ON MEDICAL MANAGEMENT

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To be successful, academic medical centers must exhibit leadership, a strong foundation in science and education, wide-ranging clinical experience, continuous innovation, exemplary service, and an earned reputation for consistently good results. (J Thorac Cardiovasc Surg 2001;121:S25-8)

Six key factors are categorically critical to the success of academic medical centers. They are, in no particular order, leadership, a foundation of science and education, clinical experience, continuous innovation, exemplary service, and an earned reputation for consistently good results. These are the factors that add value and that differentiate the health care providers in a community.

In the twenty-first century, medicine will change even more than communication, education, work, politics, travel, or entertainment. We expect to serve an aging population that is relatively healthier than preceding generations, and we expect to serve in a medical world filled with innovations and new treatments developed from basic science and biomedical engineering. Innovation has already replaced tradition. We have moved from a world in which the big eat the small to a world where the fast eat the slow.

The six success factors affect the major management issues of the present era (Table I). Results are the first management issue because that is what we stand for. *Service* is a synonym for *marketing, facilitation,* and *quality,* and physician knowledge, skill, and judgment compose the single greatest determinant of health care quality. Facilities must be kept in good repair. This is possible only through coordinated efforts between departments and administration. The high volumes in some hospitals cause ongoing maintenance problems, which must be addressed by department leadership. The workforce design that supports the process of care will evolve continuously and will be aided by clinical informatics. Physician managers today face widespread discontent among employees, staff, and patients. Some discontent is related to health expenditures, insurance problems, referral and turf issues, and the frustrations imposed by the need for high productivity. This is a cost of prosperity. Compliance today requires management and involves a myriad of issues that did not exist until a few years ago.

The scarcest resource today is administrative management and medical leadership. The single greatest management lesson I have learned is that larger medical centers should be led by physicians. It is easier for a physician to learn business management than it is for a business executive to understand medicine. We are not in the business of business; we are in the business of medicine.

The charge of leadership is to (1) recruit and retain the best leadership at the department and division levels; (2) show the staff how to work as a unit with honesty and integrity in all decisions and to keep politics to the irreducible minimum; (3) not try to keep everybody happy—a prescription for failure—but to recognize individual and group success; (4) realize that an organization today will not tolerate bad executive direction—if your nature is not to get things done or not to deliver on commitments, you are in the wrong job; and (5) to acknowledge that failure in management is simply due to bad executive direction; that is, not getting things done, procrastination, and not delivering on commitments.

Each generation of physician managers must manage the mission and vision for the times: protect the mission, create value, reward success, honor creativity, and remain flexible. Because the clinical capability of a medical center depends on experienced, interdependent, coordinated care, the organization must invest in the physicians and physician leaders who form the intellectual capital wherein the value of medicine resides.

To enact organizational change, you must set the course. The vision of an organization is simply an enunciation of priorities. Planning based on that vision is an estimation of the futurity of the current decisions. Many experts denigrate strategic planning. The reality, however, is that planning makes you think. It is a form of feedback analysis. It forces you to understand the organization. You cannot build strong performance on weak-

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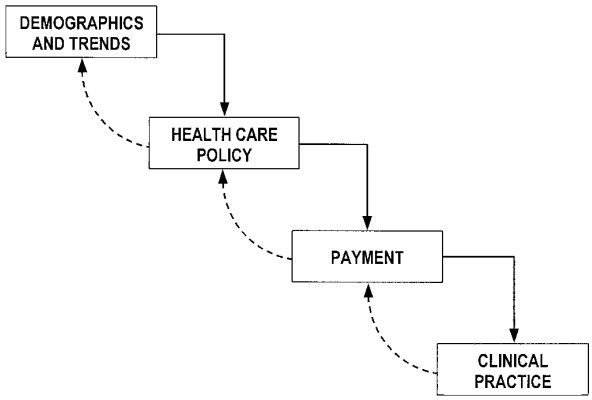

Fig 1. Factors that affect medical practice. Each complement above affects the areas below individually and collectively. *Dashed line,* untoward effects caused by consequences of each result.

ness. From strength comes excellence, and after that comes the hardest work—putting strategic plans into action.

Some leaders, good ones included, focus on competing with other health care entities. In medicine, however, I have always thought it essential for each person to compete with himself or herself to become better every year. Do not worry about being better than your contemporaries or your predecessors. Strive to be better every year personally and in your contribution to the organization in which you work.

