**9UNP0123SD\_Steven Wartman**

- It's great to be back and to see to what good use this building has been put. It's wonderful to see it's being used with all the different students in the various venues. And it raised a question that I asked earlier to Gordon, I said, well what did you do before this building was built? How did the students get taken care of? I guess that's something to think about. But it's a pleasure to be here. I'm not here to talk at you. I'm not here to give a lecture. I'm here to try to raise some issues, which I hope you will find stimulating and provoke some discussion, about issues surrounding the big picture as it affects the nation's academic health centers in general, and this academic health center in particular. I've got just a few notes that we can go on, and so forth.

A couple of years ago, I was very happy in my position as executive vice president and Dean in San Antonio when I got a call asking me to look at this position at the Association of Academic Health Centers. And I must say at the time, that I was not familiar with that organization. And it's possible that many of you are not familiar with it as well as. I had, of course, been very active and familiar with the AAHC. The person was very persuasive on the phone, and I went and looked at the position. And I realize there was a whole other world out there. A world that existed beyond the of world medical schools that may be assuming a very important role in the future. And that organization, the Association of Academic Health Centers, is not a discipline-specific organization. In other words we're not representing medicine or physicians, we're not representing nursing, we're not representing pharmacists. Specifically, we're representing everyone.

It's a non-disciplinary specific organization that's an umbrella organization for all the components of academic health centers, which we define as an accredited degree-granting institution of higher education that consists of a medical school. That medical school can be either allopathic or osteopathic. And I must say I have learned a great deal in the last couple of years about osteopathic medicine, as they are very active members. Plus, one or more other health profession schools or graduate programs. So for example, nursing, allied health, pharmacy, dentistry, veterinarian medicine, public health, of course, and graduate studies in the biological sciences. And that's one more "and" to our definition, an owned or affiliate relationship with a teaching hospital, health system or other organized healthcare provider. That's sort of our definition of what an academic health center is. A fascinating creature. One that is undergoing a great deal of evolution. And I had the impression when I was interviewing for this job that there was a wave out there that was building, a wave toward integration.

An integration of academic health centers in a very substantive way. And that this organization could be part of that wave and help and facilitate some of the organizational and structural changes that are taking place amongst academic health centers. And not only, by the way, in the United States, but I'm learning in various places around the world as well. So what I'd like to do is go over that with you a little bit today. Some of my views about these organizational issues. You know, it may not sound very interesting to you at first, but it really is interesting. It's kind of fascinating, because you need to take a step back and look at the big picture. And I try to put these pieces together for you. I'd like your reactions to some of the things that I'm about to tell you. So getting back to the AAHC, we represent all the components of academic health centers, we have a mission statement, a vision, etc.,

I'm not going to bore you with that. But let's first look at academic health centers in the larger societal context. We're going to do a lot of big picture stuff right now. We're all aware that there are a lot of forces that are driving change within our academic health center complexes. I can pick just three of them and we can discuss them briefly. Science and technology; demographic, socio-cultural and political trends; and the third would be just economics. These three categories of forces are impacting quite dramatically now the nation's academic health centers. Let's look at them very briefly. Science and technology is something I don't need to dwell on for this audience, but there clearly is exponential growth and discovery in everything that's going on right now in the basic mechanisms of disease, human genetics, proteomics, information technology, new medical devices and tests. You know, I had a very interesting discussion.

I'm part of a group called the Blue Ridge Group, which puts together some very interesting reports every year. And they talked about knowledge management and medical decision-making. We had somebody come in from Vanderbilt, who is an expert in this area and said, you know, an average clinician can juggle about five facts simultaneously in making a patient decision, comfortably. And actually, if you are a really good specialist, you can probably do up to ten-- five to ten facts. Well right now, we suspect in the next five to ten years, the good clinician will need to juggle about 100 facts. And that if this curve continues of information development, in 20, 30, 40, 50 years, there might be a 1,000 facts that surround a clinical decision, which is beyond the capabilities of the human mind, far beyond the capabilities of the human mind. What does that mean for healthcare delivery? And what does that mean for medical decision-making? You begin to get into these kinds of discussions, and you realize the power of science and technology to change drastically the way we do things and the way things are going to happen. So that's a force that is very powerful and is one that we're comfortable with, because we know about science, we know about technology.

we don't know where its taking us, we don't know where it's leading us, but we understand the basic ethos of science and technology. But when we get into the second area, socio-cultural and political trends, well you know, we get a little more uneasy. To realize that our enterprises are vastly impacted by socio-cultural and political trends. You could pick, just simply, the aging of the population, population growth, issues in chronic disease, end of life management, and a host of socio-cultural issues and political issues that are beyond our control. We like to be in control of things. And these are way beyond our control. Yet all of these factors dramatically affect how we do our business, how we get our work done, how we are employed, how we take care of people, how we run our lives. And that's a huge factor. We're undergoing tremendous demographic changes in the United States, and around the world. These will impact what we do.

