Academia and Industry: Partners or Protagonists? A Review of Critical Business Issues in Academic Medicine

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Graft 2001; 4; 392

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A Review of Critical Business Issues in Academic Medicine

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Can any role be more challenging than balancing the demands of a culture based on economics, with a call to the service of preserving human health and welfare?

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Introduction

Today's leaders in any specialized area of medicine face unprecedented challenges in managing effective organizations. Leaders in health care, pitted squarely against the forces of a health care dynamic that is seemingly beyond control, must now function with a skill on par with CEOs of major corporations. The future of these leaders' "corporations," that is, their centers, rest upon the ability to understand harsh new business realities that are now a rigid part of their professional domain. They must take steps to incorporate what they understand of this new reality into survival strategies that ensure efficiency today—and solvency tomorrow—while maintaining the high standards of practice that are, historically, elemental to the academic set of ethics and principles. Can any role be more challenging than balancing the demands of a culture based on economics, with a call to the service of preserving human health and welfare? Boundaries that were once clearly drawn are now becoming indistinct. Strong arguments persist from all sides, and understanding them is the indisputable beginning, but where to begin?

Constructing Dialogue

Socrates' model of the dialectic—wisdom discovered via the process of open-minded dialogue—typified his uncompromising search for truth and improved quality of life. When Chaerephon declared that the Oracle at Delphi told him that Socrates was "the wisest of all men," an uncomfortable Socrates went to question the sages of Athens and disprove this claim. His subsequent queries led to anger, suspicion, and dismissal from the presence of those whose ideas he examined. Furthermore, he found that the poorly considered ideas of the so-called wise men were often parroted and arbitrarily defended by those surrounding them because of a general unwillingness to question "time-honored" concepts. After one disappointing conversation, Socrates reflected: "He thinks he knows something that he does not know; whereas, I am quite conscious of my ignorance." Socrates concluded that perhaps the Oracle was right, not because of what he knew, but because he admitted the limits of what he knew and sought always to fill the gaps in his understanding of the world. His way had less to do with harsh judgments and more to do with an attitude of open-minded good humor as he sought solutions to the dilemmas of his day—many of which still persist.

As Socrates saw it, wisdom could be found in the academy but was uncovered principally via direct relationship to self (i.e., a sense of one's own well-considered values) and others. Wisdom was earned through examination of experience and from a continuous, meticulous inquiry of one's assumptions. The Socratic method is still relevant with its emphasis on dialogue between people across boundaries. Boundaries serve to protect, but they can also imprison. For our purposes, it is particularly important that we understand the standards academia and industry have traditionally lived by, and the effect each has had upon the other. There is much paradox to address and complexity to unravel, but without comprehending the dichotomies involved, solutions to today's myriad health care dilemmas will be difficult to find.

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There is a common view that business values are based on a profit motive and little or nothing of substance beyond that. This mindset also holds that academics are primarily motivated by nobler purposes—altruism and public advocacy. As some academics see it, boundaries separating academia and industry should not only be distinct but also be universally applied. One academic leader has publicly called upon major medical schools to establish uniform and rigorous rules prohibiting "certain financial ties," equity interest, and many writing and speaking arrangements. Rules regarding conflicts of interest should be imposed and enforced. House officers should buy their own pizza, and "hospitals should pay them enough to do so."[1]

The ensuing pressures make sorting out the dilemmas related to realistic and ethical relationship building between academia and industry intensely difficult. First, what is industry? Obviously, pharmaceuticals, durable medical equipment, supplies, but also services, such as health care contractors and information services, compose what we might deem "products." One can argue that academia is in some sense an industry, especially in competitive environments where one compares "our" results to "theirs." Why? Because those results are, and in a sense have always been, a commodity. They have market value. Renowned individuals, in all honesty, are also commodities, offering centers cachet and opportunities for self-promotion, and are attractive sources of funding as long as the intellectual capital is maintained.

To complicate matters, researchers, teachers, and clinicians within a given academic setting may have strongly conflicting perspectives of industry standards. For example, until recently, financial accountability was not a uniform requirement of academics. Although the skills of their own internal business people are more important to the survival of both clinical and research enterprises than ever before, business professionals in a role as financial representatives for the academic center are typically not valued by faculty members. As a result, some believe it is time to transcend the established view that the roles of scholar, scientist, and healer are in opposition to those of leaders and managers.[2] In fact, literature examining business issues of the academic center confer the idea that today's medical directors and division chiefs must function with the mindset of corporate CEOs to lead their centers safely into the future. The authors of such articles typically represent the growing pool of physician-MBAs.[3]

The inescapable fact is this: The core *business* of academic medicine, financing, and its relation to academic medicine's core *mission* has become profoundly destabilized.[4] This necessitates exploring new paths of fiscal viability and profitability. Profitability within an academic enterprise, such as transplantation, confers a measure of leverage when negotiating for resources from internal administrative boards or any large-scale donor seeking affiliation with a "brand name" institution. This is language academicians may not like, but it nonetheless describes, in straightforward terms, an unmistakable reality.

