The Financial Management of Research Centers and Institutes at U.S. Medical Schools: Findings from Six Institutions
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Abstract

Purpose
To explore three questions surrounding the financial management of research centers and institutes at U.S. medical schools: How do medical schools allocate institutional funds to centers and institutes? How and by whom are those decisions made? What are the implications of these decision-making models on the future of the academic biomedical research enterprise?

Method
Using a qualitative research design, the author and associates interviewed over 150 faculty members and administrators at six medical schools and their parent universities in 2004. Interview data were transcribed, coded, and analyzed using a grounded theory approach. This methodology generated rich descriptions and explanations of the six medical schools, which can produce extrapolations to, but not necessarily generalizable findings to, other institutions and settings.

Results
An examination of four dimensions of financial decision-making—funding timing, process, structure, and culture—produces two essential models of how medical schools approach the financial management of research centers. In the first, a “charity” model, center directors make hat-in-hand appeals directly to the dean, the result of which may depend on individual negotiation skills and personal relationships. In the second, a “planned-giving” model, the process for obtaining and renewing funds is institutionalized, agreed upon, and monitored.

Conclusions
The ways in which deans, administrators, department chairs, and center directors attend to, decide upon, and carry out financial decisions can influence how people throughout the medical school think about interdisciplinary and collaborative activities marshaled through centers and institutes.

In the past decade, U.S. medical schools and their parent universities have created, with increasing frequency, broad-based interdisciplinary research centers and institutes to tackle complex medical and scientific problems that, proponents argue, cannot be solved through traditional department-based structures. Drawing on the expertise of many disciplines, these research centers assemble multifaceted teams; delve into cutting-edge, complex, and interdisciplinary questions; raise funds; and contribute to the economic development of the region. These large-scale institutes represent only the latest in the long history of organized research centers in academic medicine, which have always generated a degree of controversy. A previous study examining the benefits and challenges of centers and institutes in the academic biomedical research enterprise found that while research centers offer medical schools and universities many potential advantages (for collaboration, faculty recruitment, research resources, fundraising, and other benefits), they also pose management challenges for institutional leaders.¹

A central concern in the management and leadership of research centers is related to money. How do medical schools identify, decide upon, and allocate internal funds to support research centers and institutes? A common assumption is that research centers and institutes should be self-sufficient; that is, institutional leaders expect centers to secure outside funding to support their activities.²⁻³ Previous scholarship across a range of research methodologies and sampling frames has corroborated the fact that external funding predominates. A 1971 study found that most centers’ funding came from external sponsors⁴; in a 1994 study of 511 research centers, 82% of total funding was externally generated⁵; and most recently, a 2004 survey of the Association of American Medical Colleges (AAMC) of 604 biomedical research centers and institutes demonstrated that, on average, 78% of the funds came from sources outside the university, with government grants and contracts the largest single source.⁶

Even with the expectation that research centers and institutes will generate their own funding, the fact remains that nearly all consume university and/or medical school (that is, institutional) resources. In fact, previous research has demonstrated that large amounts of external funding are highly correlated with large amounts of institutional funding. In the 2004 AAMC survey, of the $2.9 billion in total funding received by the research centers in the sample, a mean of 13% came from the institutions themselves.⁷ Extrapolating these data, the top 40 research-intensive medical schools in the United States (from which the sample of research centers was drawn) contributed nearly $380 million annually of their own institutional funds to the operation of research centers. This figure does not include those schools’ allocations to centers with other missions, such as patient care, education, and outreach.

Despite the considerable financial resources that universities and medical schools devote to research centers and institutes, there has been little discussion in the scholarly or professional literature about the financial management of these units. With that in mind, I organized a research team and carried out a
qualitative research study, described below, to investigate three important questions surrounding the internal financing of research centers and institutes:

- How do medical schools allocate institutional funds to centers and institutes?
- How and by whom are those decisions made?
- What are the implications of these decision-making models on the future of the academic biomedical research enterprise?

Based on data from site visits to six research-intensive medical schools, I review below four components of institutional financial allocations to research centers: the timing of funds, the funding request process, decision-making structure, and funding culture. In turn, these elements suggest two basic models of financial decision making to research centers and institutes. Finally, the ways in which schools make financial decisions to research centers also have implications for the management and leadership of academic medicine in general.

