Governance of Academic Health Centers and Systems: A Conceptual Framework for Analysis

Vincent D. Pellegrini Jr, MD, David S. Guzick, MD, PhD, Donald E. Wilson, MD, and C. McCollister Evarts, MD

Abstract

Health care has evolved from a cottage industry to a very complex one constituting nearly one-fifth of the U.S. economy. Large aggregated health care systems have evolved primarily for the purpose of optimizing financial performance by capturing greater market share and taking advantage of economies of scale in care delivery. With the noble intent of providing a broader base of support for the academic mission, academic health centers (AHCs) have followed suit by partnering with community hospitals and organizations with variable prior experience in the education and research arenas. Such a strategy makes good business sense, but it creates challenges for the academic mission. Singular emphasis on physicians' clinical productivity enhances financial margin but often reduces faculty time and effort dedicated to the academic mission. While individual AHC governance is varied, the leadership structure of large aggregated health systems built around an AHC is even more complex and heterogeneous. Yet, to ensure the prosperity of the academic mission, the governance structure of such health care systems is of critical importance. Preservation of academic oversight of the faculty practice plan, a unifying central focal point of organizational decision making, and genuine physician leadership are three overarching governance characteristics that strengthen the prosperity of the academic mission within large aggregated health systems. Despite the heterogeneous nature of academic health system governance, these critical components of organizational leadership structure facilitate support of a robust academic mission. Understanding these principles and objectives of governance is essential for critical faculty engagement in AHC leadership activities.

> If you've seen one academic health center, you've seen one academic health center.
>
> —Anonymous[1]

This adage is often glibly cited in reference to the seemingly unfathomably complex and unique governance structures of academic health centers (AHC), loosely defined as organizations with a teaching hospital associated with a university, its medical school, and health science school(s). Unfortunately, the simple recital of such a statement implies that understanding the structure and workings of such institutions is a hopeless task. This position ignores the importance of understanding the governance of such complex organizations for the sake of successfully navigating them and discourages analysis of AHC governance for the purpose of actually making it better. Indeed, recognition of desirable, if not essential, elements might assist in optimizing performance throughout these hallowed halls of academic medicine. Here we propose a conceptual framework for analysis of contemporary AHC governance models for the purpose of defining key principles that influence their success in serving the tripartite academic mission.

Over the past several decades medicine has evolved from a cottage industry, wherein health care delivery was a local phenomenon specific to each community, to a model where provision of medical care has expanded in size, scope, and complexity to take advantage of economies of scale and optimize financial performance.[2] While acknowledging the uniqueness and individuality of AHCs, there may be common governance elements that are critical to their individual success.[1–6] Understanding governance may arguably be more important than ever for our faculty to understand, effectively navigate, and succeed in these work environments. Many university hospitals and their associated medical schools are venturing into structured collaborations, mergers, or other legal relationships with nonacademic entities for various financial and academic objectives. As health care systems aggregate around teaching hospitals and medical schools—together known as academic medical centers—marquis educational and research programs that distinguish world-class academic medical centers can be threatened by overemphasis on a financial margin driven primarily by clinical care. While Sister Irene Kraus recognized that there is no mission without a margin to support it,[7–9] it is occasionally forgotten that the mission in health care cannot *become* the margin.[10] Clear understanding of the fundamental governance needs of academic medical centers is essential to optimize their financial performance while preserving the critical education and discovery missions that differentiate them in an increasingly competitive health care industry.

Structure Versus People

Prior to embarking on a discussion of the desirable elements of AHC governance, it is important to acknowledge one common observation. Talented and effective people are capable of transcending an imperfect governance structure; the best leaders can succeed in most any environment. An optimal governance structure enhances the likelihood of organizational success, but talented individuals can overcome many ill-conceived tables of organization.

Please see the end of this article for information about the authors.

Correspondence should be addressed to Vincent D. Pellegrini Jr, 96 Jonathan Lucas St., MSC 622, CSB 708, Charleston, SC 29425; telephone: (843) 792-2433; e-mail:pellegvd@musc.edu.