Operating from the presupposition that an honorable academic-industry relationship is not possible could be severely limiting in situations where resources are quickly becoming scarce. People on both sides of the academia/industry fence are committed to achieving optimal outcomes. One professional seems to be inherently the nobler of the two, seeking to benefit humanity, whereas the other's professional requirement is to take responsibility for the health of the bottom line. This attitude unfortunately precludes the possibility that there are conscientious people involved in industry willing to take corporate money and apply it meaningfully to the structures that support the health care organization.

"The leadership mind is spacious," declares Peter Koestenbaum, a philosopher who serves as a leadership adviser to major corporations (including a pharmaceutical company). "It has ample room for the ambiguities of the world, for conflicting ideas and contradictory feelings."[4] The synergistic possibilities of the disparate entities can have an effect far beyond the expectations of either group struggling to operate alone. If each operates in a vacuum, it is likely both will be subject to assumptions that ultimately serve neither side well. It should be emphasized that aligning activities to reflect common values and shared goals is by no means the same as "selling out." As opportunities grow under the mindful and creative vision of well-informed and participatory leadership, a greater range of mutually beneficial outcomes emerge, and ultimately a more productive system.

Developing "Systems of Excellence": A Call for Committed Leadership

Systems comprise individuals. Individuals who form the interrelated systems deserve careful consideration as the system itself is analyzed from a historical perspective.

Academia

Consider today's academic and the system in which he or she operates. This person is responsible for bringing something of distinct value to the institution under whose auspices his or her work is done. A scientist must try to piece together support for his or her work while dealing with new cost-accounting structures that had little to do with the efforts of a researcher in the not-so-distant past. He or she must then carry on with the research. An ivory tower, that sheltered environment where one might focus single-mindedly on the myriad research tasks at hand, no longer exists. The idea that institutions produce informed scholars and research is the core of a now defunct social contract: We pay tax dollars to support academia and in turn reap the benefits of research and discovery.

Without a plan for economic viability, researchers will find it increasingly difficult to continue their work, while high-quality professional and support staff will become a rare commodity. Fewer young professionals and students will be afforded educational and networking opportunities. Therefore, in a quickly evolving field such as transplantation, gaps in sources of funding and allocation of benefits, to both employees and patients, must be addressed. The need for resources is constant, and the legitimate reasons for soliciting support are numerous. Industry has historically had money to invest, and clearly, it often does.

Today's modern academic institution must uphold and defend its significance to all with a stake in the outcomes, including grant sources and the surrounding community. There are academics who aggressively seek to profit in exchange for a positive word publicly expressed about a product or technique of a given company. Even where such personal inclination is not present, many institutions of higher learning do not hesitate to solicit large grants from private industry for capital investments or other worthy purposes. Similarly, if a company has an opportunity to sell a product on a valid premise; if a scientist/physician has been careful and honest in assessing opportunities to inform others; is this necessarily unethical? Does the answer change if earnings resulting from such addresses are transferred to a fund from which a university research team benefits? What does the "academic presence" produce in exchange for the support it receives? Such dilemmas create the foundation for the formulation of a new social contract, which may or may not lead to the research outcomes a progressive plan requires.

Industry

Industry (defined as pharmaceutical and related companies, as well as managed care organizations and their related entities) is pressed to offer new and better therapies given market pressures, competition, patient and provider outcry, patent expirations, burgeoning research costs, and governmental constraints.

An industry professional is familiar with the commercial marketplace and must account for his actions as they relate to profitability. This person possesses a working knowledge of complex systems and how they relate to economic structures. Theoretically, this knowledge, if applied insightfully, could help formulate the financial freedom the investigator/clinician needs to discover new and improved means of offering hope and quality of life to others. Secure financial arrangements, although not the crowning achievement of any ethical existence, nonetheless offer a measure of freedom and choice not attainable through other means. At any rate, each side would agree that no one profits when customers are displeased, or when patients do not heal. Neither is there a benefit when medical progress slows or is unattainable by many.

