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Negotiating a Change in Medical Center Governance: A Case Study of Institutional Alliances

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Abstract

In the summer of 2000, faced with escalating debt that threatened one of America's premier research institutions, Milesburg University* sold its clinical enterprise to Emanon Health, an independent health system. The sale resulted in the separation of operations and staff, with the hospital and its clinicians becoming the responsibility of Emanon, and the basic scientists and research-focused faculty in clinical departments remaining in the employment of the university. Over the years, the turbulent economic and political environment that impinged upon academic centers nationwide had led to a breakdown in the relationship between research-focused faculty and clinicians, where each group had little knowledge of the role the other played—either fiscally or academically—in the center's mission.

Adding to this latent sense of mistrust between the two groups was a governance structure that did not have a mechanism for candid feedback regarding the performance of the center. Those two together—the overall sense of suspicion in the faculty body and a governance structure that impeded sharing information among decision makers—were particularly troubling in view of the new arrangement with Emanon and how that would affect the operations of the medical center. It was evident that a new governance structure that encouraged a focus on common goals, combined with a strong leader at the helm, would be vital for the medical center's survival. But a new governance structure would need to meet with the approval of the faculty as a whole. Given the poor communication history between the two groups, arriving at an agreement would be difficult. (While not all faculty fall into one of these two categories, the majority can broadly be considered either research focused or clinically focused.)

With these exacting problems to contend with, the medical center faculty began a nine-month, open-table negotiation process. The authors relate a process in which faculty confronted their preconceptions and arrived at a shared vision regarding the center's mission. Ultimately, this unified vision paved the way for developing a new governance structure.

Introduction

Faced with escalating debt that threatened one of America's premier research institutions, Milesburg University sold its clinical enterprise to Emanon Health. Under the terms of the agreement, Emanon Health, an independent health system, acquired the hospital, and hence responsibility for the clinicians. The university retained ownership of the educational and research enterprises, which employs the scientists and educators in basic science departments, and research-intensive faculty in clinical departments.

* Though this work is factual, names have been changed to maintain the privacy of certain individuals and organizations.

The sale exacerbated the need for a shake up in the medical center's financial management and reporting systems, long buffeted by a vastly altered economic landscape. Clearly, the medical center would need strong leadership in the form of a high caliber executive vice president (EVP) to manage this new situation. First, though, Milesburg University President Albert DiSimone recognized that if the newly configured medical center were to operate effectively, with faculty working toward the same goals, it would require a robust governance structure that would support the research, clinical, and educational missions across two separate organizations.

A Hostile Environment

The negotiation process took place in a troubled political and economic environment. Over the years, economic difficulties had placed pressures on faculty. While all were concerned about the future of the medical center, the two faculty groups—researchers and clinical educators—had become divided and had lost sight of the role the other group played in sustaining and fulfilling the center's mission. On the one hand, clinical educators felt that it was the clinical practice and revenue from billing that kept the medical center afloat, and that it was clinical teaching that prepared medical students for their future professions. On the other hand, researchers contended that it was their research activities and revenues, as well as teaching, that were central to maintaining the medical center mission. Each group, therefore, identified with only one part of the environment (their own) and viewed that part as the whole. Such narrow identification invariably undermines productivity; management theorists advise that "when people begin to think in terms of 'us versus them' … they are engaged in a relationship at the identity boundary," which can be disruptive to the broader purpose of the organization.[i]

The sale served only to further fragment the two faculty groups, with clinical educators viewing the transaction between Emanon and Milesburg as a divorce at the medical center, referring to themselves as the "unwanted children" who no longer had a place with either "parent." Furthermore, the sale made more difficult the very thing that would be vital to the success of the Emanon/Milesburg arrangement—reaching agreement on a new governance structure. As leading organizational theorists Nonnemaker and Griner have noted, "It is more difficult to achieve a shared vision, integrated planning, and alignment of incentives among the medical school and its principal teaching hospital when they are not under common ownership."[ii]