**Method**

I focused on centers and institutes that organize, facilitate, or conduct basic, clinical, or another type of research (such as health services, health policy, or community health research). I did not consider centers and institutes that are organized primarily for purposes of education, clinical service, or outreach, although the issues of institutional funding to these types of units may be similar.

I used a qualitative research design to understand the operation and management of research centers and institutes in academic medicine settings. Qualitative methods are appropriate for exploratory studies that require in-depth analysis to answer “how” and “why” questions. Qualitative research assumes that there are multiple realities of human phenomena that require interpretation rather than measurement.

**Participants**

Six medical schools were studied: Case Western Reserve University School of Medicine; Stanford University School of Medicine; University of California, San Francisco, School of Medicine; University of Michigan Medical School; and University of North Carolina at Chapel Hill School of Medicine. My research colleagues and I selected these medical schools purposely: each institution either had a large number of research centers or it had one center in particular that was especially prominent and broad-based. The medical school dean at each institution agreed to participate in the study.

A primary contact—usually the associate dean of research—assisted in scheduling interviews with a range of faculty and administrators at each institution, including university presidents, provosts, medical school deans, associate deans, department chairs, center directors, and faculty members. Over 150 people participated in the site visit interviews, which occurred in Spring 2004. A two- or three-person research team, which I led, used semistructured in-depth interviews to understand the participants’ perspectives of the organizational and management issues surrounding the creation and use of centers as mechanisms to facilitate and conduct research. Interviews were audio-recorded and later transcribed for analysis.

**Analysis**

To analyze the data, I used grounded theory, an approach to build explanations and understanding as analytical categories emerge from the data. I read the 600 pages of interview data several times to develop coding strategies and categories and identify recurring regularities. I compiled codes and categories into meta-codes, collapsing and combining data elements. These codes and meta-codes were entered into an Excel database, in which I could sort and manipulate codes by interview category or coding category.

The analysis and interpretations in the present report are based on themes that emerged from the comparison of data across institutions. Rather than portray the intricate financing details of each medical school in the report (as a single case study might do), the findings are composite in nature; that is, they are abstracted from the particulars of any one institution in order to offer broader findings and analysis. The quotations in this article are meant to explicate research findings and are illustrative, but by no means exhaustive, of the themes that emerged during the interviews.

While this report analyzes many aspects of the management of institutional funding for research centers and institutes, the sources of those funds are not addressed, for two reasons (1) the fungible nature of institutional funds would make it difficult for the medical school to identify the actual source of internal support, and (2) such an inquiry lends itself more to quantitative methods and thus is outside the scope of the present study.

**Trustworthiness**

Qualitative research does not produce generalizable findings that are statistical and probabilistic, as do quantitative methods. Rather, the purpose of this study is to offer rich descriptions and explanations, which can produce extrapolations to other institutions and settings. Whether this study’s findings apply to other medical schools is up to the people in those institutions. This article uses quotations from the interviews to illustrate and explicate research findings, but participants are not identified by name or school to protect their confidentiality.

**Results**

**Dimensions of financial allocations to research centers and institutes**

The six medical schools in this study demonstrated similar patterns in how they allocated financial resources to research centers and institutes in the start-up phase. Consistent with previous studies on centers and institutes, all six schools ultimately expected most research centers to secure external funding in order to survive long term. But in their nascent stages, centers and institutes need money to begin operation. The medical schools differed along four dimensions in their management of such needs: the timing of when institutional funds are allocated to centers, the funding request process, the decision-making structure, and funding culture.

**Timing: first dollar or last dollar?** The first dimension concerns the point at which the school considers a financial
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contribution to a research center. Several schools took a “last dollar in” point of view. One associate dean for research described their process as follows:

If someone wanted to develop a center, I think they’d be told to put together a group of investigators and get a center designation from the NIH or major foundation. Then we’ll talk. So the ante is usually outside funding to create a center. That sets a bar; it gives you an external reality test of quality. And it proves that the leadership can galvanize faculty to work together and hold focus. It gives you something to work with, because there’s already external funding coming in; it’s not like the institution has to build it from the ground up. There are a few counter examples to that, where the institutional funds went in before the external funds . . . but [typically] some type of external imprimatur gives the dean confidence that this is a reasonable thing to do.

Similarly, at another school, a vice chancellor bluntly declared, “In general, the rule is that centers have to have their own support.”