Acad Med. 2019;94:12–16.
First published online August 14, 2018
doi: 10.1097/ACM.0000000000002407

Yet, structure does serve a critical purpose in at least two important circumstances. A thoughtfully conceived governance structure, customized to the organization, can result in even an average leader being quite successful. Perhaps less apparent but even more important, well-conceived governance is critical during times of transition in leadership. When respected and successful leaders leave their roles, there is always uncertainty and anxiety within the organization. A clear and thoughtfully conceived governance structure facilitates repopulation of key roles and serves to perpetuate guiding principles, operational priorities, and organizational culture. Especially during times of leadership transition, structure not only *supports* function but often *determines* it.

Critical Elements of AHC Governance

There are numerous organizational attributes that portend institutional success. Yet, we suggest that three critical structural elements are essential to ensure that the AHC's education and research missions are sufficiently robust to preserve the differentiating value of academic medicine: (1) academic oversight of the faculty practice plan, (2) a single focal point of integrated decision making, and (3) genuine physician leadership.

Academic oversight of the faculty practice plan

This characteristic primarily determines the health and vigor of the academic mission. AHCs are a triumvirate of three principal components: faculty practice, hospital, and medical school (Figure 1). A triumvirate is a political regime ruled by three powerful individuals; though nominally equal, it is often true that one individual holds more power than the others. Such is also true in academic medicine. Typically either the hospital, school, or faculty practice has a dominant influence in the governance of the AHC. Indeed, at various times and institutions, each of these three components has assumed primacy and enjoyed a modicum of success. This variability is the basis for the time-honored statement that introduced this discussion, "If you have seen one academic health center, you have seen one academic health center." Not surprisingly, because of its largest financial margin, the hospital most often wields the greatest influence in AHCs. Similarly, regardless of variation in balance of power among this triumvirate in any institution, the historical common denominator in traditional AHC governance was that the faculty practice fell under the purview of the medical school and typically reported to the dean or the dean's designee. Specifically, faculty employment was at the behest of the school and overseen by the dean or a more senior academic official. Hospital or freelance employment of physicians was often tacitly precluded by the requirement of an academic appointment and consent of the department chair or dean.

With the appearance of larger health systems aggregated around AHCs, a portfolio of community hospitals and their employed physicians were added incrementally to the ranks of faculty. Not surprisingly, a spectrum of institutional governance and a host of new reporting relationships for the faculty practice have developed in parallel with these large health systems (Figure 2). Faculty practice oversight can have a traditional "academic" emphasis, well suited to support of education and research, or a more "corporate" slant with primary emphasis on generation of clinical revenue. In 2017, 86 (58.5%) of 147 accredited medical schools reported having oversight of their faculty practice plan, 34 (23.1%) had practice plans affiliated with the hospital or health system, and 27 (18.4%) reported having no practice plan or some other configuration. Of those with practice plans residing in the medical school, 49 (57%) were owned by the university or school and 37 (43%) were independently incorporated.[11]

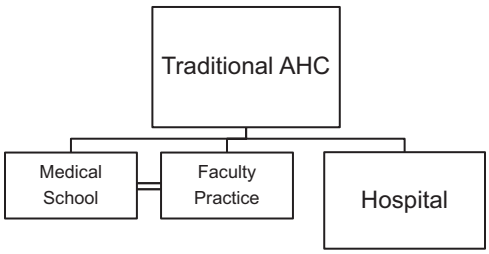

Figure 1 Traditional institutional governance of the academic health center (AHC). The traditional model includes a triumvirate consisting of the medical school, the clinical practice of the faculty, and the associated teaching hospital(s). While the three entities are notionally equal, this is rarely the case in reality. One entity is often more dominant over the others, and any of the three entities can assume the dominant position. Regardless of the dominant entity, traditional AHCs were characterized by a strong bond between the medical school and the faculty practice plan, typically through the dean. Similarly, the hospital was commonly the dominant entity on the basis of its major contribution to the financial performance of the organization.

Of concern is the fact that those newly bestowed with oversight of the faculty practice are not necessarily responsible for ensuring success of the academic mission. Only in the "academic" model does the faculty practice retain a strong and singular reporting relationship to the dean or senior academic officer. Because the dean is also uniquely responsible for successful pursuit of the academic mission, it is logical to expect persistence of a strong commitment to education and research under the academic governance model as the dean can allocate faculty effort to both clinical and academic pursuits with appropriate balance. Additionally, the faculty practice often provides the largest and most flexible revenue stream to the dean for financial cross-subsidization of loss leaders that are mission-critical for the school. In the "affiliated" model the faculty practice retains a direct reporting relationship to the dean, but with a dotted-line reporting relationship to the hospital system. The dean and school retain sole authority to hire and fire physician faculty, as well as oversight of faculty time allocation in support of the academic mission. However, control of faculty practice revenue may be shared with the health system depending on contracts with community hospitals and private practice organizations.

