Introduction: Strategic Alliances in Academic Medicine: Adding Value, Enhancing Mission, Ensuring Survival
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This installment of the Academic Medicine Management Series focuses on institutional strategic partnerships and alliances—that is, affiliations and collaborations among an academic medical center and one or more partners to develop strategic value and resources not possessed by any single organization. The notion that academic medical centers would enter into mission-critical alliances—in many cases with institutions once viewed as competitors, not collaborators—has emerged as a strategy only recently. An academic medical center’s traditional course of action was marked by its independence, a ship of self-sufficiency and expertise. That idea, like so much in the modern enterprise, traces its roots to Flexner, who promoted the development of the self-contained academic medical center—consisting of a single medical school and teaching hospital, jointly owned or at least intimately connected—as requisite for sound medical education and patient care. In his 1910 report, Flexner endorsed the idea that a teaching hospital should “enter into [an] exclusive and practically complete relationship with a single medical school.”1,p.107

As the once-quaint medical school and teaching hospital evolved into the sprawling academic clinical—biomedical complex in the mid—20th century, its organizational structure reinforced a normative culture defined by its authority, self-reliance, even insularity—one that disdained working with other partners, especially those that were deemed of lower prestige and quality. In fact, medical historian Ludmerer writes that in the post—World War II era, medical schools “repeatedly refused requests from community hospitals to establish formal affiliations.”2,p.172

The notion of academic medical centers’ “jealously guarded independence,” where “collaboration is the veritable antithesis of individualism,” has remained.3 Historical developments in the 1990s reinforced the organizational preference among some academic medical centers for autonomy and control. Many leaders in academic medicine viewed an integrated delivery system—in which the medical school, primary and secondary hospitals, primary care practices, nursing homes, and rehabilitation and other facilities are brought under one umbrella—as a way “to have it all: the best medical school, the best hospitals, the largest primary care networks.”4,p.172 These organizational models dovetailed with the preferences and ambitions of many leaders, who were enthralled with single-owner structures that presented not only “the traditional responsibilities of a dean or vice president (or both), but also, . . . executive authority over the business operations of the organized delivery system.”5,p.114

Of course, medical schools have always had different levels of affiliations with other institutions. Indeed, the very essence of an academic medical center is a partnership between a medical school and a teaching hospital,6 where the ability of each to carry out its multiple missions depends upon collaboration. For 60 years, many medical schools have had partnerships with Veterans Affairs (VA) medical centers—in which medical schools have benefited by gaining additional educational and research opportunities, while the VA has achieved access to higher standards of care than could be offered by a wholly full-time VA medical service.7 These examples notwithstanding, today’s environment requires a more intense, more strategic level of engagement. With the current upheaval in health care delivery, specialization of knowledge, diffusion of technology, commercialization of research, and globalization of everything, medical schools and teaching hospitals cannot thrive, perhaps not even survive, using the solo approaches of a bygone era.

Collaborations, partnerships, alliances, joint ventures—all are touchstones that mark the age, as the articles in this collection demonstrate, and as we might expect with increasing frequency in the future. And academic medical centers are not alone in this regard. Every industry faces similar challenges. The questions, then, are how can organizations make these partnerships sustainable and fulfilling and, in an era when the command—and—control model of leadership is an amusing anachronism, what characteristics and habits of mind do leaders need to succeed?

Alliances as Strategy

The first seismic restructuring in the corporate world—mergers, acquisitions, and divestitures—barreled through the banking industry in the early 1980s and then spread to other sectors. By the late 1980s and early 1990s, however, alliances and joint ventures began to gain popularity over outright mergers. The thinking that drove these partnerships was that a single organization could not possibly buy every company with the resources it needed to compete.8 The solutions, therefore, were cooperative agreements, alliances, joint ventures, and other types of partnerships. Collaborate, not amalgamate, became the mantra—one that remains evident in the business literature today.

Academic medicine faced similar challenges about a decade after many corporations experienced merger mania. The first set of pressures arose from changes in health care delivery and financing in the late 1980s and 1990s: the onslaught of managed care and price competition, declining Medicare and private insurance reimbursement, and technological advances that shifted health care from inpatient to ambulatory settings. Some academic medical centers responded by divesting their clinical enterprises; others pursued the “do it alone” strategy of integrated delivery systems; and a prominent handful tried merging, the results of which are
documented by several articles in this collection.

While the tide of teaching hospital and medical school mergers has ebbed, the undertow of pressures on the clinical, research, and education missions of academic medical centers has only grown stronger. Those clinical pressures that contributed to the rash of mergers and divestitures—cost containment, declining reimbursement per unit of physician productivity, shifts in health care delivery away from inpatient settings—has, if anything, intensified. Adding to the complex and turbulent environment is a research enterprise that is increasingly interdisciplinary and team-based, technology-enabled, competitive, and commercialized; and a medical education enterprise that has been called on to increase capacity but not cost, and also continues to become more ambulatory-based and internationalized. Is it realistic to expect any single academic medical center to expand clinical efficiencies, manage competition, and lower costs; build research infrastructure, buy expensive technology, and manage large teams; provide adequate clinical educational experiences; and compete in a global medical education marketplace without the benefit of strategic institutional partners?