In politics, you know, who knows? Except that healthcare, and I'll talk about this a little bit later, is emerging other than the war in Iraq as a lead issue in Washington. And I want to get into a discussion with you about that. So, socio-cultural and political stuff, very important. Then finally, brute economics, you know we have to pay our bills, don't we? We want to grow and expand. And we want to grow in development. I got a quick look at some of the buildings going up on the campus. And my reaction was, okay, how are they paid for? What debt have they incurred?

How will you keep these buildings open, the electricity going, fully populated and flourishing? Especially in an era where NIH has lost considerable purchasing power. An NIH dollar is not worth very much compared to what it used to be worth. I met with Dr. Zerhouni recently, a couple of weeks ago. We meet on a regular basis. And he said tell your folks to be prepared for 2-3% increases for the foreseeable future, which you know, doesn't even keep up with inflation. So, I look at these buildings and I think okay, how does this great university and this great academic health center going to keep the lights on, the researchers flourishing and everything else happening. There are three things that happened in the last 30 years to drastically affect the economics of academic health centers. The one is the BiDole Act.

Is everybody familiar with the BiDole Act? Is anybody familiar with that? It passed in, I think it was around 1980. I don't need to go into that. It was really very seminal in allowing universities and other entities that receive federal funding to harness the intellectual property that they produced. And has spawned a revolution in tech transfer amongst the nation's universities and academic health centers. It had a very profound impact. It opened up avenues for licensing and commercialization that are indeed very, very powerful. And I predict, in an era of constrained NIH funding, it will become even more important, as we work in the area of tech transfer and intellectual property, intellectual property bundling, and things of this sort. However, the real change in 1980, we're only just beginning to see the full impact of that.

Then there's something called the anti-tax movement. When was the last time a politician got elected who proposed tax increases? Can anybody tell me? Does anybody have a memory of that? There had to be somebody, or maybe that person wasn't elected. But can you think of anyone who was elected on a platform of tax increases? This is one of the most interesting sociological phenomena in the United States. For the past 30 or so years, we've had an anti-tax movement in this country that has been indeed profound. And it has affected so many aspects of our public lives, in terms of the basic infrastructure that we have: Police, fire protection, social services, funding of universities, education. It goes on and on and on.

But we've adopted a very, very powerful anti-tax mentality. And that has had dramatic, and some people would say draconian, I'm not necessarily saying that, but they've had dramatic impacts on the way we fund things and how we look for money and resources for things that don't necessarily make a profit. We don't look for a fire department or a police department to turn a profit, do we? And then finally, I think perhaps the most significant economic force has been the rapid growth of the market in healthcare. You know, the times have changed so dramatically. You know, direct advertising to patients by drug companies is a fairly new phenomenon. Yet, we can't escape it on television today. In the early 1970s, under Richard Nixon, there was an opportunity for national health reform. Nixon believed in HMOs. He saw an opportunity.

This was opposed by organized medicine, socialized medicine. And a very hard fought campaign was successful in not letting that move forward. I think what happened is that was a very short-sighted campaign. Because instead of having socialized medicine, a far stronger force has come into healthcare. And that is the force of the free market and the free market economy. And that's been very dramatic in the last 30 years. Extremely dramatic. And as a result, enormous wealth has been created in the health sector, in the trillions of dollars. And I'm not talking wealth in the hands of rich physicians and specialists. I'm talking about wealth in the hands of insurance companies and medical device companies, and spin-offs, and all the things that surround the health market.

Enormous wealth. When you think about how changing the healthcare system, you know, somebody's got to reach into those pockets and take some of that money away, a very, very difficult thing to do. Even more concerning about this has been that the market, as efficient and effective as it is, is a very blunt instrument. It seeks profit. And there are many aspects of healthcare delivery that are simply not profitable. Certainly not in the short-term. And the market tends not to move in those directions. It tends to move in other directions where profit can be had. So you see for example, more and more activity in cosmetic surgery. There's an interesting study, and I'm probably going to misquote it, because I don't remember exactly the facts and figures, in a dermatology journal within the last month or so, in which they looked at time to schedule an appointment with a dermatologist.