The Economic and Political Climate

The Milesburg University Medical Center (MUMC) was exposed to the same financial pressures that plagued academic medical centers across the country, including changes to Medicare reimbursement under the Balanced Budget Act of 1997 that threatened the operations and missions of teaching hospitals. [iii] In a 1999 briefing, the AAMC predicted that the provisions of the Balanced Budget Act

would cost the average non-federal teaching hospital around $45.8 million in reduced Medicare payments alone by 2002, with 38% of such hospitals projected to lose money.[iv] The operating margins of major teaching hospitals owned by universities have been particularly hard hit since 1996.[v] Also hurting AMCs was the growth of managed care, resulting in both pressure to reduce costs and in an oversupply of beds.[vi] Furthermore, greater health care expenses, such as new medical technology investments, increasing compliance costs, escalating malpractice costs, and rising personnel expenses have added to the burdens experienced by AMCs.[vii] Leading medical centers, including MUMC, were in such financial peril that they could potentially have taken their university under with them.

Internal pressures had been building at medical centers as well. Since the 1980s and 1990s, medical schools have required clinical faculty to spend more time on clinical care and billing, often leaving clinical-educators with "little time to teach and even less time to do scholarly work."[viii] At universities nationwide, clinical faculty have grown exponentially while basic science departments have shrunk to the point that now, according to some reports, they comprise less than 20% of full-time medical school faculty members.[ix]

Under these difficult circumstances, contentious issues arise. While clinical educators have been under pressure to spend more time on clinical practice, the pressure on basic scientists has been to spend more time on research and obtaining extramural grant support.[ix] Furthermore, since tenure is linked to the publication of research papers, substantially fewer clinical faculty were even eligible for tenure. Between 1997 and 1999 just 24% of all new hires (assistant professor and above) of clinical faculty nationwide were appointed to tenure-eligible tracks, compared with an average of 68% between 1981 and 1983.[x] The merger agreement between Emanon and MUMC called for the elimination of tenure for Emanon-employed clinical faculty, adding yet more uncertainty to their ability to sustain their academic credentials, and deepening the sense of separation between faculty. All of these issues affect how faculty—researchers and clinical educators alike—identify themselves.

A Financial Imperative

At the time of the Emanon sale, the degree of economic risk represented by Milesburg's Medical Center threatened not only the medical center but the university at large. From 1996 through 2000, the medical center lost approximately $250 million, most of which occurred in the clinical enterprise.[xi] Losses forced the university to borrow $100 million to pay for renovation and technology projects on the main campus and at the Law Center,[xii] and led Moody's Investor Services to downgrade the university's bond rating.

Under these conditions, the university's board of directors authorized the administration to find an entity to assume full responsibility for the clinical enterprise. Agreement was reached with Emanon two years later. Milesburg received an up-front payment of $80 million, plus an additional $15 million for the

rights to certain clinical facilities.[xi] Emanon took control of the 3,000 to 4,000 medical center employees, including about 250 faculty physicians.[xiii] The agreement also ensured that Emanon would continue to participate in the clinical teaching programs of the medical school.

While the sale solved the immediate problem of continuing to manage a debt-ridden clinical enterprise, it raised new concerns. Medical school faculty now had two separate employers, with researchers employed by the university and most of the clinical educators on the Emanon payroll. The question for clinicians was what role did they have in the academic mission—how would their Emanon employment affect their academic role and their status as faculty members? As negotiators note, when there are political strains, members of a group can feel "unrecognized, underrepresented in important decisions, and exploited."[i]

If the Emanon/Milesburg University partnership were to succeed it would also be important to resolve what Fortgang, Lax, and Sebenius refer to as "the spirit of the deal."[xiv] A governance solution that both identity groups—clinical educators (Emanon employees) and researchers (Milesburg employees) would be comfortable with was critical to the stability of the deal and the future of MUMC.

