Academic Medical Centers and Underserved Communities: Modern Complexities of an Enduring Relationship

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Background: Most private academic medical centers are located in underserved areas, yet fiscal pressures have led many to struggle with balancing their commitment to surrounding communities with other missions.

Objective: To explore stakeholders' views regarding the ethical, legal, and financial obligations of private academic medical centers to their surrounding neighborhoods.

Design, Participants, and Measures: Qualitative analysis of key informant interviews during 2008 with medical students, faculty and community physicians, administrators, and community health leaders at a large urban academic medical center. Grounded theory was used to iteratively review, code, and revise a taxonomy of themes, with abstraction of illustrative quotes.

Results: Nineteen in-depth interviews were conducted. All respondents believed academic medical centers have an obligation to their surrounding communities but characterized the extent of this obligation in a variety of ways. Respondents disagreed about how the core mission of an academic center should be defined, although many recognized the tripartite mission, conflict centered on the balance that should be sought between research and clinical care. A majority of interviewees expressed frustration with the nation's current health care system. Many provided unprompted recommendations regarding how academic medical centers might engage their underserved communities, including conducting formal needs analyses, promoting ongoing dialogue, and using information technology to bridge the provision of clinical care in community and academic settings.

Conclusions: These data provide enriching perspectives from stakeholders regarding this enduring yet evolving relationship. The diversity of views illustrates one of the challenges that will accompany health care reform impacting academic medical centers and their surrounding, often underserved, communities.

Keywords: education ■ minority health ■ qualitative research

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INTRODUCTION

Academic medical centers have a tripartite mission of education, research, and clinical care. However, as early as 1970, at a national meeting of the American Association of Medical Colleges, an address was made that suggested community service to be "the fourth dimension" of the academic medical center's mission.[1] A central challenge raised during the address was to identify what constitutes *community service* and to determine the challenges that arose when teaching hospitals committed themselves to such initiatives. Almost 40 years later, academic medical centers still grapple with similar questions, albeit with the complexities of today's health care environment.

About 75% of academic medical centers are located in underserved communities with large minority populations[2] that are often underinsured or uninsured. For example, recent estimates suggest that academic medical centers represent 2% of hospitals nationally, yet account for 22% of uncompensated care.[3,4] As the number of Americans with private insurance has declined,[5] covering the costs of financially unfavorable care has become even more difficult. This has been especially true for private academic medical centers, which receive less government support than their counterparts associated with public hospitals.[6]

Many researchers have examined the relationship between academic medical centers and their surrounding communities, particularly the components of effective community engagement[7-10] and the barriers that hinder such collaboration.[11] Private medical institutions, such as Johns Hopkins,[12] Montefiore,[13] Columbia-Presbyterian,[14,15] and Duke,[7,16] all have well-documented community programs that vary in scale and level of community integration. These case studies offer useful

guidance on specific partnerships but leave broader questions unanswered, such as stakeholders' views regarding the nature and extent of commitment that academic medical centers have to these communities.[17]

To explore these issues, we conducted key informant interviews with a variety of stakeholders at a single academic medical center in a large midwestern city.

METHODS

Selection of Key Informants

We selected a purposive sample of 19 key informants from within a large academic medical center and its network, representing key stakeholder groups (medical students, faculty physicians, community physicians, administrators, and community health leaders) chosen based on their profession and role in the academic medical center-community relationship (Table 1). Within each stakeholder group, individuals were selected to ensure a variety of backgrounds (eg, training, specialty, frame of reference), rather than to provide a statistically representative sample of the group.

Survey Development and Administration

We developed a semistructured interview guide based on an extensive literature review and consultation with administration and faculty members involved in previous or current community partnerships. The majority of the items explored the potential obligations between the medical center and community, as well as how any community commitment should be balanced with other aspects of a medical centers' mission (Box). Most interview items addressed private academic medical centers generally, rather than any specific institution, and *community* was defined as both the people and institutions surrounding the medical center.