While a traditional faculty practice plan remains an important part of most academic health systems, totally integrated physician employment in a multidisciplinary clinic model may be embedded directly within the health system. In this "corporate" governance model, all physicians have a solid-line reporting relationship to the health system (Figure 2). Such a structure invites diminishing allegiance and accountability to the academic mission because system and hospital leadership are typically more

focused on work Relative Value Unit generation than on research or education. Ideally, "corporate" health system leaders transfer a sizable fraction of financial margin to the medical school dean to advance the academic mission, supporting a virtuous circle of patient care, research, and education. This creates a positive feedback loop enhancing all missions, including size and stature of the clinical enterprise. However, a more modest level of academic support derived from faculty clinical effort becomes an ongoing source of frustration and tension between the clinical enterprise and the school, resulting in a vicious cycle of faculty unhappiness, burnout, and turnover with a decline in both clinical and academic missions.

In an "integrated" governance model, allocation of faculty effort in support of education and research may be similarly at risk depending on the relative influence of the system and the school. Moreover, in both corporate and integrated models, the health system may have the ability to employ physicians independently, which adds incremental stress as faculty may work side by side with clinicians who are better paid for the same work and have no obligation or passion to support the academic mission.

On the basis of our collective experience, we strongly believe that faculty practice oversight has a large impact on faculty morale and performance, and a structure in which the faculty practice reports to the dean or a similar academic officer ensures robust support for the academic mission. A less palpable commitment to education and research is too often evident when the faculty practice reports to health system administration. How go the reporting lines of the faculty practice—to the system or the school—so goes the enthusiasm of support of the academic mission. In short, the nature of oversight of the clinical faculty practice is generally predictive of the vigor and success of the academic mission.

A single focal point of integrated decision making

This characteristic primarily determines the operational efficiencies and nimbleness of the organization. Natural tensions exist between the hospital and the medical school in the traditional AHC, especially if clinical leaders have dual reporting lines, and they are further magnified when an aggregated health system is built around a core AHC. As the clinical enterprise becomes more expansive as the dominant revenue source, incentives for clinical productivity grow, as does the risk of neglect of the academic mission.

Such a scenario is both the blessing and the curse of AHCs participating in large health care systems composed of community hospitals and practitioners having limited prior involvement in teaching and research. The hope is that a greater margin derived from the expanded clinical enterprise will enhance the financial support of the AHC's academic mission. However, there is also risk that a heightened emphasis on clinical productivity will lessen the institutional commitment to teaching and research. Recent evidence suggests that patient safety and outcomes may also be adversely impacted.[12] These tensions are not new, but they are amplified in aggregated health care systems and increase the risks to the academic mission.

Alternatively, it can be argued that a fully integrated governance model, with a single focal point of authority and decision making, provides greater opportunity for optimal integration. This individual is tasked with reconciling the inevitable differences between the hospital's clinical revenue interests and the academic missions of the medical school. Such is