And I can't remember what state it was in or what kind of national sample or local sample it was, but they had two things. If you had a mole that you were concerned about, it might be changing color, you wanted to get it evaluated, the average wait time to an appointment was 28 days or so. But, if you wanted to get a wrinkle taken care of, it was much less, maybe 10, 12, 14 days. I think there's a message there. There's a message about the market in healthcare that's very profound. And to me that is a substantial thing we have to consider as we look at the landscape of healthcare reform and the forces that are impacting on our nation's academic health centers. So if you take these together, socio-cultural and political, the BiDole act, economic forces and so forth, science and technology, and there's probably a host of other things that I haven't mentioned. These are contributing to a fundamental remolding of what we call the academic health center enterprise. And the remolding, in the broadest terms, that's taking place is from an ivory tower to a complex business enterprise. Ivory tower.

Complex business enterprise. All in a generation, or so. Big change. Big change. We just need to be aware of it. But unlike business enterprises, academic health centers have missions that must go on regardless of profitability. We can't tell your dean that we have a little shortfall in the budget next year, I guess we won't educate third-year medical students. You know, "That's a no-go folks." We have missions we just can't discard. So the complexity of our business enterprises are doubled or tripled by the fact that we can't truly run them as businesses.

I had the honor of giving a talk at the business school at the University of Texas at Austin to some MBA candidates. And I to convince them in the course of an hour that running an academic health center was more difficult than any other corporation you could think of. And of course, they laughed a little bit when I started with that, but they all agreed with me at the end. Where else can you not cut product lines that are not profitable? Where else do you deal with things like tenure? Where else do you have the comprehensive regulatory web that engulfs us in almost everything that we do. We are in a transition to a very complex business enterprise that can't be run strictly as a business. Anybody want to make any comments or things before I get to a little bit more specific level of stuff? Anybody have any reactions to things that I'm saying? Am I off base, or is some of it resonating, or comments of any kind?

I'm sure this is not a bashful group.

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- (inaudible)

- That's a really great question. I've evolved so much on that issue. I've gone through so many permutations. And I think it's a great, great question. What is it going to take to make a fundamental change? First of all, I don't think that the health system is dysfunctional. I don't think that the health system is unsustainable.

I think people who tell you that are missing the boat. Because I come from the school of thought that says every system is perfectly designed for the results that it gets. Our system is perfectly designed for the results that it gets. Bad outcomes, expensive, etc. Beautiful. It works fine for that. I've come around to a philosophical point on this, my philosophical point is this. It kind of dawned on me when I was up in Canada. And that was before I saw the Michael Moore film, Sicko. And I don't know if anybody's had a chance to see it.

I was up in Canada, and I was attending a meeting of the organization that's kind of the companion organization to ours up there. There was something going on in Quebec at the time, some bill for more private health insurance, or whatever. And they were having a debate over this. Speaker after speaker after speaker came up to the podium and said we can't have this bill because it violates the fundamental Canadian principle of solidarity. As a people, as a country, solidarity. We care about each other. We want to have a safety net that's meaningful and real. That really made an impression on me. Then I saw the movie Sicko, which I agree with the critics. He takes small examples and generalizes to whole health system in France, or wherever, you know, and does the thing in Cuba or whatever.

But he makes the same point, which is that, you know, when are the American people going to start to care about each other. So I've come to the conclusion that substantive healthcare reform in this country is only possible when there's a change in the American psyche. A change from being rugged individualists, who, you know, pull yourself up by the boot straps and get the job done. And if you can't do it, tough, kind of thing, to a change where we care about each other. Whether that's even possible. Because I think to get substantive change requires a change in the psyche. And I've written a little piece where I say change the psyche before we change the system. Whether that can happen or not, I have no idea. But there's where I'm evolved to at this point in time. Yes?

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- (inaudible)

- You're getting into a lot of important issues here. Thank you for raising that point. First of all, there's the whole patent law situation. There was just a patent bill that was passed recently that you might want to look at, I think yesterday or today. We do have a dysfunctional patent system, which impacts everything that we do in terms of intellectual property. But the future in intellectual property for universities, we believe now, is more in what we call IP bundling, intellectual property bundling, because it turns out that for many discoveries and particularly on the road to commercialization, there are many, many points along the way where things have to be joined and put together. It's not one thing, often, that is the thing. It's this in conjunction with this, which puts this, and this device is made to work with that, whatever.

