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Recruiting Leaders for Reorganizing AMCs

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Academic medical centers today are nothing like those of the past – the model of a medical school and teaching hospital within a parent university with physicians organized as an unincorporated practice plan is a distant memory. Today's AMC typically consists of a medical school and other health professional schools embedded in or affiliated with a health system. These systems usually include a comprehensive university teaching hospital, one or more community-based hospitals in large, sometimes multi-state geographies, and networks of out-patient sites of care with physicians' offices, providing sophisticated medical services to hundreds of thousands of patients annually. Some of these amalgamations include an insurance product of one type or another. The revenues associated with these complex, integrated systems – commonly a city's or region's largest employer – are measured in the billions of dollars.

In short, AMCs have become very large healthcare business enterprises, whose primary services are education, research and patient care, although not necessarily in that order. In the majority of AMCs patient service revenue dwarfs the combined budgets of the health science schools, and the parent universities have grown increasingly dependent on the clinical enterprise for the financial support of the medical and health professions education programs.

Managing a business as large and complex as the AMC has become an enormous challenge. The AMC no longer operates solely within the context of the parent university, rather it has become an extra-university public enterprise, immersed in the business and regulatory world of healthcare. This change has been rapid and enormous, and is a continuing work in progress. The optimal structure that facilitates the AMC's continued success in the business of healthcare and preservation of a university's academic mission is the subject of ongoing, intense consideration.

Two Leadership Models

As universities assess the challenge of optimizing how they are organized to operate and anticipate what lies ahead, two trends are emerging. The first is a commitment to unified leadership of the academic and clinical missions in order to integrate the two as seamlessly as possible, including the framework for strategy and decision making and the allocation of resources for growth and investment. The second is the separation of leadership of the academic mission and clinical mission in a way that permits mission-focus and narrower responsibility bandwidth for each, and that ideally facilitates operating performance of the separate but related divisions. The latter of course presumes a unity of vision and commitment to the integrated mission and places a premium on cooperation and collegiality of leadership. Both models can work and both models require exceptional leadership for success.

For many AMC systems the former model – unified leadership of the consolidated system – is preferred. This doesn't simplify things, however. There is the old adage that says "*when you have seen one AMC you have seen*

one AMC." Each has its own unique history, culture and traditions. Each operates in a unique environment that poses particular opportunities, demands and challenges, especially in the clinical arena where the economic scale is a multiple of the academic enterprise.

The Leadership Challenge: Protecting the Academic Mission

Scale has brought with it the predictable challenge of leading and managing increasingly complex health care organizations – as noted, comprising the university medical center, one or more community-based hospitals, one or multiple physician organizations of faculty and non-faculty physicians, networks of outpatient sites, and possibly an insurance component, all under one system "banner".

Finding executive leadership with the skills to create a system from disparate parts is a challenge in its own right. The leadership challenge includes not only building common operating and management systems, but also achieving operating efficiencies, maintaining institutional identity and employee morale, updating system/network growth strategy and, importantly, creating the governance structure that the expanded system requires.

In the midst of these extraordinary challenges that are attendant to clinical consolidation, it is critical that the centrality of the academic mission be maintained and protected, and that the commitment of the clinical enterprise to the education and research missions of the AMC be reaffirmed in clear and tangible ways. Too often the scale, complexity and urgencies of the healthcare enterprise can risk marginalizing the agenda and importance of the academic mission of the AMC. This has become a tension in some AMCs and continues to foment discussion about an optimal organization that preserves and advances mission and effectiveness.

Some of this tension relates to leaders' backgrounds. In every AMC system there are academic/physician leaders who are expected to adapt and become more comfortable with the burgeoning business side of operations. Meanwhile, there are non-physician leaders with business-oriented backgrounds who typically need to adapt and gain a full appreciation of the academic mission in order to succeed in their roles. This dynamic between physician and non-physician executives is something that each organization must wrestle with as it looks to evolve its culture while adhering to its core mission.