Medical practice

Four major factors (Fig 1) set off cascades of events that ultimately affect the practice of medicine. Counteractions and unintended consequences can influence any of these events.[1]

At the top of the sequence are demographics and trends driven, in the intermediate term, by persons born between 1946 and 1964, who will become seniors by 2010. More than 20% of Americans will be older than 65 years by 2030, approximately twice the number today. The ratio of workers to retirees, now 4:1, will be 2:1 in 2030. This evolving ratio affects Social Security and Medicare financing. These and other demographic events affect how Congress approaches health care financing.

Health care policy depends to a large extent on demographics. Policymakers know that to control cost, they must control price and utilization. They forgot, however, that expanding benefits will not control spending and that many policies have the unintended effect of penalizing productivity, efficiency, and profit in health care.

The next component is payment. Basically, we are operating under price controls. Physician payments are increasingly tied to the gross domestic product. Private payors tend to follow government pricing and methods. Payment slowdown to physicians and hospitals comes as a result of tighter budgets.

Clinical practice is at the bottom of the cascade. We know that the physician practice management industry is failing. Physician groups and professional societies are marked by disunity. Cost savings and managed care are essentially exhausted. The number of applications to medical school has decreased, and the specialty of primary care is not growing. It is clear that medicine is no longer a wealth-building profession.

Now we come to the acid reflux. As costs increase and reimbursement fails to keep up with inflation, physicians will reduce time spent with patients, cut amenities, limit access, and not renew or update equipment. The payment-to-policy reflux is exemplified by the effects of the Balanced Budget Act, which have injured the hospital industry and will accelerate closure of smaller hospitals. Policies also can adversely affect the people they are designed to help. Many components of postacute care, such as nursing homes, home health care, and rehabilitation have suffered. Although it has not yet affected access to care, postacute care is unprepared for the aging of the baby-boomer generation. Today's economy and policies cannot match the needs of tomorrow's retirees.

Management

Health care would do well to learn the following four lessons from business: (1) any complex organization is managed best on a decentralized basis; (2) if you hire mediocre people, they will hire mediocre people; (3) it is more important to focus on potential than it is on problems; and (4) managers who have respect for performance tend to acquire the right information and act appropriately. Never hire supervisors who cannot do the work themselves. That includes clinical development chairpersons.

The enemy of every hospital is its own infrastructure—voluminous data in paper, indecisive middle management, difficulty with compliance, poor service, bad attitude, and lack of understanding that the greatest cost improvement lies in improving the efficiency of the system. To improve, you must have good managers and good ideas. Ideas are the lifeblood of the organization.

We have a rule in our administration: someone must have a bright idea every day that improves the environment or the process of medicine. Good ideas not only improve the structure, process, and outcome of medicine, but also coordinate where the individual physician is headed within the goals of the organization. Ideas help translate objective management into personal goals.

Table I. *Success factors and management issues*

Factors critical to success	*Current management issues*
Leadership	Result
Foundation of science and education	Service
Clinical experience	Facilities
Continuous innovation	Workforce design
Exemplary service	Discontent
Deserved reputation for good results	Compliance

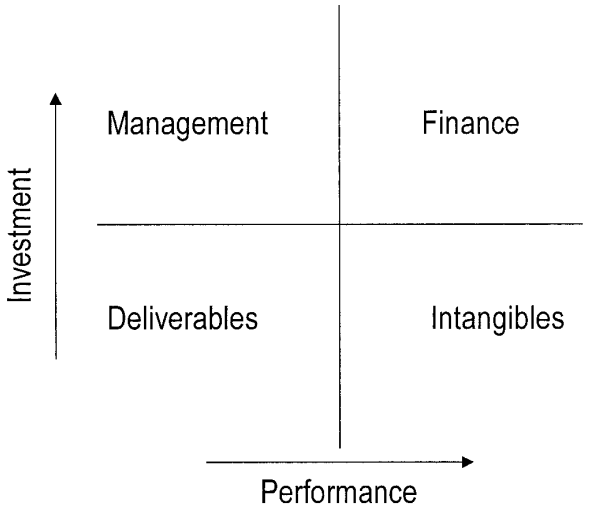

Fig 2. The business of medicine depicted as a trade-off between investment (capitalization) and overall performance. The four variables primarily responsible for success are management, finance, deliverables (the practice of medicine and the delivery system), and intangibles relating to reputation.

