



Notes from the Editor-in-Chief

ACADEMIC HEALTH SCIENCES CENTRES (AHSCs) have long been considered paragons of excellence in medical research, education and patient care. Yet, there are signs everywhere in the Western world that AHSCs are in trouble and may not be able to live up to the grand expectations of healthcare providers, patients and the public. In this issue of *HealthcarePapers*, Jeffrey C. Lozon and Robert M. Fox address the complex task of making sense of AHSCs in Canada and suggest some strategies for the future. The authors bravely lead us through the maze of multiple, and often conflicting, roles of AHSCs and the forces that are changing Canadian health services organizations.

Lozon and Fox address the complex question: What is an academic health sciences centre? Previously, the answer to this question was easy – a medical school and a teaching hospital together, yet each having a clear and distinct role. Today, it is no longer such a simple notion. First, in many universities, the concept of the medical school has been expanded to include all health professionals – nursing, pharmacy and other therapists. Second, an urban teaching hospital does not have the sufficient breadth of service to encompass all the aspects of healthcare that must be taught to students of the health professions. As the continuum of care moves beyond the traditional hospital to include ambulatory care centres, home care, community and social agencies, so must the settings for teaching expand accordingly. The Academic Health Sciences Centre thus becomes a network of organizations that must live and operate in harmony.

In their paper, Lozon and Fox outline recommendations they believe will clarify the vision and mission of AHSCs. They also advocate a stronger role for governments in ensuring the most appropriate missions for these complex organizations. In the authors' view, AHSCs should be seen as national resources for the advancement of patient care, education, innovation and science.

To continue this discussion, we were fortunate in obtaining eleven commentaries from experts on AHSCs. Each respondent represents a very different point of view, yet there are common themes. Each is unequivocal in the need for improvement and for AHSCs to re-evaluate their roles and mission in light of the many changes in health-care. Equally interesting, more than half of the commentaries call for AHSCs to re-evaluate their responsibility and responsiveness to the communities they serve.

In a similar vein, several writers touch on the need for special attention to the ethics of decision-making in AHSCs. Apart from the more obvious issue of not doing harm to patients, there appear to be a multitude of ethical trap doors ready to swallow up the unwitting university administrator, clinician or health services manager regarding conflicts of interest when decisions are made. It is these extraordinarily complex issues that attract the attention of the media and can also expose AHSCs to undue negative criticism.

The commentaries begin with a piece by Eldon Smith, former Dean of Medicine at the University of Calgary, who raises important factors that have impinged on AHSCs,

in terms of governance and authority, as provinces (with the exception of Ontario) have implemented regional health authorities. He also points to the plethora of reports that are emerging questioning the sustainability of Canadian healthcare systems, including AHSCs in their current form. Next, Keith MacLellan, a founder of the Society of Rural Physicians of Canada (SRPC), encourages AHSCs to respond to societal needs by expanding their reach beyond the traditional mission of research, education and patient care to include community-based and rural service. He puts forward a thoughtful and provocative perspective outlining the shortcomings of AHSCs in educating professionals for rural settings. He suggests AHSCs could join the SRPC in developing a comprehensive plan for teaching and community service models based on primary care reform. Alan Bernstein, CEO of the Canadian Institutes for Health Research, describes the benefits that will accrue to AHSCs as a result of the current revolution – and increased funding – in health research. This relatively new emphasis on funding for health research precipitates the need for closer collaboration between hospitals, community agencies and universities for the creation and testing of new knowledge.

We next turn to a series of commentaries from experts in the United States. Kenneth Ludmerer, who is acknowledged as one of a small handful of students of academic health sciences centres, outlines the complex changes in medical education and the need for appropriate “laboratories” for practice since the Flexner report of 1910. Flexner wrote the classic book on the revolution of medical education in 1910, and the influence of this writing has pervaded medical schools throughout the world. The report emphasized the need for medical schools to be university-based and thus formed the basis for the complicated relationships that exist today. Ludmerer is the author of the recent book *Time to Heal: American Medical Education from the Turn of the Century to the Era of Managed Care 1999*, which traces the revolution that took place in medical education as we reached the end of the twentieth century. Ludmerer concludes that today’s AHSCs may have lost sight of their original mission of altruism for public good and are fully occupied with issues of survival. Steven Schroeder, President and Chief Executive Officer of the Robert Wood Johnson Foundation provides an insightful review of Ludmerer’s book in *Health Affairs* 19(1) (January/February 2000): 256-57.

Richard Culbertson, of Tulane University, outlines the market pressures on AHSCs in the United States, which initially induced AHSCs to integrate service delivery but are now causing some systems to dis-integrate. Like Bernstein, he believes health research and the dramatic increase in financial support for this endeavour will be critical to AHSCs. Models for how harmony can be achieved among the partners in AHSCs vary throughout the Western world, and some of these are touched upon by Culbertson. In some countries the organizations, are united under a common ownership, organizational structure or unity of command. Not so here in Canada, where we are accustomed to multiple reporting relationships, matrix organizations and other ambiguities that are open to a variety of interpretations depending upon mood or the nature of the issue to be resolved.

Eugene Schneller, from the University of Arizona, calls on AHSCs to develop their vision and market share in ways that will allow them to become more self-determining.

He also discusses the need for strong leadership during this evolution. Schneller points out that AHSCs no longer enjoy the favoured position in society that they have in the past – reorganization of health services around the insurance industry in the United States has diminished the influence of AHSCs such that, for many integrated health systems, they are considered a burden rather than an asset. Part of this problem is because of costs. New experimental treatments are expensive, and governments and other payers may not always be eager to pay for treatments that have not necessarily been shown to be successful. So the question still remains – Who should foot the bill?

Ian Shugart at Health Canada suggests that a supportive relationship between government and AHSCs would provide policy-makers with access to a pool of expertise and evidence that is critical to developing sound health policy. Thomas Ward of the Nova Scotia health ministry warns that times have changed and that AHSCs must recognize emerging issues such as demands for new community service and the demands of an increasingly inflexible workforce.

Robert Woollard, at the University of British Columbia, strongly recommends that AHSCs recommit to an ethic of “service” so that all parts of the organization are dedicated to the needs of patients.

Joshua Tepper, past President of the Professional Association of Internes and Residents of Ontario, identifies a growing rift between Faculties of Medicine and academic teaching hospitals as medical schools strive to educate physicians to meet broader societal needs. He points out the unique role that medical residents have carried in the past, especially in terms of patient care service. With smaller numbers of residents and the pressure to obtain comprehensive education in all aspects of medicine, this backbone of service cannot be maintained. New educational models are necessary. Similarly, D. Wayne Fyffe and John Srigley emphasize the need for the academic enterprise to move beyond the traditional teaching hospital to encompass the community hospital and other healthcare providers in the community.

The conclusion from all our writers, however, is that AHSCs are expensive, and they have additional costs because of their three-pronged mission. No country as yet appears to have the perfect solution for all the dilemmas that AHSCs pose. But as Gerald Anderson, George Greenberg and Craig Lisk suggest: “As long as the public sector continues to pay a large proportion [or all] of the costs ... then the long-run viability of AHSCs looks secure” [see “Academic Health Centers: Exploring a Financial Paradox,” *Health Affairs* 18(2) (March/April 1999): 156-67].

Reflecting upon the varied views and opinions, Lozon and Fox respond with a list of specific recommendations they believe would allow AHSCs to move to the next level. If implemented, these recommendations would result in dramatic changes in the ways in which AHSCs have traditionally operated. There is no question that change is necessary. Lozon and Fox have given us an excellent base from which to begin that process.