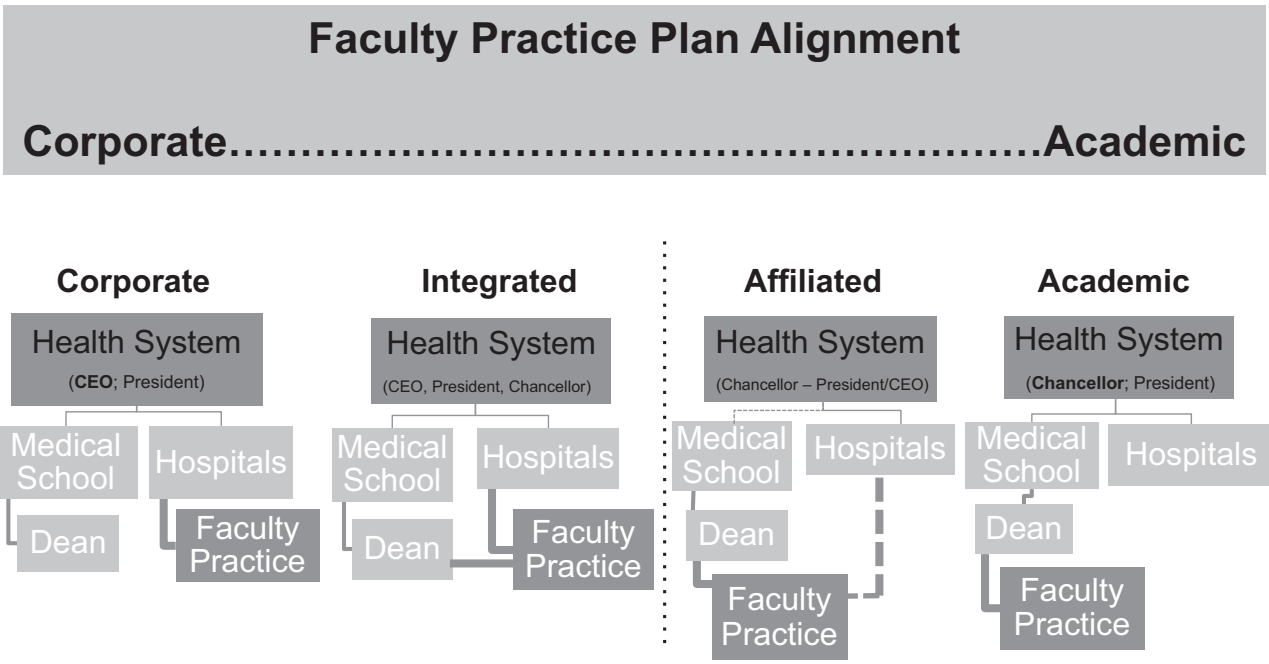

Figure 2 Contemporary academic health system governance. With the aggregation of large academic health care systems, often incorporating community hospitals and other organizations having variable or limited experience with education and research, oversight of the faculty practice plan has taken on greater variability. In more "corporate" systems, linkage of the faculty practice plan is primarily to the health system; under these circumstances, linkage to the medical school and dean is diluted or even disconnected, and the commitment of faculty time and effort to the academic mission may be less secure. In systems with a more "academic" manner of governance, the rigor and success of the academic mission is reinforced by direct oversight of the faculty practice plan by the medical school and dean.

a full-time job deserving of the full and undivided attention of a capable leader. Conversely, with a single individual at the helm, there is some risk with this "all eggs in one basket" approach to governance. If the anointed leader does not embrace the needs of the medical school, hospital system, and practice plan in a balanced manner, he or she will not gain the trust of key stakeholders. In this instance, having the right organizational governance structure takes on even greater importance.

While no organizational structure is perfect, and each is challenged by shortcomings, most aficionados of true health system integration favor a governance model with a single focal point of decision making as the most nimble arrangement. With the right individual, who understands and values the academic missions of education and research, this system is poised to outperform all others and avoids the potential trap of surrendering leadership of the clinical enterprise to nonphysicians.[13] Such a leader is well advised to create a leadership team with representation from clinical, education, and research enterprises. With a leader having a track record of demonstrated respect for the academic mission, and valuing it accordingly, there exists opportunity to grow and develop a fully integrated clinical delivery system without endangering support for teaching and investigation. In the absence of a leader with expertise and equipoise for all missions, the corporate model with separate but enlightened hospital and school leadership can offer a balance of power that is less nimble but more reassuring to the concerns of all constituencies.

Genuine physician leadership

This characteristic primarily determines the authenticity and primacy of the organizational commitment to the patient. While this tenet quickly garners full support of physician–leaders, it is often poorly executed and does not guarantee success. The underlying premise is that it is easier to teach a physician about the business of health care than to teach an administrator about the practice of medicine. While navigating the choppy waters of health care may be stressful and challenging for anyone, it is critical that the physician executive not become so entangled in the business of medicine as to become divorced from the fundamental ethos of being a physician.[13] Continued involvement on a part-time basis in the practice of medicine is one way to preserve this state of mind for physician–leaders. A commitment to protect even only one half-day per week for such involvement can be critical to preserving the credibility and unique value implicit in a physician–leader. The physician executive who retains this ethos, and balances it with good business sense and leadership skills, is a certain winner. Such a dual existence should be supported by the organization whenever possible. Nevertheless, pursuing a time commitment to both clinical practice and health system governance can be challenging on the best of days, even for the most talented leader.