Actual day-to-day management is highly subjective. Chief executive officers have their own styles; some are controlling, others are distributive. The workplace should be proactive and have a quiescent intensity and endurance. Management must be both rewarding and demanding. Our administrative group meets for about 2 hours a day, 4 days a week. On this schedule we practice preventive management, keep up with issues, and follow up. No "one" can be as smart as "everyone." There is no real formula for optimal management, but the person in charge must be organized, must insist on accountability, and, above all, must be there. Some people in charge of large medical centers are absent half the time or more. The business of medicine is so detailed now that physician managers should be on the scene most of the time and even take their problems with them when they travel.

One concept to quantify management abilities is called *return on management:* the ratio of productive energy released, to the management, time, and attention invested.[2] *Management* means understanding priorities, setting a direction, articulating a plan, having consistent credibility, and making it happen. Management depends on key diagnostic measures, accurate data, and compliance with federal regulations. High return on management requires a good plan and follow-up, new ideas, and no fear of failure—only fear of poor service.

The biggest detriments to good management are lack of common sense, the word *can't,* and inability to remove inefficient health care. Reasons behind a low return on management include inability to plan and deliver, relying on politically correct performance, lack of accountability, indecisiveness, and allowance for mediocre middle management. To improve consistently, one must rely on new ideas. In one way or another, an organization is always under construction. There is continuous improvement in structure, process, and medical outcome.

A high return on management depends largely on administrative middle management. This is the no-man's-land, often disregarded, often not held accountable, often paralyzed by domineering department heads or, in nonmedical areas, by supervisors who are going along to get along. This necessary layer of middle management frequently is not held accountable because it presumes no authority. It follows that neither creativity nor innovation is often found there. This middle layer often presides over employees in the worst bureaucratic style. Yet rank-and-file employees, given the chance, are filled with creative ideas. They want to do things differently; they have solutions; they are aching to talk to someone who will listen and help them stop doing things the same old way.

Business

The singular purpose of an academic medical center is to benefit humanity through the efficient, effective, ethical practice of medicine, by maintaining the highest standards of quality, and by honoring creativity and innovation. Each member of the organization is a guardian of the enterprise and is responsible for assuring that the hospital is synonymous with the finest health care in the world. You can do that only if you are aligned with your medical center through common incentives and input into management.

For illustration, the business of medicine can be divided into management, finance, delivery, and intangibles (Fig 2). Managing takes common sense, courage, and judgment. Physicians stay in an academic organization for opportunity, security, and an interesting clinical practice. Part of that opportunity is to par-

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ticipate in science and education. However, physicians also have an immature, unbridled desire for unmanaged freedom. Remind them that fame is what you take; character is what you give. There is abundant talent in the medical sciences. The challenge for management is to motivate the motivators. You have to explain to people who are sometimes difficult to manage that freedom is simply the right to discipline oneself.

Organizational effectiveness must include financial viability. The purpose of profitability is to keep the mission intact, invest for progress, pay off the debt, and maintain workforce security. Finance entails an organized, decisive approach to asset management. This requires deployment of technology and human capital in a way that assures a good return on investment and that serves legitimate medical needs.

On the delivery side, multihospital systems have had a record of unfulfilled promises and no competitive advantage, although there are exceptions. Success is measured by the extent to which essential support functions are coordinated across operating units within the system. The biggest mistake for many centers has been acquisition of a large number of practices, amounting to a credit negative. Market leadership depends on physician input at the community level and continuing education about cost, service, and outcomes. Parent organizations must accept that patients want to stay in their communities for health care.

The requisite intangible assets are the good will of the organization, the medical model, the reputation, and an innovative climate in the organization. How well has the academic medical center succeeded in making social capital out of investment capital? Success sometimes presents new problems. The language of entitlement has become so pervasive in US culture that the champions of this new-age nonsense worry that contemporary America is becoming too meritocractic. The egalitarians want everybody to be the same and cannot stand excellence. This notion is the antithesis of cardiothoracic surgery, which exemplifies excellence of performance.

Summary

You may long for the old medicine and a less business-like approach. So do I. But that day is gone and we have no choice but to change. The only choice we have is between doing better and doing worse. What we must do as physicians is build the best and most attractive delivery systems for patients, payors, purchasers, and physicians. To do that, we must coordinate physician input and management with the strategy of the delivery system. Don't lose your idealism; the practice of medicine is still a cooperative effort of physicians on behalf of society. Each year we grow stronger in science, education, clinical acumen, and health care delivery. In a good medical center, these strengths constitute a commonwealth of intellect, a republic of ideas, and a foundation for success in physician-managed health care.

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