So we put together a group to deal with issue of IP bundling. We think that will be a powerful change agent for academic health centers to work together, or amongst each other in new ways to get IP bundling done, which will help commercialization and which will put forward, I think, a much more doable kind of structure for reaping some of the economic rewards. But really what we're after is just good commercialization of our products. So it's a complicated area, I'm not an IP lawyer. I've talked to a lot of them. We need reform in the patent law. But you think we need to have this idea of working together, bundling our intellectual property, as a way to have a substantive change in how things are going now in tech transfer. Right now, many offices are doing the best they can, hoping to get a hit. It's almost like playing a roulette. You have a lot of things coming in, and maybe something will happen and maybe something won't.

Sometimes, the incentives for the faculty aren't well aligned with tech transfer. You know, not just the inventor, but the lab, the department, the school, all should benefit. The university should benefit. And they're waiting for a hit to come through. We think that by bundling things together, cross fertilization, we may have a better chance of having a more robust operation. But yes, there's a lot of activity in this right now. Yes?

- (inaudible)

Unless a miracle happens. Unless you have a "Gatorade," or the equivalent.

- (inaudible)

I would argue that it's necessary for us to do this, just the way that I would argue that the necessary for us to do clinical trials. If you look at the clinical trials operation at this university, I would venture that it's small potatoes in terms of revenue, compared to your overall research budget. A fraction, a small fraction of that. The risks are very high. It's a very high risk area. It's a very complicated area. Yet, I would argue that fundamentally academic health centers need to do that. We need to be a magnet for clinical trials. We need to be conducting them.

We need to be developing the new knowledge that comes from it. And the same thing with tech transfer. I think these need to be profitable areas for us so that we can sustain them, not necessarily make a fortune off of them.

- (inaudible)

Absolutely.

- (inaudible)

And we're also very weak in the area of legal help, in this regard. If you come up with something that you're going to be sued for infringement of somebody else's-- You need really deep pockets to sustain something through. So you're right about that. Yes?

- (inaudible)

I actually have-- It's in here. Can I save that for a little bit later, because I've got some very strong feelings about that. It's a very important trend. Yes?

- (inaudible)

Correct.

- (inaudible)

I think we've made a lot of progress. I really want to congratulate the AAHC for doing great work in this area.

You know, it's only as good as the disclosure in the first place, as you know. Getting a system of adequate disclosure has proven to be a challenge in many of the academic health centers around the country. Is it the faculty chose not to disclose, or they're not aware they should disclose, they're not disclosing properly, that's one thing. Then getting it into a database or a meaningful format that can be assessed by somebody is another thing, and then having a process in place to actually gauge whether this is a significant conflict of interest or not. And then if it is, how to manage that conflict is an enormous issue and requires a lot of resources. As we get closer and closer to industry, which we will do because of the changing financial economics, and the NIH budget getting flat, we need to figure out the best ways to manage those, and it has to begin with the idea of integrity. And it's got to start right at the top and go right through the entire organization. There's no substitute for that. It's got to be clear that this is a fundamental thing that we're going to do at every level. But it's a big, big issue.

Yes?

- (inaudible)

Yes I do. I mean, don't misinterpret me, I think the market is doing some great things in healthcare right now. And you want each sector to do what it does best. I think we're out of balance right now, that's all.

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Absolutely. Yes?

- (inaudible)

Well, what I see happening is changing relationships with the university. And development-- This is my mother's doctor again, hang on a second. Nope? Good. That's the only call I take during lectures. She's turning 90, so I've got to deal with that. She's a standardized patient at Jefferson Medical College in Philadelphia. I've written about it, it's an amazing story. But anyway, yes, I do. I think for universities like this one, it's in establishing new and meaningful ties with new departments, and other departments, that have not had good relationships with the academic health center in the past.

Departments of Sociology, Departments of Psychology, Departments of Humanities. All these other things that can be blended in. There's a clear trend toward doing that. Go ahead.

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Well, I've learned a lot about nursing in the last two years, let me tell you. As I have about pharmacy, and veterinary medicine, and dentistry, and so forth. There's a whole world out there that I'm just learning about. And we're just completing a major Macy's sponsored work force project, in which we're looking at work force shortages, particularly in the academic sector, but in the nation as well. I'm going to be reporting on that in October.

And it's clear that no one has really looked at the impact of a short in "X" health profession, impact on somebody else's health profession. So what does a shortage of nursing really mean? What does a shortage of radiology techs really mean? What does a shortage of neurosurgeons really mean for everybody else? We're trying to big picture this and to work on that work force area. It's very exciting. But it's one that I think also influenced greatly by globalization and the migration of health workers around the world. Let me jump back. This has been great, by the way. Let me just jump back a little bit here.