The alternative is a “first dollar in,” or seed-funding, model, in which the institution had a process for allocating small financial resources to jumpstart innovative research ideas. In this model, the institution saw its contribution to a research center as a lever to secure additional funding. As one principal business officer maintained, “People should be able to leverage resources . . . if you have a great idea, you ought to be able to take our dollars and leverage them into other dollars.” Several of the institutions in the study had “innovative research funds,” typically administered at the provost level, which new centers could tap for seed funding. A provost emphasized the short-term nature of these types of funds: “You get help when you start up, but if you are a viable center, we feel you need to be self-sustaining.” Administrators at schools with these programs concurred that seed funds do not provide substantial or ongoing amounts of money, but they enabled center directors to get their operation moving forward. While the size of institutional funds varied, they typically were in the $3–4 million range annually, with individual center grants of $50,000–60,000 annually for cycles of two to three years. These types of “venture capital” funds for innovative research ideas are common among research universities.

A recent National Academies study reported that 88% of universities offer such mechanisms, offering grants in the range of $1,000 to $1 million for individual projects. It is not clear, however, how many universities have funds specifically for research centers versus for faculty projects in general.

Funding request process. The second dimension of resource allocation to research centers and institutes concerns the degree of formality of the funding process. By funding “process,” I mean the systematic steps in which faculty and administrators make requests for budgetary allocations to the medical school administration. In some institutions, centers obtained school funds in an ad-hoc, informal manner, typically based on the individual persuasiveness of the center director in appealing for funds from the dean. Once a center obtained a budgetary allocation, it often remained with the center over time, as one principal business officer explained:

[The rationale for which centers get allocations from the dean] is historical. I’m not sure there is a rationale for who gets what. . . . They grow up based on who the champion is; some are able to find resources and others aren’t.

This process reflects a traditional entrepreneurial paradigm in academic medicine, in which individual chairs, chiefs, and program heads who successfully “made their case” to institutional leaders were given resources to grow. Moreover, it reflects a funding paradigm in which ongoing budgetary allocations often were based on history rather than an ongoing review of strategic needs and opportunities.

In contrast, other medical schools have migrated to a formal, institutionalized process for reviewing and awarding funding requests from research centers and institutes. In these cases, centers apply for funds through a competitive, peer-reviewed process. Center directors do not make individual appeals and negotiations with the dean but rather apply for funds through a formal process operated and governed by a committee of faculty and research administrators. An associate dean for research explained his school’s process:

Instead of using not well-defined criteria and private negotiations with the dean in order to define a center’s budget, the new policy dictates two levels of review: the college level then the university-wide level. The review committees have a chance to discuss what’s going on with all the centers on the table.

The schools with these formalized processes did so in response to dissatisfaction with the prior ad-hoc method. In an earlier era, deans could accommodate these funding requests because both the number of appeals and the size of the enterprise were limited; the small “clubby” atmosphere was to everyone’s liking. As medical schools have become larger, as research has grown, and as requests for new centers have proliferated, leaders noted that the informality of prior years, once an asset, had become a liability. But few institutions have a pure model of this type. Institutions in the present study indicated that they can revert to the ad-hoc method should an opportunity arise that demands flexibility and quick response.

The financial decision-making structure. The third dimension of resource allocation is the funding structure; that is, the formal organizational arrangements in which budgetary choices are debated and decided, not only regarding centers and institutes but other organizational units as well. Historically, financial resource decisions in academic medicine were made behind closed doors and kept close to the vest. Only a few individuals (the dean, principal business officer, and perhaps a few others) would have a sense of the total institutional financial situation. Department chairs and other unit leaders would only be aware of and be responsible for the financial particulars of their domain, not of the institution as a whole. More recently, as schools have embraced concepts of mission-based management, financial decisions have become more open and shared, reflecting the desire to broaden participation, create mechanisms for peer accountability, and emphasize the interrelated nature of the various departments, centers, and other units to the financial health of the medical school as a whole.

In allocation decisions to centers, as in other cases, several of the institutions in the study have opened up the decision-making process to representative groups.
of faculty and administrators, who help decide which centers receive institutional financial support. For example, one school formed a research advisory committee, which had among its responsibilities the review of funding requests from centers and recommendation of annual budget allocations to the dean.

The funding culture. A fourth dimension of resource allocation to centers and institutes is the funding “culture,” by which I mean the shared assumptions, espoused values, group norms, and implicit rules of the game that dictate organizational behavior. At the institutions in this study, two distinct cultures emerged regarding budgetary allocations to centers and the view of research centers in the life of the medical school and university.

