Change, Challenge and Opportunity: Departments of Medicine and Their Leaders

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ABSTRACT

Academic Health Centers are evolving to larger and more complex Academic Health Systems (AHS), reflecting financial stresses requiring them to become nimble, efficient, and patient (consumer) and faculty (employee) focused. The evolving AHS organization includes many positive attributes: unity of purpose, structural integration, collaboration and teamwork, alignment of goals with resource allocation, and increased financial success. The organization, leadership, and business acumen of the AHS influence directly opportunities for Departments of Medicine. Just as leadership capabilities of the AHS affect its future success, the same is true for departmental leadership. The Department of Medicine is no longer a quasi-autonomous entity, and the chairperson is no longer an independent decision-maker. Departments of Medicine will be most successful if they maintain internal unity and cohesion by not fragmenting along specialty lines. Departments with larger endowments or those with public financial support have more flexibility when investing in the academic missions. The chairpersons of the future should serve as change agents while simultaneously adopting a "servant leadership" model. Chairpersons with executive and team building skills, and business acumen and experience, are more likely to succeed in managing productive and lean departments. Quality of patient care and service delivery enhance the department's effectiveness and credibility and assure access to additional financial resources to subsidize the academic missions. Moreover, the drive for excellence, high performance and growth will fuel financial solvency.

Key Indexing Terms: Academic leadership; Health systems; Interdependent organizations. **[Am J Med Sci 2016;351(1):3–10.]**

INTRODUCTION

"Will Internal Medicine survive to see a bright new dawn?" Petersdorf and Goitein[1] posed this question about the future of internal medicine more than 20 years ago. Although this is still a relevant question today, much has changed for Academic Health Centers (AHCs) and for their constituent departments of medicine in the past 2 decades. AHCs are evolving to Academic Health Systems (AHSs), reflecting financial stresses requiring them to become nimble, efficient and patient (customer) and faculty (employee) focused. AHCs are experiencing reductions in clinical revenues. Disproportionate Share Hospital payments may diminish considerably under provisions of the Patient Protection and Affordable Care Act. Federal funding for biomedical research remains stagnant. Uncertainty exists about future decisions concerning federal support for Graduate Medical Education. These are a few of the financial concerns driving organizational change in many AHSs. The evolving AHS organization includes the following many positive attributes: unity of purpose, structural integration, collaboration and teamwork, alignment of goals with resource allocation and increased financial success.[2] In these health systems, the business of medicine and financial performance are dominant concerns; recall the oft repeated quip—"no money, no mission."

AHSs and their constituent Departments of Medicine must maintain a mutually beneficial relationship to achieve success in an uncertain future. Departments of Medicine can play a key role in shaping the future of the AHS, as they are a critical resource for expert clinicians, innovative researchers and dedicated educators. However, the evolving organizational models adopted by the AHS would challenge the department chairperson's adaptability and leadership. To be an effective leader, the chairperson must be an engaged mentor, facile communicator, systems manager, budget wiz and successful negotiator. They prioritize departmental cohesion, balance among academic missions, pursuit of excellence, high performance and accountability. In addition to traditional academic credentials, department chairpersons function as healthcare executives with the requisite business skills to guide their department and faculty through these current changes, despite an uncertain future. The chairpersons' increasing leadership and management responsibilities would diminish the time available for their personal academic pursuits. In the complex business of medicine, a department chairperson achieves success by focusing on aligned goals and incentives, strategic growth, quality of care and service and productive faculty and satisfied staff. Goal alignment, appropriate incentives, and growth initiatives begin with the AHS strategic priorities that are then

cascaded to all levels within the organization: departments, divisions and individual faculty. The department's future is even more secure when the chairperson prioritizes teamwork, collaboration, continuous and clear communication and department unity. Coupled with efficient business operations and effective financial systems, these characteristics will assure a department's fiscal stability.

ORGANIZATIONAL STRUCTURES

Integrated AHSs

The current, decentralized, and department-based governance structure that characterizes many AHCs and medical schools is not sustainable.[3] An AHS can choose from an array of available organizational and governance structures. As the available organizational models are quite varied, an individual AHC can tailor its selected AHS model to meet its specific organizational, governance and financial needs. The AHSs may decide to keep the academic missions and their discrete entities unified—hospital, faculty practice plan and school of medicine—while creating a more integrated and interdependent organizational structure. In addition to integrating the key clinical and academic units, the AHS may add additional hospitals, physician networks, imaging and ambulatory surgical centers and other partners. Alternatively, the AHS may decide to separate the patient care mission from the academic missions of medical research and education. The AHS may select separate leadership for the clinical (hospital and faculty practice plan) and the academic enterprise (school of medicine). Yet under other circumstances, the AHS may decide to partner or align with for-profit or not-for-profit healthcare business entities that are not part of a traditional AHC.