Conflict Resolution

Long before the agreement with Emanon, the university had been investigating ways to change its organizational design to reflect changes in the economic environment. Recommendations from three previous task forces and committees had failed to overcome stakeholder affiliations, however, and the governance structure remained unresolved. The sale of the hospital exacerbated competition between the medical center missions—Emanon-based clinical educators and university-based researchers—for resources and for share of voice in any new structure. Problematic though agreement would be, restructuring would be critical to the success of ongoing operations. It was with this in mind that efforts for a collaborative process got under way.

Stakeholders across the medical center worked in partnership with the authors over a nine-month period, broken down into four broad phases.

Table 1

Phase	Timeframe
1. Preparation – Gained understanding of the environment and the interests at stake through interviews with internal stakeholders and outside experts	April
2. The Negotiation – Drafted the governance document over the course of ten facilitated problem-solving meetings with the microcosm group.	May – July
3. Commitments and Agreements – Vetted the new structure with faculty groups.	August – September
4. Influencing Public Opinion – Worked out a final structure with the president and took it on a "road show" with faculty.	October – December

The process created a forum for dialogue, in which complex issues were explored from many points of view, where before there had been only debate and discussion. As negotiators have discussed, the point of dialogue is to "go beyond any one individual's understanding" of a particular situation, to provide insight that could not have been achieved individually.[xv] A framework known as track-two diplomacy, which establishes informal interaction between members of adversarial groups[xvi], was employed to help navigate and resolve the inter-departmental hostilities and to arrive at an outcome that would benefit all parties. Track-two diplomacy uses a facilitated, interactive problem-solving method to engage members of adversary groups in a series of dialogue sessions aimed at producing outcomes that benefit all parties, rather than a single "winner." Using these negotiation techniques, a foundation was created for a new culture based on collaboration and on a shared vision for advancing the center's educational mission.

1. Preparation

The perceived difference of interests, both hierarchical and inter-departmental, necessitated a process that would be inclusive, open, and constructive, while ensuring that any outcomes were within the parameters of the agreement between Milesburg University and Emanon. The first step was to unearth the interests, perceptions, and aspirations of all parties regarding the way the medical center was and should be governed.

Central to the preparation phase was the formation of a "microcosm group." The microcosm group consisted of representatives brought together to develop "workable personal relationships," understand the perspectives of the other players, and develop ways to tackle conflict as a "shared problem." [xvi] The group, which was formed by President DiSimone, reflected the range of viewpoints at the medical center and comprised a number of highly respected faculty from across the medical center. Members of the group did not explicitly represent any particular constituency, but rather acted as a sounding board to vet and discuss alternative ideas. In keeping with the track-two approach, the process enabled participants to analyze perceptions (including how they view themselves and colleagues in other departments), explore conflicting views and common ground, and expand on ideas and solutions.

Throughout this stage in the process, all stakeholders were invited to join the discussions at any time, and all faculty members received regular updates on progress made from those at the heart of the discussions. A transparent process was paramount. As Mallon notes, "secret negotiations are an affront, in particular, to the academic culture."[xvii]

During dialogues in this first phase it became apparent that there was widespread agreement on two crucial points—that the old governance structure was dysfunctional, and that maintaining excellent education and the reputation of medical center were paramount. Faculty were, however, deeply at odds over the specific structure of a new governance plan. Added to this was uncertainty about

how the mission of the medical center could be carried out across two organizations. Traditionally, the academic mission comprised three parts—education, research, and clinical care. With the sale of the clinical operation, it raised questions over whether the clinical operation would remain part of the medical center mission. This threw into doubt whether clinicians would have a place in the mission, and was one of the key issues that the dialogue addressed.