First, some participants saw the financial allocations made to centers and departments as a zero-sum game. In economic terms, a zero-sum game describes a situation in which one participant’s gain is another’s loss. Those who adopted this philosophy viewed the interaction between centers and departments as a competition. If the center secured institutional financial (or other) resources, then the department lost.

We’re using institutes as a substitute for solving some basic problems of resource base. . . . a classic zero-sum game. (From a clinical department chair.)

Department chairs approach the world as if there is a finite amount of funding available. There is the logic that says if centers are getting something, or something more, then the departments are getting something less. (From an associate dean for faculty affairs.)

Every time [a faculty member is involved in a center], chairs think, “it’s being pulled away from me.” The other concern is there are only a finite number of resources. If resources are put into centers, the worry is that you’ll weaken the disciplines that the centers have to draw on to form their interdisciplinary activities. (From an associate dean for research.)

For these faculty and administrators, the lens through which they viewed other organizational units (research centers, other departments) was adversarial and competitive because they saw these units removing resources rather than contributing to the whole.

Other study participants described a culture with a different view of the role of research centers in academic life. These individuals talked about centers adding new funds or opportunities to existing resources, a non-zero-sum or “win-win” situation:

You have to do it in a way that chairs feel respected and partner from the beginning so they aren’t having something shoved down their throats. Rather, they’re seeing it as an opportunity that’s good for both sides. (From an associate dean for research.)

At the institutions where the “win-win” mentality predominated, faculty and administrators articulated the vision of collaboration, in which the campus “doesn’t have a lot of walls or boundaries or political battles” (center director), “value[s] collaboration, collegiality, and civility” (clinical department chair), and “the culture is very supportive of interdisciplinary efforts” (faculty member).

Overall models of financial allocation to research centers and institutes

The four dimensions described above—funding timing, process, structure, and culture—often go hand-in-hand. Examining these dimensions in concert produces two essential models of how medical schools and universities approach the financial management of research centers: a “charity” model and a “planned-giving” model (described in Table 1). Schools that operate under the charity model allocate resources to centers through an informal, hat-in-hand appeal directly to the dean and a private funding culture. Just as they make personal choices for charitable contributions, academic leaders operating in the charity model may provide seed funding for some centers but leave others to find their own resources. Because the choice process is not open and explicit, other organizational units may view those who tap the dean’s largess skeptically and with mistrust, contributing to the “zero-sum game” mentality in the institution. The advantage of this model of resource allocation lies in its responsiveness. Someone with an innovative idea can tap institutional resources quickly, with little bureaucracy or formality. Under this model, the institution can be nimble and highly adaptive to new opportunities. But there are disadvantages, too. This decision-making process and structure can create tension in the long term. At one institution where the dean often

Table 1
Two Models of Financial Resource Allocation to Research Centers and Institutes at U.S. Medical Schools, 2004*

<table>
<thead>
<tr>
<th>Aspect of the model</th>
<th>Charity model</th>
<th>Planned-giving model</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Timing</strong></td>
<td>First or last dollar in, depending on will of institutional leaders</td>
<td>First dollar in through seed-funding, or “venture capital,” mechanism</td>
</tr>
<tr>
<td><strong>Process</strong></td>
<td>Ad-hoc, informal</td>
<td>Formalized, institution-wide process, dependent on competitive peer-review</td>
</tr>
<tr>
<td><strong>Structure</strong></td>
<td>Controlled by dean. Closed doors. Data not shared.</td>
<td>Peer committee makes financial allocation recommendations based on transparent criteria, shared knowledge, and accountability</td>
</tr>
<tr>
<td><strong>Culture</strong></td>
<td>Zero-sum game</td>
<td>Non-zero-sum game, win-win</td>
</tr>
<tr>
<td><strong>Overall</strong></td>
<td>Center directors make hat-in-hand appeals directly to dean, the result of which may depend on individual negotiation skills and personal relationships. Decisions can be made adaptively and responsively but without comparative information or peer input</td>
<td>Process for obtaining and renewing funds is institutionalized, agreed upon, and monitored. Decisions made based on relative value of other centers and institutional priorities, but process can be bureaucratic and cumbersome</td>
</tr>
</tbody>
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* Understanding of these models was gained through in-depth interviews with a range of faculty and administrators at six U.S. medical schools and their parent institutions in the spring of 2004.
provided start-up funding to centers in an informal basis, the principal business officer explained:

[Our dean] has been big on centers and he provided a lot of money to jump-start many of them. But one of the challenges is, what to do when they can’t pay their own way? When these start-up packages expire, what do you do? Do you put more school resources in them to keep them aloft? Or do you say to the center, “Now you’re on your own; if that means you’re going away, so be it”?