It must also be emphasized that a medical degree is no substitute for the requisite leadership skills or experience expected of a successful physician executive. Many accomplished academic physicians are unschooled and uncertain about what constitutes effective AHC leadership. It has been suggested that "the concept of physician leadership will not be taken seriously by non-physician health care executives until the physician community becomes as serious about leadership and management training as it is about clinical training."[4] Herein lies the fallacy of physician-led health care systems. Often such an individual is eager to leave the rigors of clinical practice before having developed the leadership skills necessary to succeed at the helm of a large and complex organization. This is the wrong person for the job, no matter how enthusiastic the commitment may be to create a physician-led organization. Many opportunities currently exist to cultivate the leadership development necessary to become an effective physician executive.[14,15] Some pathways include earning a formal degree, while others are based on experiential learning in positions with graduated experience and critical context; neither is superior, but one or the other is essential to developing a successful physician–leader.

Three Essentials of Academic Health System Governance

In an era of rapid hospital and health system consolidation, a real threat exists to the survival of AHCs. Essential to the rigor of the academic mission is the oversight of the faculty practice by the academic leadership of the organization. A single focal point of decision making facilitates the nimbleness of an academic health care system. Physician-led organizations make a profound statement about the primacy of the commitment to the patient and the ethos of health care as a servant profession. Effectively implemented, these three components of AHC governance provide a strong foundation for a successful health care system with robust teaching and research missions woven into a tapestry that prioritizes providing high-value patient care.

Funding/Support: None reported.

Other disclosures: V.D. Pellegrini has served as past member of the Board of Directors of the Association of American Medical Colleges (AAMC). D.S. Guzick has nothing to disclose. D.E. Wilson has served as past member and chair of the Board of Directors of the AAMC. C.M. Evarts has served as past member and chair of the Board of Directors of the Association of Academic Health Centers.

Ethical approval: Reported as not applicable.

Previous presentations: The material in this manuscript is based on a presentation at the Annual Meeting of the Council of Faculty and Academic Societies of the AAMC, entitled "How to Understand, Navigate, and Be Part of Your Academic Health Center's Governance," March 11, 2017, Orlando, Florida.

V.D. Pellegrini Jr is John A. Siegling Professor and chair, Department of Orthopaedics and Physical Medicine, Medical University of South Carolina, director, Integrated Center of Clinical Excellence, Musculoskeletal Institute of MUSC Health, and adjunct professor, Department of Bioengineering, Clemson University, Charleston, South Carolina.

D.S. Guzick is senior vice president for health affairs and president, UF Health, University of Florida, Gainesville, Florida.

D.E. Wilson is John Z. and Akiko K. Bowers Distinguished Professor and dean emeritus, University of Maryland School of Medicine, Baltimore, Maryland, and senior vice president for health sciences, emeritus, Howard University, Washington, DC.

C.M. Evarts is distinguished university professor and former senior vice president for health affairs and CEO, University of Rochester School of Medicine and Dentistry, Rochester, New York, and former senior vice president for health affairs and dean, Penn State University College of Medicine, Hershey Medical Center, Hershey, Pennsylvania.

References

1 Kastor JA. Governance of Teaching Hospitals: Turmoil at Penn and Hopkins. Baltimore, MD: Johns Hopkins University Press; 2003.
2 Wartman S. The Transformation of Academic Health Centers: Meeting the Challenges of Healthcare's Changing Landscape. Cambridge, MA: Academic Press; 2015.
3 Aaron HJ. The Plight of Academic Medical Centers. Brookings Policy Brief. Washington, DC: Brookings Institution; May 2000. https://www.brookings.edu/wp-content/uploads/2016/06/pb59.pdf. Accessed August 1, 2018.