2. The Negotiation

The second phase took place over 12 weeks. The microcosm group held a series of problem-solving meetings that focused on addressing the issues at stake and exploring possible solutions. In what might appear to be a counterintuitive move, this work began by emphasizing the differences between constituencies. The goal was to encourage participants to confront and work through these differences from the start, rather than risk a standoff over these issues at the end of the negotiation. This was vital since "the recognition of historic grievances and hurts is a critically necessary early step in any psychologically sensitive conflict-resolution process."[xvi]

As the meetings progressed, members of the microcosm group began to realize that the structural problems were solvable. One example of this was defining the composition of the main advisory body at the medical center. This body had been dominated by administrators (deans, associate deans, and department chairs) and clinicians in the past, and had only one faculty representative. At the start of the negotiation, there was a sense that there simply could be no agreement on a new composition, and that a solution would have to be imposed from the top. For example, many department chairs felt that each chair should have a seat on the executive committee, which would have continued the legacy of little meaningful faculty representation in this body. Framing the debate in terms of institutional share of voice—Milesburg's and Emanon's—had served only to accentuate the divisions within the medical center community and reflected differences of opinion as to which group was most important to the mission.

As the process unfolded, however, participants began focusing on the fundamental academic mission of the medical school, and from there a solution was posed. It was suggested that the advisory body be re-framed to represent the missions—medical education, graduate biomedical education, research and nursing and health studies—rather than the institutions. This was a breakthrough moment in the process; one which would not have been arrived at had the group not taken the time and energy needed to explore differences.

By the end of the second phase, perceptions and divisions had begun to break down and alliances had formed between formerly adversarial parties. Participants began to understand that they shared a common goal, that being to protect and promote a successful medical center that would offer premier education and research to the larger medical community. To achieve that goal, it was clear that all faculty were vital to the academic mission. Perhaps more critically for future debates, the process of working through problems together created a forum for

faculty to grapple with common issues and to address future problems, since group collaboration enables parties to "redefine their conflictual relationship as a joint predicament to be jointly resolved."[xviii] A powerful example of this occurred soon after this phase, when the group successfully addressed the problem of creating new academic faculty tracks for Emanon employed faculty, to recognize various levels of academic achievement. Throughout this second phase, and in keeping with an open-table philosophy, the microcosm group expanded into a "microcosm-plus group" to include points of view of the faculty at large, before contracting again to consolidate ideas for the drafting group.

3.Commitments and Agreement

The ideas that had arisen during the series of meetings in the negotiation phase were translated into a set of recommendations for the new governance structure during phase three. A drafting group, a subset of eight members of the microcosm group, was created to develop the governance document. The composition of the drafting group was important both practically and symbolically; therefore widespread representation on this group was critical. It was essential to ensure that concrete solutions addressed the range of interests that had surfaced during the problem-solving sessions, and that the agreement would not fall short of any group's expectations. Symbolically, if both the microcosm group and the larger medical community were to accept the draft, it was important to show that no one had been left out of the process.

The language in the draft agreement became the basis for further negotiation between the groups. As ideas and concepts began to take shape on paper, it clarified the thinking about specific interests and pushed participants to find solutions that met the needs of faculty and the university at large. As is the case in all politically charged situations, it is important for participants to balance their interests with that of the organization as a whole.[i] The negotiation process allowed participants to better understand the interests of the university at large, rather than just their slice of the environment.

4. Influencing Public Opinion

During phase four, the draft recommendations were shared with a wider range of stakeholders at the medical center, including the faculty as a whole, influential university groups, and Emanon's leadership. The process of influencing public opinion was geared toward establishing "a climate of opinion within a community" that clears the path for a leader to move toward resolution.[xvi] All stakeholders were invited to offer input to the university president to inform his thinking and decision on a final governance structure. Although it had been an open-table process throughout, there were concerns that those who hadn't participated in the microcosm group meetings, despite explicit invitations to do so, would be less committed to the process. It is customary for those closely involved in negotiation workshops to gain an understanding of the conflict and an altered view of those

once seen as adversaries, but problems can arise when those ideas are brought back to the community at large. [xvi]

While not all faculty had embraced this process, President DiSimone was presented with the diverse and deeply considered thinking of a varied group of medical center stakeholders. Most importantly for the credibility of this document, it was negotiated and created by faculty. Ultimately, it was the support and commitment of President DiSimone to that process—a process that was fundamentally different than the hierarchy-bound culture of medical centers in general—that enabled a new governance structure to be implemented.