Another disadvantage of this model is that its tightly held decision-making process can breed confusion and mistrust. Department chairs, division chiefs, and other center directors who don’t have access to or a voice in allocation decisions to centers may view them as illegitimate, wasteful, or inappropriate rather than as contributing to shared institutional goals that benefit all.

The second type of resource allocation is the planned-giving model, in which the institution has a form, systematic method of allocating funds to research centers, institutionalized in a committee structure and peer-reviewed decision-making process, and an open, transparent funding culture. In a planned-giving model, goals are explicit and the process of decision making is clearly defined. At medical schools that operate in this model, new centers may face the same challenge of long-term sustainability when start-up funds expire as they do at charity-model institutions. The difference is that the process for obtaining institutional funds and the duration of those funds is institutionalized, agreed upon, and monitored. The advantage of a planned-giving model is that the university or medical school can make resource decisions based on the relative value of each center compared to all others rather than on a case-by-case basis. As an associate dean for research noted:

It’s easier to say how much value there is in one center versus another. If the university is going to make an investment of $3.5 million in centers, the question is, how are we going to divide it to maximize the bang for the buck?

This planned process also opens up decision-making to a wider group of interested people, subjects the centers to peer review, and makes the process visible and transparent, which thereby can allay mistruths and rumors about allocation decisions. The disadvantage of this model is that it can become bureaucratic, slow moving, and cumbersome. For example, if a group of faculty members with an idea for new center funding have just missed the date for the annual application process, they might have to wait months for another funding opportunity. In a more informal process, they could go directly to the dean to obtain start-up funds.

Models for allocation of facilities and administrative funds

Once centers and institutes become established with investigators who have obtained sponsored research dollars, another financial issue that the medical school and university face is allocation of facilities and administration (F&A, or indirect cost recovery) dollars. F&A costs are the method by which universities and medical schools are reimbursed for real costs already incurred for providing facility and administrative support for sponsored research projects.17 At each university participating in this study, a portion of the F&A costs recovered from external grants was retained by central administration for institution-wide costs and a portion returned to the medical school. Traditionally, most medical schools have returned a portion of their centrally allocated F&A funds to the academic department for unit-level costs because departments had responsibility for the investigator’s space, grants administration, and faculty appointments. When a research center or institute becomes involved, another administrative unit is added to the equation because centers sometimes provide space (facilities) and grants administration to the investigator. Medical schools are faced with deciding what portion of these funds, if any, should be allocated to the research center.

The institutions in this study varied in their policies for allocation of F&A funds. At one school, most centers did not receive any F&A funds, which put a strain on centers to leverage discretionary resources into new research opportunities, as a principal business officer explained:

Indirects go back to home department, where the faculty appointment is. Centers don’t have any funds now. They are given an allocation from the dean based on history, but they really don’t have the same opportunities as other units to grow resources.

At this institution, another tension occurred when the university president created a large interdisciplinary institute that did not conform to the traditional allocation policy. This particular center was given the majority of F&A funds from sponsored research grants. The center director embraced this arrangement as an important way to grow the institute:

The returns on endowment and indirect costs all come back here . . . So we actually have more funds available to do things like purchase shared equipment or set up core facilities or co-laboratories where people can come together. Our funding structure removes some of the typical barriers of scientists working together.

Unsurprisingly, some department chairs in this medical school balked at the arrangement because, for faculty members in their departments who participated in the institute’s activities, the department did not receive their traditional portion of F&A cost dollars.