Current business literature offers a wealth of information and encouragement to business people determined to preserve their human values.[5] This reflects a force of its own that has been growing as business professionals take stock of what matters in life. Peter Koestenbaum poses the question, "How do we handle competition without becoming either the kind of fool who allows it to crush us or the kind of fool who forgets people?"[5]

Those associated with industry are, after all, sometimes patients, public advocates, suppliers of free or low-cost goods, and underwriters of academic, peer-driven research foundations. They are major supporters of various nonprofit organizations and societies. Individuals may contribute in various ways to activities such as patient and public information drives, meetings with managed care case managers, and other programs that directly relate to the center's business. They may also volunteer their help in center-related programs, not because their career requires them to do so, but because they understand what needs to be done and what they can offer to help. In specialty sales and marketing sectors of industry, growing numbers of professionals have clinical and/or research backgrounds. As academia looks for ways to fund its complex activities, industry's contributions are not inconsequential and could be expanded in areas that both sides deem appropriate.

The Evolving System and Managed Care

Reactions to pressure from several directions, including industry, academic centers' capital investments, research costs, billing practices, and countless other elements, played a role in shaping the current system. There was a time when doctors and hospitals decided fees for services, which were then paid by insurance companies. Advanced research and medical schools subsidized research and education from profits and provided necessary care to the uninsured. This is "yesterday's social contract." However, as costs doubled every 5 years with no foreseeable end,[6] a shift with greater emphasis on the bottom line was necessary.

Managed care was founded on the principles of comprehensive, preventative care and medical treatment at a reasonable cost. It sought to impose methods to contain spending. As these constraints were imposed, care providers, including academic centers, began to lose money. Research and education suffered, as did patients who experienced problems accessing care. Physicians' incomes declined, and staff cuts became prevalent. As managed care evolved, it raised concerns among doctors and patients that many critical decisions were increasingly out of physicians' hands. Managed care organizations have been charged with putting profits before patients, and ultimately discouraging innovation and research in the pharmaceutical and technological industries. Today, they too are in a less stable position owing to physician and consumer backlash, and their own rising costs.[7] Given that controls of some type are necessary, it would seem critical that dialogue be established with those in the managed care industry.

A lack of open dialogue among those in a contracting role within various institutions can result in managed care contracts that just don't seem to work or, in some aggravated cases, can result in situations where direct costs to the transplant center cannot be recouped. It takes someone knowledgeable in all aspects of transplant-associated costs, from organ acquisition to posttransplant care, to craft a reasonable contract. For reasons clear to most—especially those operating in competitive areas—many administrators believe that a new "contracting language" should be developed to help manage the extenuating circumstances experienced by many patients.

Effective leadership is required to make headway in this and in many areas. The turnover of valuable professional staff and other employees is inordinately high in areas where feelings of uncertainty and vulnerability persist. An important role of the chief, division head, or CEO is to create a context that draws upon the historical mission of the unit and its short- and long-term goals to establish the distinct responsibility of each team member. The fundamental approach to dealing with uncertainty is to have a survival plan and a commitment to stability and growth in which everyone participates. By giving everyone a stake in the outcome, an overall sense of commitment to the organization's mission is generated—and will eventually constitute a powerful force.

Where such leadership does not exist or is inadequate, situations emerge—largely owing to staff turnover and lack of sustained teamwork—whereby institutions constantly have to relearn the basics of practice and development. In some cases, they must work hard to maintain a status quo that is quickly becoming archaic. If such centers are going to survive, however, more advanced practice approaches in the areas of research, medicine, and business must be consistently applied across the board to shape the evolving health care environment in favor of the majority.

The Informed Leader versus the "Loss Leader"

Some of transplant medicine's challenges, such as the inadequate supply of organs available for transplant, are uniquely its own. As a distinct enterprise, it offers a detailed examination of many dilemmas that institutional specialty areas universally face. By establishing dialogue and cooperation within its organization and outside entities, it could provide a model by which academic medicine as a whole might benefit. Examining the important questions and finding their solutions requires a careful merger of science and business to, first, craft stabilizing measures.

As centers struggle to regroup in order to eventually reinvent, administrators insist that patients receive the best care possible regardless of the profit/loss margin. To their credit, this appears to be exactly what is offered to the patient and, by extension, society. It is the scholarly, humane thing to do. But in light of huge losses due to the financial pressures created by many variables within the new administrative fiscal environment, the center's long-term survival may be in question.

The argument is sometimes heard that transplantation medicine must expect to be the "loss leader" in academic centers for the following reasons:

- The lack of organs available for transplant (countered somewhat by the development of strong living donor and other awareness programs).
- The high cost that is associated with research and practice.
- Unfavorable funding and reimbursement that affect centers to various degrees.

This notion, if accepted, serves only to weaken its overall position and further threaten its structure.