The Recruitment Challenge: Leaders Who Can Do It All

It can seem like a daunting task for these evolving academic medical systems to identify and pursue CEOs and other executives who embody the skills and spirit required to run a major consolidated enterprise. We offer the following recommendations as a template for such recruitments. It's imperative to recruit leaders who . . .

. . . think big but don't lose sight of the academic mission. The profile of the desired candidates to assume these leadership positions is a recruitment challenge. Identifying candidates who possess the skills, talents and experiences to manage these increasingly complex AMCs is the starting point. But the best candidates also possess the ability to lead and inspire them. The critical importance of AMCs to American medicine and their individual success depends upon being able to integrate and synthesize their related missions. Success of the whole depends on the success of its related parts. That requires leadership that understands the essential elements of the AMC, is committed to maintaining its integrity, and has the capacity to lead and manage change.

. . . accept leadership development as part of the equation. Few individuals possess from Day One all of the management skills and the aptitude to lead today's academic health science systems. Successful candidates have the ability to grow into the job. This is where leadership development becomes crucial. A fundamental element of the hiring process can be the creation of a leadership development plan which outlines how an individual will grow into the role over a matter of months and years. Coaching can be a catalyst. In short, AMCs need to become more systematic and intentional about leadership development. Leadership development is a long-term challenge in itself.

. . . are change agents. Institutions will need to be more open minded about how they are organized, and more open minded about the characteristics of the leaders they are willing to consider. Change is not one of AMCs' long suits. Universities and their AMCs are inherently conservative. But consolidation in the health care sector has already brought with it change in decision-making that is more aligned with the business world than with the traditional university environment. As academic medical systems and health systems continue to grow, they will necessarily become more culturally diverse. This can be a good thing, as long as leadership understands what should and should not be subject to change. Cultures are changeable and negotiable. Institutional values are not.

. . . embrace the community. AMCs have become more externally facing organizations than they have been historically. In their inclusion of community-based hospital and community-based physician groups they have created opportunities for community engagement that AMCs have not traditionally embraced. These represent an expanded agenda for AMC-led systems that are enriching for the AMCs and for the communities in which they live and work. To be successful will require leadership that sees this work not as burdensome or a distraction from the academic mission of the AMC, but as a valuable and important component of the AMC's role and work. This is an example of organizational transformation that leads to cultural change.

. . . build win-win scenarios for community physicians and the AMC. The inclusion of community-based physicians in the expanded AMC has been a very positive element of consolidation. It has resulted in substantial expansion of the cadre of clinical teachers for the medical schools, increased the sites and settings for students' and residents' clinical training and, in some settings, has augmented clinical trials and community-based research initiatives. These initiatives provide rewarding new opportunities for community physicians to grow. Not all of them are interested in greater involvement with the AMC's medical school, of course, but those relationships can enhance clinical programs as well to the benefit of patients and physicians.

. . . can deftly manage the inevitable relational issues between community and academic physicians. In the community hospitals there has been concern about loss of autonomy and over-stepping by community physicians' new academic colleagues. And in the medical school there has been concern about the dilution of academic mission. These are the kinds of relational issues that one expects in the increasingly complex AMC organizations which, if managed with consideration and intention, are culturally enriching opportunities to mutual benefit. Good outcomes require time, insight to see what's possible, and the interest and skills on the part of leadership to work them out. It's a good example of the interpersonal skills necessary to be effective in a complex leadership role in addition to the technical, operating skills that are more easily measurable. Again, we need to be developing these skills in the individuals we expect to have the capacity to manage and lead complex organizations.

Recruiting leaders for today's consolidated academic health systems is a tall order indeed. These executives must have the business acumen to succeed in an increasingly diverse, complex enterprise yet with a sensitivity to connect with both academic and community colleagues for the good of all and the furtherance of the collective mission.

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