Governance at Milesburg Medical School

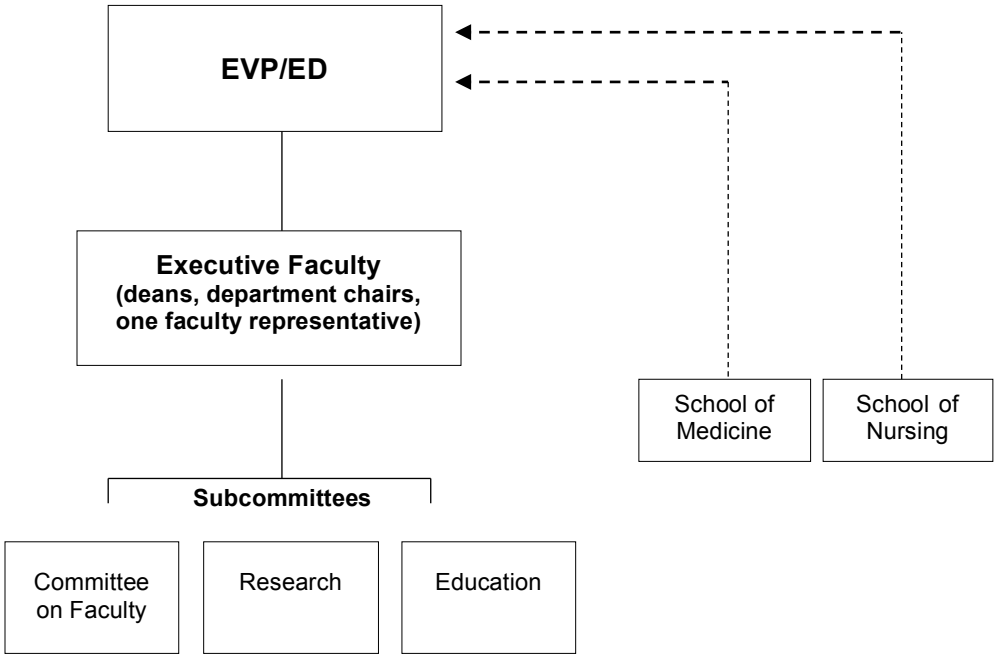
The negotiation process helped to resolve what Fortgang, Lax, and Sebenius refer to as the social contract, including how parties interact, how unforeseen events are handled and how to resolve disputes.[xiv] What was achieved in the nine-month negotiation process was to reach agreement on a structure that represented a new mission in which university-based faculty and Emanon-based faculty would work together as colleagues, and in which faculty were centrally involved in decision-making. Below, we outline the key features of both the previous structure and current governance structures.

The Way it Was

At the head of the former governance structure was the EVP, who in theory received advice from the governing body of the medical center, the Executive Faculty. The Executive Faculty was chaired by the EVP, and was composed of department chairs, deans, and associate deans. There was one faculty member on the Executive Faculty, who also served as the chair of the Medical Center Caucus of the University Faculty Senate. Any medical center policy required formal consent from this body. However, because all of the chairs reported directly to the EVP, there was effectively little meaningful input from this group on decisions made by the EVP.

Figure 1
The Old Organizational Structure

The EVP needed consent only of the executive faculty (deans and chairs.) There was minimal input or agreement from faculty at large.