Is the idea of being an institutional "loss leader" acceptable in light of the continuous stream of capital needed to conduct a center's business? In situations that involve appeal to governance or administrative boards within institutions, how strong a case can transplant leaders make on behalf of professional interests if they are heads of glamorous, but ultimately unprofitable, endeavors? This seems to put transplant's future much in the control of others, who have become *de facto* underwriters, especially when the evidence they present cannot be skillfully discussed by transplant administrators.

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A counterargument persists that transplant generates referrals within so many other areas of an institution that, despite hard evidence to the contrary, it should still be generally considered a "profit center," not a loss leader. But evidence in support of this claim is hard to quantify, thereby weakening this position unless more sophisticated standards of measurement are discovered and utilized.

The crucial areas transplant centers need to review can be summarized as follows:

- The transplant center must assess its infrastructure. Leadership must also be established and the following question must be answered, "Are the right people in the right places at the right times doing the right things?"
- Contracting personnel must be well educated in the realm of transplant-specific negotiating processes. They must be prepared to account for every cost incurred and charged back at all points with respect to organ acquisition, to the transplant itself, as well as the period following. They must further be aware of all billable procedures, and all other issues related to the transplant fiscal scenario.
- The capability to appropriately market and promote its practice to managed care organizations and networks must be evaluated. This includes offering educational programs and developing data resources and customer satisfaction tools (the results of which are incorporated into the means by which centers attract referrals and contracts). This also means taking the lead to inform case managers of potential therapeutic strategies even before they become utilized in practice. This positions them reasonably for future reimbursements as science progresses to clinical reality.
- The quality of communication with patients and the public must be reviewed. Patients are the ultimate "customers." Their satisfaction

enhances a center's negotiating power in any discussion related to managed care. The care they require includes giving them a better understanding of their financial responsibilities, as well as introducing them to available support, resources, and other forms of assistance. This, in turn, can facilitate the compliance needed to effect optimal transplant outcomes.

Each of the above elements represents the domain of those relative few who demonstrate skill in each area. If those charged with these considerable responsibilities are not well-known by the leading physicians in transplant centers, it is often for the reason given before: Some academics have not given professional credence to their internal business people. Low levels of interaction make it difficult to assess who is doing their job and doing it well, or who should be promoted and who needs assistance, to benefit the team. Indeed, some business experts within centers are widely known within their own professional peer groups—and outside their centers—for their expertise. It is when his or her internal team supports and affirms the value of what they provide that everyone will benefit.

Conclusion

The elements briefly described here, taken as a whole, form the basic foundational approach for the creation of a strong academic center. Investments in the form of time, energy, and resources are required to locate the right people, build the best internal structure, and construct a shared set of values. Dialogue with industry can follow to examine what resources it can offer, whereby mutual expectations can be discussed. It is incumbent upon all to be candid and accountable. Such efforts can pay off in the formation of acceptable, commonsense internal and external partnerships that compromise no one's ideas of how to practice his or her livelihood.

The need for scrupulous assessment with respect to academic and industry relationships is clear. This process involves serious self-assessment and a commitment to what, in a leader's opinion, seems to be the right thing to do. Further change will follow as the landscape changes with new discoveries, new products and technologies, new threats, and new opportunities. Solid partnerships ensure access to a vast informational network, and new conversations will generate new perspectives. Renewal happens in tense situations when people feel inspired and enabled to function at the highest levels of competency they can achieve. Peter Koestenbaum reminds us that "you don't teach (leading edge) ideas: you challenge them into existence, not by technique but by a commitment to greatness, and through the demonstration of courage."[2] In short, the work of reinvention is ultimately accomplished through constructive dialogue and by the example of committed individuals whose vision is attuned to possibility. They are our leaders, and we need them now more than ever.

Acknowledgment

The author wishes to thank the following individuals for their assistance: Dave Young, Tom Filipczak, Jeffrey D. Carlson, Amy Katz, Stephanie Fraser, R.N., Christine Morris, R.N., Jeff Jackson, Jacquelyn Jutchess, Rick Nida, Cheryl Buntley, Lisa Blind, Zoe Emerson, Andrew Camarillo, Mark Miller, Nicole Montpetit, Jeffrey Xander, Elizabeth Catton, R.N., Kristen Scholz, Patrick Parker, Randy Howard, Lynette Roudebush, Larry Pietzyk, Karen S. Morey, Edward Gonzalez, Tony Murante, Donnie Coker, Dan Foust, Keith Tabor, JoEllen Falco, Kristy McCorkle, Glenn Stafford, Lynn Imbaro, Timothy Waugh, Matt Marcus, Denise Faherty PhD, Martin Bunke MD, Dennis Preston, Ernest Hodge, MD, and Tammy Reilly.

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