What's happening with organizational models? You have basically two prototypical or organizational models of academic health centers. You have the fully integrated model. And that's a fully integrated model where there's a single board of some kind, under which is somebody with a title, whatever it might be, chancellor, CEO, who knows, whatever that title is. And that person, everybody reports to, who reports to a single board. Hospital, clinical, health system, research, deans everybody, comes up through this one person, a fully integrated model. Vanderbilt would be a good example of a fully integrated model. Penn State is one that's thinking about, is pretty well integrated. University of Pennsylvania has integrated the medical school and the health system, but not the other health profession schools, so there's a prototypical model. The other is a splintered or split model, where you have the dean, for example, reporting to somebody, the Dean of Medicine reporting directly to not a provost, but to the president of the university.

And you have the other deans reporting to a provost, the other deans of the health profession schools. And there are many, many permutations of this particular splintered model around the country. If you ask, well why do you have the particular model that you have, you've got to look at your history, economics and politics. And that will explain why things are the way they are. Now, what is happening in terms organization to address the challenges that I mentioned earlier? It is clear to me, and I visited at least 40 or so academic health centers recently-- A trend toward what I would call corporate management. And I don't mean corporate in a pejorative sense, but in a management sense. What are we seeing by corporate management? We're seeing expanded roles for existing physicians, such as a VP for health affairs. That may be a single person called the VP for health affairs, or it may be the VP for health affairs and the dean title, or whatever.

What people are telling me and what I'm seeing is that the VP role is getting bigger and bigger all the time. So much so, that in many cases there's an executive dean, or vice dean or something like that to help run the medical school. VPs for research with system wide responsibilities, not just for running the compliance office or grants management or however, that is done, but the brain power, collaboration bringing groups together. Creating liaisons where there weren't before. Creations of new roles in this corporate management structure in compliance, and so forth. I'm seeing a lot of this happen around the country and a lot of reorganization along what I would call non-disciplinary lines. So the creation of centers, and institutes and other venues for cross fertilization of disciplines, breaking down the silos. Markedly increased efforts to relate to stakeholders. I know there are people here from public affairs and development. That is a big push right now.

Why? Because people need the money, and also because it makes sense. It makes good sense. The stakeholders are very broadly defined, including the public, and grateful patients and community leaders. But the stakeholders is a long list. Accelerating the transition of research into practice. That is a big push. The CTSA that you've gotten, congratulations. That's a wonderful coup for this institution, has been an example of that. Trying to move the continuum more towards translational and clinical research.

The gap between basic science, our knowledge, and what we're actually putting into practice is getting larger and larger. It's getting increasingly intolerable. And we need to try to close that gap. So there's a lot of effort now in the translational and clinical areas. Not isolated, but linked in the continuum. Globally minded. Somebody mentioned globalization, thank you. I've written a piece called, "The Multinational Academic Health Center." I am convinced that, if we're not today, we will be multinational organizations, in the truest sense of the word. I've been working closely with a group from Singapore, which is a very interesting island state, an island nation.

Duke is starting a medical school there. Some very famous researchers from the University of California have relocated there. They want to build an academic health center, an integrated model. I just met with them in New York last week. And I'm going to see them in November. It highlights this globalized phenomenon that's taking place in clinical care, in research and in education. And every place that I've been to has something going on in the international arena, although it may not be totally well organized, it might be decentralized, etc. But, you know, I have a vision that we're all going to be in this together globally, and that my organization can play a role in bringing this together. Academic health centers are, in a sense, apolitical organizations. They just want to do good.

We want to improve the public's health and well-being, whether it's the United States or around the world. Why can't we work together with our friends who operate centers around the world to develop programs? Mutual programs that seek to improve the public good, whether it's in discussing the dicey issues of the migration of medical personnel from around the world, from country to country; whether it's issues of public health, which are very dramatic and important; whether it's issues of research and education. I mean, there's so many things that we can do in a multinational sense. I think that your point is so well taken, that we will see our evolution into multinational academic health centers in the very near term. And Asia is going to be a place that we need to pay a great deal of attention to. If the 19th century was the European century, or whatever. If the 20th century was the American century, everybody's saying that the 21st century is going to be the Asian century, You've got to pay attention. You've got to learn what's going on and be part of it. So those are some of the things that I see happening, and this trend toward running it more like a business.