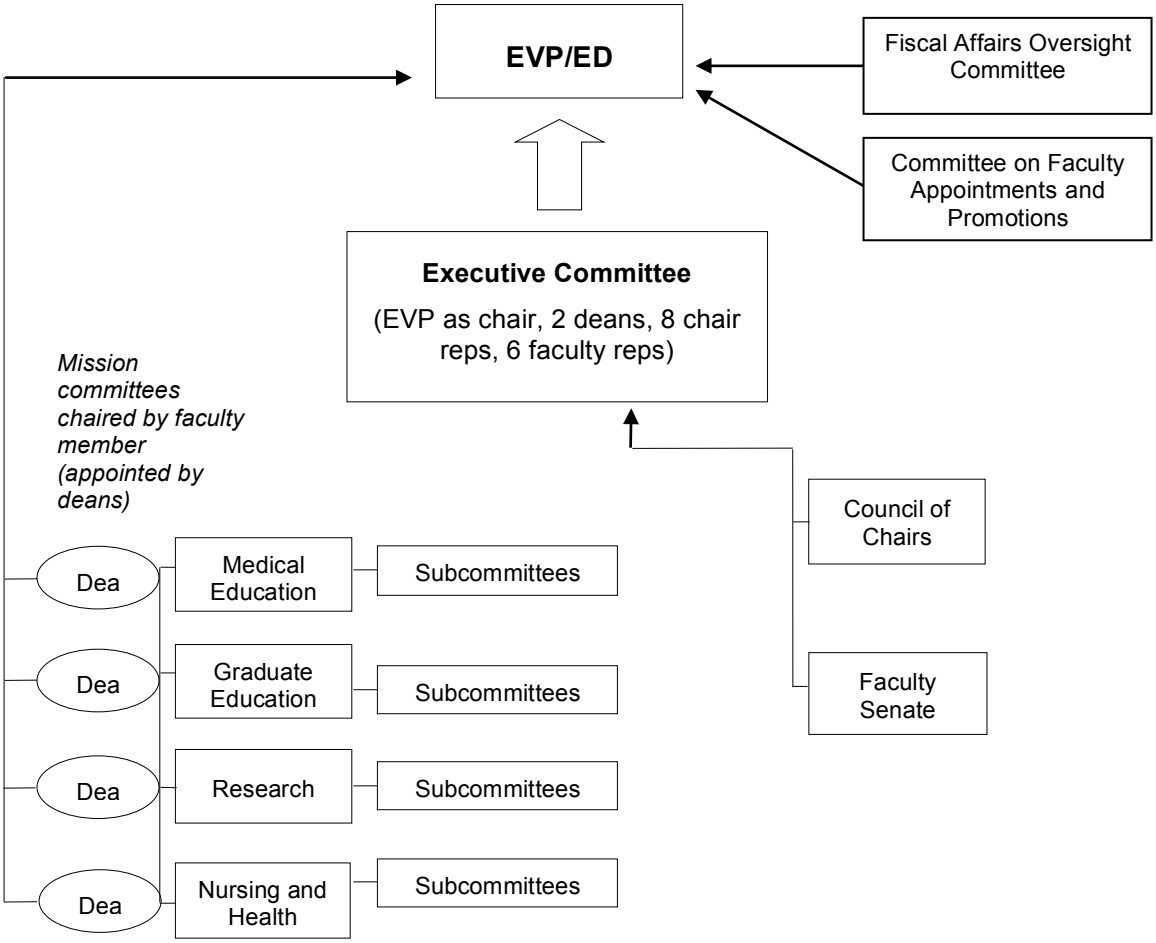


Governance Post Negotiation

The new governance structure is led by an EVP who is also Executive Dean of the Medical Center (EVP/ED). He works in collaboration with deans, department chairs, two advisory bodies (the Council of Chairs and the Faculty Senate), and a newly-formed Executive Committee.

Figure2
Shared Governance: The New Organizational Structure

The EVP has authority to make all decisions, but also has greater accountability. The EVP is advised by the Council of Chairs, the Faculty Senate, and the Executive Committee. The structure allows a checks and balances system that had not previously existed.