Whatever specific organizational model AHSs choose, it would be more systems-focused, integrated and aligned, interdependent, performance-based and accountable. Departments of Medicine must embrace this integrated systems approach, and chairpersons should volunteer to be constructive partners in the organizational realignment. In many AHSs, such a reorganization requires significant change, if only to survive as financially viable entities. With reductions in clinical reimbursement, or centralization of clinical revenues to the AHS, Departments of Medicine are likely to become increasingly dependent on financial resources from the AHS. Few departments would remain financially solvent without such additional support. In pursuit of institutional goals, the department should capitalize on opportunities to acquire additional institutional resources. For example, if the AHS identifies oncology as a major growth specialty, the department should obtain institutional resources to grow medical oncology, increase oncology research and even expand fellowship training. By embracing institutional goals, the department can grow programs and benefit financially, because the AHS would invest additional resources in growing and achieving excellence in priority specialty areas. If Departments of Medicine exploit their extensive clinical expertise and leadership in medical education and research, they can realize new opportunities in the AHSs.

Departments of Medicine would have to adapt to the evolving organizational structure in the AHS and collaborate with the AHS leadership. The skills, experience and business acumen of the AHS leadership would be vital to the department's future success, in addition to the organizational structure and governance.[4,5] During this time of change, it may be difficult to anticipate which organization pathway an individual AHS would follow. For example, in an AHS model, the university hospital, faculty practice plan and school of medicine integrate, collaborate, make decisions and allocate resources jointly as a virtual (not structural) organization, but remain quasi-independent entities (Figure 1A). Departments can

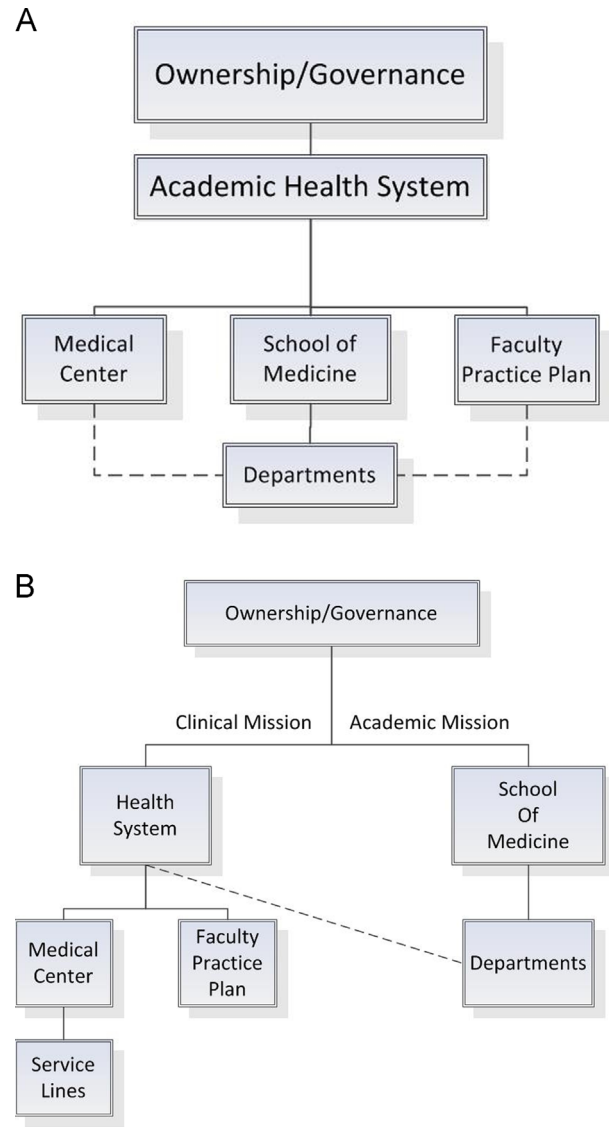

FIGURE 1. Several organizational models for academic health systems.