Remember I said the evolution from the ivory tower to a complex business enterprise. Very, very important. It means that the faculty and the staff have to change fundamentally the way they view their jobs. And not necessarily in a negative way. The sense of entitlement that is so important to many people in academia, needs to be understood in the context of doing something productive, and doing something productive that advances the strategic plan of the academic health center that everybody's labored on. Basically, we're in this together as an organization. And we all have to be moving in the same direction. It doesn't mean we can't have new ideas, we can't go out on promising on paths of research and investigation. But at the end of the day everybody's got to be working together toward the same ends. This gets to the point that I like to make, which is that we're getting to a point in our evolution where we cannot tolerate the degree of internal dissidence that we've had traditionally in many academic health centers, internal dissidence, friction between the medical school and the teaching hospital, friction between departments, friction between this and friction between that, and whatever.

That's a problem for us now, because it consumes a lot of time, a lot of emotional energy, and eats up a lot of resources, and you don't get anything done. And I'm convinced that those places that minimize internal dissidence through reorganization and corporate management or other good things, integration, are going to be the places that clearly advance and move ahead. Those that fall prey to the quagmire of internal dissidence in whatever way it develops, are going to have trouble staying where they are today. They're not going to be able to maintain even the status quo. I think you all know what I mean when I talk about that. So we're going to see a continuing horizontalization of the academic health center enterprise throughout all its mission and management areas. We're going to see a process of accelerated change. This is good, because I think the process of accelerated change enables you to make the tough decisions quickly. That will facilitate resource allocation. If you're stymied by a rigid structure, as many places are, you're going to figure out a creative way to get around it.

So I've been working with a couple of places that have intolerable situations between their hospital and their school, or their schools. It's tough because the hospital has a separate board, maybe not unlike here, and you need legislation to get around it, etc., so they're coming up with ideas, creative solutions because they're working together. Creative solutions, maybe a bridge board can be developed. Maybe a new position can be created that will oversee some of these things. People are trying to do what they can to get around rigid structures that are preventing progress and presenting people from moving ahead. Yes?

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Great point. I saw this yesterday in Chicago.

I won't tell you which institutions I was visiting, but I visited a whole bunch. You know, it brings to point-- There's two things going on in all these relationships between the academic health center and the university or the hospital there. You've got structure, and you've got personality. Structure and personality. Okay? Is the structure in such a way that it's impossible to get things done? And if it is, you've got to change that structure somehow, and be creative to do it. But even more importantly, are the personalities such that the job cannot be done? Because there are often people in leadership positions who don't have the personality that's integrative and collaborative in seeing the big picture. And it doesn't matter what the structure is, it doesn't matter what the org chart shows, you've got to have the personalities that work together.

In every hire that comes up, if I were sitting on a board or a search committee, or whatever, looking for somebody in an important leadership position, the main thing I would look for, maybe personality isn't the right word, but I would look for someone who's got the skill of working with other people, and is not totally focused on advancing their own career, but are looking at the big picture for the organization as a whole and willing to work with people and to develop new relationships and that float new ideas, and to bask in the reflected glow of other people around them, rather than being themselves. Do you see what I mean? So yes, this is a big issue. The thing that causes almost the maximum amount of casualties in leadership positions that I've been in, I've noticed in the last couple of years, has been friction between-- personality clashes, essentially. Friction between a leader here and the leader right above that person, whether it's a university president or somebody else, whoever that might be. The compatibility there is absolutely crucial for getting the job done. Now some places have put into place, have a university president that puts into place, a structural format that protects the president from problems that might occur in a health center, because it's such a high risk, high profile, high economic driver. And therefore, will delegate a good amount of authority, not to a provost-- A provost generally comes from the humanities. And they're brilliant provosts around the country in history and whatever, but they don't know much about how to run an academic health center, what it means, what it's all about. So they will delegate that to another person who has that responsibility.

And that person could have the title of vice chancellor for health affairs, or whatever. Some university presidents don't want to do that, because they don't like having two reports. And they think they're taking something away from the provost and doing something bad with the university. But in my experience, I was involved on a blue ribbon panel, in a very high profile investigation, involving a failure of a major transplant program at an institution in the country. It was the kind of program that just went belly up with a lot of bad publicity. And all kinds of bad things happened. We went out to investigate it. And what we saw was not that anybody was doing a bad job, or criminal, or anything like that. What was happening was that everybody in their own narrow sphere was trying to do the best they could, and felt that if you gave them another couple weeks or months, they could fix the problem. So whether it was transplant director, the hospital director, the dean, it didn't really matter.