Another school adopted a different methodology for allocation of facilities and administrative cost recovery. In this case, F&A funds were allocated to both center and department based on guidelines that accounted for the entity providing the investigator’s space, grants administration, and faculty appointment. Of the F&A funds returned to the faculty-level administrative unit (which was a small fraction of the total F&A funds received by the institution), 50% went to the entity (department or center) providing the investigator’s space, 25% to the unit administering the grant, and 25% to the unit controlling the faculty appointment (in every case, a department, not a center). These guidelines had several advantages: first, they were implemented school-wide, thereby eliminating private deals and individual negotiation. Second, they provided some ongoing funds flow to research centers to cover costs already incurred for research-related expenses and provided a means to fund new or expanding activities. Third, they were not rigid formulas. If the parties involved agreed upon a different split of resources, the school could accommodate those requests. Instead, the guidelines became
the “default.” The disadvantage was that the guideline negatively affected the financial health of some departments, as the dean described:

Take a center like Health Promotion and Disease Prevention, for example. It’s a big center. A lot of times the stuff they do might normally be in pediatrics. You have indirects taken out of pediatrics into the center. Pediatrics isn’t very rich; they need every dollar they can get. [Our allocation model] takes 25% out of the pediatrics department.

Question: Is this a problem for vulnerable departments?

Yes, for poor departments, it’s a drain. They have all those start-up [costs] with faculty members, they have the tenure responsibility, they have to get faculty members to do teaching and clinical work. The research center just sits there and has seminars and collects the indirects.

Schools report that they grapple with these resource challenges. Administrative leaders—medical school deans, their associate deans, and university vice presidents—noted the difficulty of striking a balance among departments and centers, all of which have an insatiable desire for a larger portion of indirect cost funds:

How do you fairly support a center or institute without starving the department, without financially or intellectually monopolizing key faculty members in a center’s activities? I think it’s a constant tension that has to be negotiated almost daily between the needs of the center and the needs of the department. (From a university vice president for research.)

Several administrators recognized that the desire of centers for financial autonomy must be accompanied by accountability. In order to achieve their mission and goals (interdisciplinary research, collaborative activities, etc.), centers want “a certain amount of independence and autonomy,” said a principal business officer. But in a world of limited resources, having any amount of funds flow to the center also means it must be held accountable for achieving its goals and contributing to the mission of the medical school and university.

Conclusions and Discussion: Centers and the Culture of Collaboration

The six medical schools in this study displayed distinct patterns of allocating financial resources to research centers and institutes. Several had informal, private methods, in which decisions were handled between the dean and individual center directors. Others had an institutionalized, transparent method, in which allocation decisions were delegated to faculty-led committees. Still others had a hybrid of the two models, in which they were moving to an institutionalized approach but had vestiges of an ad-hoc, private process based on individual negotiation.

These and other findings suggest that leaders throughout the organization can affect culture through their beliefs, values, assumptions, and patterns of behavior.15 The ways in which deans, administrators, department chairs, and center directors attend to, decide upon, and carry out financial decisions can influence how people throughout the medical school think about interdisciplinary and collaborative activities marshaled though centers and institutes. Consider the views of one center director who had been given substantial resources from the dean:

We have the Mother Theresa model of institutes. We get [resources] from the dean and give them away. In the Mother Theresa model, you find money and you give it away to the departments. You find space, and you give it to the departments, including indirect costs. You go to the dean and say, we need more faculty slots. And he gives them to you, and you give them away.

Being virtual, and virtuous, is good because then I get everybody to work with me. Then you have power, right? Once you give away everything, you have enormous power to decide who you are going to give it to. And people like that; they work with you. You can motivate a lot of very good behavior.

I am very eager to see the [center] transition away from what I see as a culture of prestige. In the culture of prestige, what’s good for me is how many grants I have, how many papers I’ve published, how many talks I give, how many awards I win. Let’s face it: what’s really important is what’s good for my career. That’s what we emphasize: a single tall tree standing in the forest. If the tree got tall by suppressing the other trees, that’s okay, just as long as it’s tall. It’s a culture of prestige. And it’s mean-spirited. It’s withholding information. It’s preventing progress.

Where we have to go is toward a culture of service. We don’t have this money, we don’t have these medical schools, these universities, to glorify ourselves. We have them for the expressed purpose of improving the health and wellbeing and knowledge of humanity. We owe society something.

This philosophy assumes not only an institutional but a societal point of view. It articulates a vision in which the center does not amass financial or human resources for its own sake but works collaboratively for the “health and wellbeing and knowledge of humanity.” How many medical school department chairs and center directors currently share this philosophy is unknown, but the future of academic medicine depends upon more doing so. Leaders throughout the medical school may find such a philosophy an appropriate framework in which to address the specific financial arrangements of creating and sustaining research centers and institutes, academic departments, and the entire academic medicine enterprise.

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