The answer emerging from many academic medical centers is no, not now and especially not in the future—which is why the successes and failures, sidesteps, and leaps chronicled in the reports in this collection are so important. Whether it is the stories of mergers, demergers, and disaster recoveries11–15; medical school and university partnerships16; alliances between academic medical centers17,18; or international institutional collaborations,19 the examples in all mission domains—education, research, clinical care, service—are likely to become more frequent for academic medical centers. Their effective management will be dependent upon the competencies, skills, behaviors, and attitudes of institutional leaders as well as the cultural, organizational, political, and human aspects of the institutions themselves.

Leadership habits of mind will be particularly important. The traditional academic medical center CEO exercised “command-and-control” authority; by the 1990s, however, scholars speculated that “greater emphasis had been placed upon the role of [the medical school executive] as a collaborator and negotiator in a variety of organizational relationships.”20,p.122 The very notion of partnering with, rather than acquiring and controlling, another organization demands institutional leaders at many levels who are willing to cede, or at least share, some degree of authority and power. The lessons from this collection suggest a leadership model predicated on openness and transparency, joint planning, flexibility and compromise, and team-based decision making and learning.

Why Strategic Alliances Work

The failure rate of institutional alliances is comparable to the divorce rate in the United States: about half end prematurely.21,22 So why do some succeed? While the scholarship on strategic alliances and partnerships has identified numerous components to healthy and long-lasting relationships, I would like to focus on three key themes repeated in both the business literature and the articles in this collection: trust, communication, and compatibility.

Trust

Trust is “the cornerstone of strategic partnership success.”23 Alliances are living, organic systems, much like real relationships among people.24 They both produce, and rely upon, interpersonal and interorganizational trust.25 In fact, trust among strategic partners is the unifying theme in the literature across research paradigms and sectors.24–29 Trust is important because an alliance between organizations is, at its heart, about intent, not response; the future, not the past. The strategy undergirding any institutional partnership ultimately focuses on improving the future conditions for each organization,24 which means weathering unplanned, unforeseen conditions. When partners face problems and crises with confidence in one another’s motives and integrity, the alliance is more likely to remain intact and produce value.

This theme is evident, even when unexplored, in many of the articles in this collection. Carey and colleagues’ description of the research partnership between Shaw University and the University of North Carolina at Chapel Hill was predicated upon “an initial basis of trust” between individual faculty members.16 Building trust between Meharry Medical College and Vanderbilt University Medical Center is a theme throughout their partnership, especially important given the social prejudices and institutional traditions of separation that marked the chasm between the two for much of their histories in Nashville.17 The Weill Medical College–Methodist Hospital affiliation emerged from longstanding (and presumably healthy and productive) relationships between senior leaders at the two institutions.18

Interorganizational trust also reduces the perception of opportunistic behavior—that the other partner is just waiting to pounce. These issues were at play in the affiliation between Brigham and Women’s Hospital and Faulkner Hospital. The Faulkner hospital staff feared “an aggressive attempt at establishing control” by Brigham and Women’s.19,p.258 Similarly, in the merger between New York Hospital and Presbyterian Hospital, “each center feared that the merger would erode its identity, weaken its programs, or favor one center over the other.”20,p.1115 One of the strategies in this merger was to create data transparency, which “would be freely shared by the hospital with the physicians and the schools and become the basis of strategic and business planning and performance and quality review”20,p.1117—and which built trust among partners.

Communication

This component of successful alliances may seem self-evident, but apparently many partners do it poorly. In other words, the issue is not whether organizational partners communicate but how well they do it. Communication skills are especially important for alliances at a distance. A major problem articulated by the leaders of the international partnership between Columbia University Medical Center and Ben Gurion University Faculty of Health...
Sciences in Israel was “the difficulty in communication between the two staffs . . . [the] necessity to travel 5,600 miles to attend key meetings . . . and students’ problems resulting from or exacerbated by distance and difficulty communicating with family and friends.”19,p.710 But the issue of communication manifests itself in more than just distant partnerships. The difficulty of communication emerged with the consolidation of North Shore Health System and Long Island Jewish Medical Center, institutions that were only 1½ miles apart. In the merger’s early stages, leaders failed to recognize and acknowledge specific clinical issues parochial to one campus or the other . . . Our attempt to impose any clinical integration strategy without adequate “vetting” on either campus was almost always met with significant resistance . . . We also failed early in the merger effort to prevent some loyal physicians from leaving the tertiary hospitals in fear of the unknown impact of the merger on their clinical practices. Better communication and discussion with these physicians probably would have prevented the loss of some of these valuable practitioners12,pp.682–683