They all were trying to do their job. What was missing was that there was nobody between the president and the academic health center to point that out to anybody. And the president certainly didn't have the time and the inclination to be able to do that. We recommended putting somebody in that particular position. So I'm a big advocate of empowerment at the university level of someone to oversee the complex enterprise of the academic health center in a sophisticated way and in a way that harmonizes what goes on with the university. That's not a message that everybody likes to hear. There are many people who feel that's not the way to go, because it's not good for the university, etc. That's my position right now. But you're right about that being an important point of departure. There are many, many examples of that.

But I think your point is exceedingly well taken. Thank you. So in the end, I would posit that those institutions that are more effective in integration, or more effectively able to integrate their components, will be the ones that will be successful. Those that are unable to do so are stymied by either rigid bureaucratic structures, or personality things, or whatever, are going to struggle to maintain the status quo. There will be an increasing gap between the two kinds of institutions. I was going to conclude with a couple of comments about healthcare reform and what's coming up on the horizon in Washington, and maybe a little bit about the association, but I get the sense maybe I've gone on too long. Do you think I have? Before I move on to that, if you have the time and patience, would anyone like to comment about some of the thoughts up to this point, about organization and management and things of that sort? Yes?

- (inaudible)

Correct.

- (inaudible)

That's a very insightful comment. Could everyone hear what he had to say? That was extremely insightful. I thank you for bringing it up. I think it's a leadership issue. I think it's a leadership issue that is emulated from the very top. I think it has to do with transparency of management, and transparency of management decisions and sharing of information. One thing I've learned about academics throughout my career is that if you give academics information, they will pay attention to it.

And if you give them feedback they will understand that feedback. If you tell them why you made a decision, whether they agreed with it or not, and were willing to tell them, that's good. That's transparency. So I think to develop this kind of change, cultural change, it's a change that starts at the top with transparency at all levels and the sharing of information and data. But it's a long row to hoe.

- (inaudible)

Yes. No, no, I mean-- Tenure, you mention that word and you get a room full of people very quickly. It's an interesting historical perspective on tenure, if you read about it. I believe it started with the church many centuries ago.

And I mean, it's a whole interesting thing. Basically, there is a cultural difference between being part of an academic health center and being part of a university in say the department of English or Psychology, or one of the other departments. There is a difference. The fundamental difference is in how the economics works and what the expectations are. Bridging that is very, very difficult. I think that, again, I would posit that discussions with the leadership of the Senate would be a very worthwhile thing to have, to try to achieve some level of understanding. You know, often Senates, especially universities view the administration as the dark side. You've crossed over the line. You're the enemy. You're the evil, or whatever, because they have a lot of false ideas and misunderstandings about what it is that administration does, and what their responsibilities are, and how complex and difficult their jobs are.

Trying to demystify academic administration for the Senate and for the faculty in general would be a wonderful thing to try to do. One thing I always would have liked to have seen is for universities and academic health centers, in particular, to develop leadership programs, where they train the next cadre of academic leaders through whatever kind of program they might set up and put together. I know Emory has tried something in that regard, to demystify this whole thing, because academic administration is exceedingly important. It's not the evil part of the university. It's something that can make things happen and make things happen for the better. But it's a very difficult job. And I think communicating that to the Senate and the faculty on a regular basis is important and then engaging them to come over and try it a little bit and see what it's like. It would be a good idea.

- (inaudible)

The answer is yes.

I'm saving that for tomorrow.

- (inaudible)

Is that okay? (laughter)

- (inaudible)

Let me refine that a little bit. What the market does really well in healthcare is it responds to what people want and can pay for. That's what the market does. As opposed to what people need. You know, there's a big difference between want and need.

Market driven responds to want. You want to get something and you have the money to pay for it, you're going to get it. But you need a whole bunch of other things that you may not want or can't afford. In that case, that's where the market falls down. So that dichotomy is very important. But I think both of them have a role to play in an overall healthcare system. I think the want is an important component, the need is more important. How are we doing time wise?

- (inaudible)

Okay.

- (inaudible)

I think that when you think about it, as economics gets tighter, as the NIH budget is level or declining, it gets more and more attractive to take money from industry. My view is that that money never comes with strings unattached. There's something attached. It may be nearly invisible, but it comes with strings attached. It doesn't mean in my view that you should never take it, but it means that you need understand those strings, and what they mean, and whether they fit in with the overall guidelines of the university and the academic health center. I think you need to have-- It's a cultural thing for each place to decide what level of comfort they have with those kinds of relationships. And, more importantly, how do you manage those relationships. Do you have a clear plan of managing those relationships? What does that mean?