4 Culbertson RA, Goode LD, Dickler RM. Organizational models of medical school relationships to the clinical enterprise. Acad Med. 1996;71:1258–1274.
5 Osterweis M. The evolving structure, organization and governance of academic health centers. In: Bulger R, Osterweis M, Rubin E, eds. Mission Management: A New Synthesis. Vol 1. Washington, DC: Association of Academic Health Centers; 1999.
6 Snyderman R. History of the academic medical center. In: Chancellor's Tale: Transforming Academic Medicine. Durham, NC: Duke University Press; 2016.
7 Fritz V. No margin, no mission: Flying nuns and Sister Irene Kraus. Teletracking. https://teletracking.com/resources/no-margin-no-mission-flying-nuns-and-sister-irene-kraus. Published March 20, 2012. Accessed August 1, 2018.
8 Wallace N, Stephan S. No margin, no mission. BKD Thoughtware. https://www.bkd.com/docs/articles/No-Margin-No-Mission.pdf. Published 2016. Accessed August 1, 2018.
9 Voges ND. The ethics of mission and margin. Healthc Exec. September/October 2012:30–38. https://www.ache.org/abt_ache/SO12_F3_reprint.pdf. Accessed August 1, 2018.
10 Marks L. Medical School Economics: Financing the Academic Mission. AAMC Executive Development Seminar for Associate Deans and Department Chairs. October 5, 2017; Salt Lake City, UT.
11 Association of American Medical Colleges. Organizational characteristics database. https://www.aamc.org/data/ocd. Accessed August 1, 2018.
12 Haas S, Gawande A, Reynolds ME. The risks to patient safety from health system expansions. JAMA. 2018;319:1765–1766.
13 Stoller JK, Goodall A, Baker A. Why the best hospitals are managed by doctors. Harv Bus Rev. December 27, 2016. https://hbr.org/2016/12/why-the-best-hospitals-are-managed-by-doctors. Accessed August 1, 2018.
14 Letourneau B, Curry W. In Search of Physician Leadership. Chicago, IL: Health Administration Press; 1998.
15 Schwartz RW, Pogge CR, Gillis SA, Holsinger JW. Programs for the development of physician leaders: A curricular process in its infancy. Acad Med. 2000;75:133–140.

Cover Art
Artist's Statement: The Whole

I walked into the exam room. A disheveled, middle-aged woman named Dakota* was sitting on the bed holding a line drawing. She showed me the sketch and said, "This is my heart. I have more than 20 stents." I thought, "Oh, my goodness! How am I going to manage her heart?" We began talking, and I discovered she was homeless. I learned all about her: Where she had lived. Why she had moved. The medical condition she referred to as an "over healing disorder," which she had dealt with her entire life.

Throughout the time I was her physician, Dakota suffered five more heart attacks. She often came to our appointments with paperwork indicating that she had gone to the emergency room and left against medical advice. After looking over the documents and speaking with her, I discovered a communication gap: Since Dakota had been living with a heart condition for her entire life, she felt that she knew which medications worked well and which ones did not. However, Dakota believed physicians were failing to listen to her, because she only had a high school education and was living on the streets. They were talking *at* her and following protocol, which explained why she repeatedly left the hospital out of exasperation.

During one of our appointments, Dakota reported chest pain, so I encouraged her to check into the hospital. She reluctantly

The Whole

went, but refused treatment once again. Instead of letting Dakota go—letting her repeat the cycle of miscommunication and frustration—I decided to visit her in the hospital. As I entered the room, she turned to her friend and said, "That's my doctor. I'm scared." The two of us spoke for awhile. I listened to Dakota's needs, concerns, and fears. I explained the reasons for her different medications and procedures. We connected. Dakota became amenable to treatment, but reported another frustration: "They keep telling me to watch my diet and exercise. I'm homeless. I eat shelter food. I don't have options. Exercise? I live on the streets." Dakota made a good point: How could she choose the healthier food option when she had only one choice?

Dakota inspired me to paint *The Whole*, on the cover of this issue. One half of the image represents the detached, black-and-white thinking that we as doctors can have when interacting with our patients. We need to step back from our clinical mind-set and look at a patient's individual parts, like a colorful puzzle, to understand her whole image: the lion. When I followed this practice, I realized that Dakota had a unique medical condition that she lived with for her entire life. She had valuable knowledge and needed to be listened to and learned from. By taking her social circumstances into consideration, I understood that physicians didn't need to encourage Dakota to exercise. She was getting exercise, though in a nontraditional way: She had to carry her belongings for at least 5 to 10 miles per day to meet her basic needs, as opposed to running on a treadmill. When interacting with our patients, we should consider their whole being as opposed to solely focusing on the presenting problem.

*The name in this essay was changed to protect privacy.

Maryam Soltani, MD, PhD

M. Soltani is a fifth-year resident in family medicine and psychiatry, University of California, San Diego, San Diego, California; e-mail: msoltani@ucsd.edu.