devices. For instance, we have numerous coronary drug-eluting stents in Abu Dhabi, and we pay less for them than we would in the US. I think this occurs because there is more competition here and in Europe compared to the oligopoly of Boston Scientific and Cordis in the US, where they are the "Coke" and "Pepsi" of coronary stenting.

How does the country's size affect the medical process? It is a monarchy, and laws are issued by decree. There is no Congress. There are five public hospitals, and Abu Dhabi has a population of only 1.4 million. We are all on a first-name basis with the Health Authority. Change can happen very quickly because it is such a small country, and that is one of the reasons I am here.

People are fortunate because the ruling family is selfless. It is all about what is good for the country, and if a change is good for the country, it could happen in 3 minutes, not months or years. The government will invest in health care if we can demonstrate the value proposition.

Along with the Cleveland Clinic, are there representatives from other American hospitals? The country is privatizing. The government owns the hospitals but rather than running them, they solicit private entities, such as Johns Hopkins and the Cleveland Clinic, to run the hospitals with management contracts. Hopkins manages one of our sister

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public hospitals, called Tawam, in the city of Al Ain, about 90 km east of Abu Dhabi. They have been here longer than we have, arriving about 18 months ago. There are some non–US-based, for-profit, hospital management groups here as well, for instance, VAMed, an Austrian company.

Do you think you might take some lessons from Abu Dhabi back to the Cleveland Clinic? We anticipated that the knowledge stream would run in one direction, from west to east. In fact, we found that there are a lot of things we can learn from the processes here. One of them is getting rid of complexity, barriers, and redundancy. I know that is a difficult task in the US, when you have 300 million people, a Congress, and state government. We in the US have the opportunity to take waste out of the system, learning from the best practices in Abu Dhabi.

What are the patient demographics there? Is there more vascular disease? Conditions here are very similar to what we see in the US, with the exception of a higher incidence of diabetes. This was not seen before, but now that Abu Dhabi is among the richest cities in the world and now that the population is eating perhaps too well, diabetes is being unmasked. There is a lot of vascular disease and hypertension. It is more than likely that there is a great deal of undiagnosed vascular disease. We do not see a lot of aneurysms, but we do not actively look for them. There are no screening programs; patients here use doctors only when they are ill. They rarely have a family physician that they use for check-ups, and they go to the hospital nearest to them, frequently late at night. Our elective clinics are open until midnight, and some are open 24 hours. People present with problems at all hours because the culture is one of late-night activity, presumably related to the past, when they were without air conditioning and the hot climate fostered activities only after sunset.

Why do you think physicians are drawn to work in the Middle East? People wonder why doctors come out to the Middle East. They think it is because they are getting paid two and three times what they get paid in the US. But, doctors are coming because it is an exciting place. Health care is changing rapidly, and the resources are available if one demonstrates the societal value of an efficient, functional health care system. Although few of the expat physicians like being eight or nine time zones away, the environment here is so stimulating and rewarding that doctors are willing to travel this distance so they can truly benefit a society in ways that might be difficult or impossible in the US. ■