It means that there are guidelines that people have to follow in regards to these kinds of gifts, donations, whatever you want to call it. And they have to be based on some intellectualizing of some kind, so that there's a rational for it. I can understand why some places said, you know, we can't come up with an intellectual rationalization for this, and we're not going to do it. And I respect that. I think other places can say we can come up with a rationalization, and this is what it is, and we can change it as needed. But we're going to put this into place and follow it. But inevitably, we're going to drift closer and closer to industry, because of, not just the economics are going to demand it, but the world of science and technology is going to demand it. And to get certain things done, you're going to need to have these kinds of relationships So I think you need to decide where this place culturally wants to fit on that continuum, and then to figure out a program that successfully can manage those kinds of relationships. But I don't think there's a black or white answer. I respect places that take one extreme.

But every place has to have their own comfort zone for that, but it's got to be clear and manageable.

- (inaudible)

Yeah, well that's a big issue. We cannot be separated from the community in which we're embedded. And we should not be separated from it. Community can be defined as a very narrow radius around an academic health center, or it can be a huge region, or whatever. Whatever it happens to be. But we cannot be separated. And we never should be separated from the community that we're embedded. We are too much of an important driver of the community's health and well-being.

Not only are we an essential economic engine of the community, a vital economic engine to this community, look at the jobs, look at the payroll, look at all the stuff that spins off from that. But in terms of the health and well-being of the community, the public's health and well-being, the education of the next generation of health providers, the generation of new ideas and so forth, and so on. It's all for our community of some kind or another. If we lose sight of that, we lose the public's trust, And we go down the tubes. So we cannot be separated from our communities, however you define them. And we must always operate on a plane of public trust. And that public trust can only be gotten through working with our communities and acknowledging that they're an important part of what we are and what we want to become. Never, ever separate ourselves from that.

- (inaudible)

I mean, there's a lot of debate about that point.

First of all, a lot of academic health centers took the lead in developing different tracks for tenure. I don't know if there's a different tenure track system here, but there's been a lot of experimentation in that. The real debate in tenure, as I understand it-- I'm not an expert in this-- Is the relationship between tenure and salary, more so than criteria for getting tenure, is what is the nature of the link between tenure and salary. And that's a highly complicated, and maybe highly variable phenomenon from place to place. I don't want to get into that discussion. But that seems to me the level where it's really important, is how that is pursued. Maybe it would be a good time to concluded with a few remarks. You've been great. I was just going to mention a few things. I think we all agree that healthcare will have a much higher profile in 2008, as we go into 2008.

And there will be a lot of debates over the uninsured and the future of employer-based health insurance. We'll hear a lot of pay for performance, and things like that. I'm glad I'm not talking about pay for performance today. I've got some views on that. The whole issue of projected health worker shortages are going to become very, very prominent. There will be a lot of debates over what we mean by a nation, should we be self-sufficient in the production of our healthcare work force, a lot to say about that issue. We talked a little bit about the role of the market versus regulation. I have an opinion about the growing role of the states in healthcare reform. As you know, a number of states have taken some highly visible steps to change their health system. I think they're all commendable.

Massachusetts, California, and so forth. But you know, I don't see great things happening on a state-by-state solution. I think you need a national solution for this. And maybe we'll learn from these state by state experiments of what works and what doesn't. But in the end, it's got to be a national solution. I think we've got to be very careful in healthcare reform, not to lose the basic principle of insurance, which is, cover the many for the needs of the few. I was very concerned when the administration last year, or a couple of years ago, was pushing a very boutique kind of health insurance. You know, if you're under 25, you can get it real cheap, and whatever. And it would be attractive in the short-term. I think you need to cover the many for the needs of the few however you design the system.

And I want to be sure that we don't lose sight of that. Getting the message to the faculty and your staff that things are changing is very important. Getting them to understand that it's not business as usual anymore is fundamental. And taking the high road on all decisions is so important. Sometimes, you need to sacrifice short-term gain for something bigger in the long run. It doesn't help people's careers necessarily, because they're often not around for that to happen. But taking the high road every time you have the opportunity to, is just extremely important, and explaining to people that's what you're doing. Anyway, why don't I break here and thank you all for being such a great group and dialoguing with me so much. I really appreciate it. Thanks very much.

(applause)