While the EVP actually has more authority to make decisions (the advisory bodies are just that—advisory, versus consent), should he or she choose not to follow the advice of the advisory bodies, the EVP must explain in writing the basis for that decision. This ensures greater accountability in decision making in that the EVP must both solicit the advice of the advisory bodies, and provide an explanation when that advice is not followed.

Roles of Faculty

The deans of the medical center's four academic missions—the School of Medicine, the School of Nursing and Health Studies, Biomedical Graduate Education, and Research—propose plans and budgets for the operation and development of their respective areas to the EVP/ED, retaining responsibility for

the overall management of their missions. The two independent advisory bodies, the Council of Chairs and the Medical Center Caucus of the University Faculty Senate, serve as forums for discussion of academic and administrative policy at the medical center.

Both advisory bodies provide recommendations to the EVP/ED through their representatives on the Executive Committee. The Executive Committee is composed of representatives of the advisory bodies and of medical center leaders, including four elected clinical chairs, three elected basic science chairs, the director of the Paterno Cancer Center, six elected faculty members, a university leader selected by the EVP/ED, the senior dean responsible for each academic mission, a Emanon leader, and up to two additional members appointed by the EVP.

Faculty Tracks

The sale of the hospital to Emanon caused both concern and confusion for MUMC faculty members. After the agreement was announced, faculty physicians noted their anxiety over compensation issues, and professors who were previously tenured were worried about their academic status.[xiii] During the negotiation process, the issue of faculty tracks had been one of the most contentious, since it raised questions about the role clinicians would play in the medical center mission. As mentioned earlier, the manner in which clinicians would balance clinical practice and education was uncertain, as were the opportunities they would have to pursue their academic activities at the medical center. It was critically important to create faculty tracks for clinicians so that their academic accomplishments could be appropriately recognized.

After the new governance was put in place, a system was established to recognize the varied contributions that each faculty track makes to teaching, academic administration, and other scholarly activities. The agreement with Emanon included the elimination of tenure and tenure-track lines for clinical faculty, and no appointment to tenure-track for Emanon-employed faculty. Therefore, to ensure that academic accomplishments on the part of clinicians could be recognized, standards were developed for a clinical scholar track, a clinical educator track, and a clinician track. Non-Milesburg University clinicians who are on clinical scholar tracks hold the same (non-modified) titles as tenured faculty employed by the university (for example, Professor of Pediatrics rather than Clinical Professor of Pediatrics). Emanon, however, retains all economic responsibility for clinical faculty.

Conclusion

Issues remain to be resolved with regard to the dual role of clinicians, who are on the one hand required to increase their clinical load, yet at the same time are vital to fulfilling the central role in the clinical training of medical students. The

precarious financial situation continues to be a concern, and for many medical school faculty, the sale of the hospital still smarts.

Nevertheless, the success of both MUMC and Emanon depends on cooperation and partnership, and there is a real commitment from both parties to make the agreement work. Furthermore, the current EVP is committed to relying on the governance structure to reach consensus and agreements on matters of importance to the medical center. None of that could have been achieved without the process of collaboration, which drove faculty toward a unified view on MUMC's mission.

The negotiation framework enabled MUMC to work through the substantive problems the center faced—changes in ownership, financial pressures, and the need for a relevant governance structure and strong leadership. But it also allowed the medical center to address the less tangible issues—the divisions and stresses that arose in a difficult political climate and a sale that was painful to many. Both needed to be resolved for the partnership between Emanon and Milesburg University to succeed, and to safeguard the future of the medical center.

Milesburg is not the only university to have taken such a dramatic step. Indeed, academic medical centers across the nation have taken action or will likely be forced to take action, to stem the economic drain, including several that have sold their hospitals to for-profit hospital chains.[xix] As these situations arise, medical faculty will face the difficulties that MUMC was forced to confront, and an understanding of a process that led faculty to agree upon the mission might help others to tackle similar issues.

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