Scholars assert that successful alliances will demonstrate both high levels of information sharing and participation in planning and goal setting.30 The experience of the Shaw University – University of North Carolina at Chapel Hill research alliance confirms that view: “When very diverse institutions work together, the need for leadership structure, early and frank discussion of potential areas of conflict, and setting of clear benchmarks for progress becomes all the more important.”16,p.1044

Compatibility
A crucial third component of successful strategic alliances is compatibility: organizational partners must be able to get along, understand each other, enhance the other’s strengths, and respect the other’s culture and values.30 The root of many difficulties lies in poor partner relations.31 Several of the reports in this collection illustrate the outcomes of partner compatibility or lack thereof. In the case of Brigham and Women’s Hospital, a major academic tertiary teaching institution, and Faulkner Hospital, a community, secondary-care hospital, leaders cited the organizations’ complementary services as an important factor in the partnership: “distinct differences in size, patient population, and clinical expertise have allowed the affiliation to avoid some of the inefficiencies and political complexity that relationships of highly similar hospitals often endure.”13,p.257

Too often, executives fall in love with each other’s financial assets but fail to attend to long-term organizational compatibility issues, like organizational culture. The failed merger between Penn State University College of Medicine and the Geisinger Health System is an example of leaders failing to fully appreciate the subtle and not-so-subtle differences between the organizations’ preferred habits, group norms, values, and ways of working.14 The financial difficulties of the new organization could have been withstood. Rather, the demerger was ultimately driven by fundamental issues of incompatibility: the executives and the governing board could not work together, agree on decision-making norms, or develop a cohesive vision for the future.

One of the common themes in the articles in this collection is that alliance partners typically underestimate issues of compatibility, especially the difficulty in negotiating ways of working together. Successful mergers and alliances displayed resilience and flexibility, commitment to working through difficulties, and a stick-to-it quality. Executives in the merger between New York Hospital and Presbyterian Hospital realized early on that forcing integration would backfire. Ultimately, they experienced some degree of compatibility by allowing integration to evolve, using service lines as a mechanism to produce common goals among partners.11 The Meharry-Vanderbilt partnership went so far as to formalize its compatibility in a separate, nonprofit, independent coordinating office.17

An important lesson from these experiences is that organizational partners do not necessarily have to share similar cultures to succeed. Healthy alliances can exist between partners with very different ways of operating. But those differences must be acknowledged, fully explored, and reconciled during courtship, not after the nuptials have been professed.

Organizational Renewal
Despite the best of intentions, many strategic alliances fail. Some crash and burn, others fade away. In any case, what can leaders do when faced with picking up the pieces and moving on? The report by Kirch and colleagues is included in this collection because of its attention to the aftermath of a failed union.15 Leaders at Penn State Hershey Medical Center identified nine factors that contributed to organizational recovery. Interestingly, many of them—performing and acting on cultural assessments, making values explicit in decision making, fostering accountability and collaboration—are the same success factors that make mergers and alliances work.

The Future of Strategic Alliances in Academic Medicine
The borders of the academic medical center are increasingly transparent and ever thin. Where does one organization stop and another begin? When are academic medical centers competitors and when are they collaborators? With the globalization of health care and biomedical research, these questions extend beyond the traditional vectors of geography and culture. Unlike the hospital mergers of the 1990s, which sought to capture larger share of local markets, the strategic alliances of the future will not be bound by limited geographic constraints. Indeed, the affiliation between Methodist Hospital in Houston and Cornell Weill Medical College in New York City aims more expansively: The affiliation opens the opportunity for shared involvement in any project and for developing a joint presence in the international market. Developing further affiliations could enhance this model with the aim of developing a unique nonprofit global health care enterprise.18,p.1051

Other global partnerships already exist: (1) The Weill Cornell Medical College in Qatar; (2) the alliance between Duke University Medical Center and National University of Singapore to establish a new medical school; and (3) University of Pittsburgh Medical Center’s partnership with Italian government entities to create a biomedical research and technology center in Sicily, just to name a few. As academic medical centers in the United States increasingly fulfill their missions—clinical, research, and education—within
and beyond national borders, without a doubt they will rely on strategic partnerships with a range of organizations: governmental, nongovernmental, and corporate—to capitalize on the opportunities that a global marketplace and economy offer.

Yet that pathway, pregnant with possibility, also seems fraught with risk. The academic medical community could benefit from the lessons of alliances that add cultural, geopolitical, language, and geographic complexity to their development and management. As medical school and teaching hospital faculty and administrators continue to explore local, national, and international alliances, they would do well to learn from and build upon the experiences of organizations in other sectors as well as their colleagues who have already peddled down those paths.

References