Managing, Funding, and Supporting Research

Author Commentary

CHAPTER ABSTRACT: Providing a research environment that entwines new medical knowledge with education, training, and clinical care is one of the most important things a medical school can do to improve health. Research administration has become increasingly more costly, requires specialized knowledge, and can no longer exist without expectations of high-level performance. This chapter outlines an approach to growing and managing the research enterprise, applying a targeted appropriations model that strategically invests resources to meet the long-range financial plan of the medical school, and configuring that plan to support the goals of the university.

One of the interesting reflections that resulted from writing our chapter was a strong realization of how far we have come in galvanizing research at Feinberg. We started with a relatively small research portfolio that we have grown by more than 300 percent since the early 2000s. Research has really become a hallmark of the university and an area of growth that we have trumpeted.

The fact that the co-authors for this chapter include the dean of our medical school, our vice president for research, and our vice dean for finance and administration underscores the power of linking business principles with the traditions of academics to develop best practices. Sometimes applying what can be categorized as "corporate ways" of approaching problems can lead to breakthroughs in how we manage and govern medical centers.

As the Affordable Care Act changes healthcare reimbursement and delivery and the NIH budget continues to compete for limited federal fiscal resources, there will be increased pressures on academic health centers to stay relevant and solvent. Developing a coordinated approach among all medical partners will likely be the only viable way to address this new reality. For example, a hospital relates to a medical school through funds flows for research and education growth, support for academic efforts by clinician educators, and shared opportunities to incorporate advances in education and research into new and novel therapies delivered in the hospital setting. A hospital benefits from the relationship through differentiated products in a rapidly consolidating marketplace. A hospital with clinical trials, physician scientists, and the ability to demonstrate cutting-edge care will create a strong value proposition in the marketplace.

In terms of the partnerships between universities and schools, central administration depends heavily on its medical school for the reputational impact it has on rankings and for the boundless opportunities for collaborative teaching and research activities. Also, in some fully integrated systems, clinical surplus helps sustain the core academic mission of the university. In this new era and uncertain environment, aligning incentives for both shared success and shared opportunities for cost synergies across all these relationships will be vitally important tools.

With respect to research optimization, an important lesson from our chapter is how important it is to share best practices and strategies with other institutions and their leaders. As with fundamental research, findings and translation are accelerated by having others implement the approaches that led to success.

Another finding that I think comes through in the chapter is how important central planning is and, in other cases, how important not having central planning is. There is, in fact, a spectrum of central management. At certain levels, central management can motivate constructive entrepreneurialism. At other levels, it can lead to suboptimal infighting and isolationism. For example, as we discuss in the chapter, while we believe universities should decentralize their medical schools, medical schools are best off centralizing their departments. This subtle dynamic is important to understand in order to foster growth.

Another key takeaway is the importance of metrics. But equally important—if not more so—is executing against these metrics. Vision without execution is simply hallucination. You have to have the tools, processes, and will to act upon the information the numbers provide. In terms of developing metrics, an institution may be able to find models from peers, but often external benchmarks and approaches are only the start. An institution must look long and hard at its own set of data, and its own situation, and determine what approaches will best suit its needs and the many factors that the organization must manage.

I hope that this chapter—and this book—prompt further conversations on these important topics. It would be our great wish that we have stimulated constructive conversation amongst our academic health center colleagues. While there are occasions for us to compete for the best recruits or the next big grant, we must also acknowledge those occasions where we must work together. We are held in the public trust to advance knowledge, train the next generation, and deliver care to patients. Given the challenges brewing just off the horizon, we will all be better off facing them together. This chapter is our contribution to that conversation.

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