Subjects were contacted and invited to participate between May through September 2008. The interviews were conducted by one author (A.L.), audio recorded, and transcribed verbatim. Interviews lasted between 45 to 90 minutes, the research protocol was approved by the University of Chicago institutional review board, written informed consent was obtained, and participant confidentiality strictly guarded.

Analysis

As interviews were completed, the first few transcripts were independently read and coded by 3 investigators (A.L., R.M., and G.A.) to determine the major themes and identify areas worthy of further inquiry in subsequent interviews. Review of early interviews also provided an important opportunity to review the interviewer's technique in order to ensure maximal reflexivity during future interviews.[19] Based on these reviews, the interview script was iteratively revised, and interview scripts reviewed, in order to ascertain whether new themes were still emerging or if theme saturation had been met. Subsequent transcripts were coded by 2 investigators (A.L., R.M.). After all interviews were completed, the investigators reread the transcripts and identified themes using the principles of grounded theory, which is a system for analyzing raw, qualitative data. Independently derived themes were reviewed together to eliminate redundancy and to increase the likelihood that the meaning derived was of the interviewees' intent. Following this, the themes were further grouped into organic categories and organized into a working taxonomy.

Table 1. Key Informants

Medical students (4)	Second-year student who grew up in the local community Third-year student with research background in health policy Fourth-year student leader Fourth-year student involved in community partnership initiative
Faculty physicians (7)	Geriatrician Gastroenterologist Family physician who works in a community clinic Hospitalist physician with background in law Internist with background in medical ethics Emergency medicine physician General surgeon
Health care administrators (5)	Dean, school of medicine Chief financial officer of the medical center Chief executive officer of the medical center Vice president for strategy and planning, federally qualified health center network Vice president, local community hospital
Community-based physicians (3)	Endocrinologist, private practice Obstetrician/gynecologist, federally qualified health center Family physician, federally qualified health center

RESULTS

Participants and Major Themes

Our sample of 19 participants ranged widely in age, from 24 years to approximately 65 years; half (10) were women and a majority had worked in health care for more than 15 years. Review of the interviews and coded transcripts suggested several main themes: (1) the obligation of private academic medical centers to surrounding communities, (2) the missions of academic centers, (3) concerns regarding the nation's health care system, and (4) strategies that private academic medical centers can pursue to build and safeguard their relationship with underserved communities (Table 2).

Obligation to Surrounding Communities

We found numerous views on the obligation of academic centers to their communities. Several respondents defined the obligation as similar to that of any private business, such as the responsibility to be a good neighbor or to be nondiscriminatory on the basis of race. Others reported that clinical care for the underserved community was a central obligation. Common ethical arguments for academic centers to ensure the community's access to care included the general belief that health care is a human right and that responsibility comes with these centers advanced problem-solving abilities. Some cited the issue as one of equality, as one doctor put it: "I just believe that people who are surrounding the institution have just as much right as rich people coming in from far away for the best medical care." One community administrator also cited an inherent obligation to be clear and honestly communicate with the community about the medical centers' policies regardless of what they were. Other respondents quickly focused on the limits of the obligation rather than the obligation itself. For example,

there are 5000 hospitals in the United States, only 125 are academic medical centers…you have to generate enough resources, right for that academic component… if you don't, you're not an academic medical center.

A minority of respondents defined a medical center's obligation to its community in economic terms. For example, one medical center administrator felt that academic centers are inefficient at providing certain kinds of primary care and reasoned that doing so wastes the community's resources: "Society's resources…are entrusted to us…we're burning 2 to 5 times as much to provide that care and there is little or no evidence that we do it better." Others, such as the following medical student, felt that because members of the community had limited means and the medical center was well endowed, this situation in itself created an ethical obligation to treat the underserved neighbors:

There are some institutions that have limitless, or innumerable resources, then the scale of responsibility is huge…we've been taught and told "to those who've been given, much has also been expected."

The Missions of Academic Medical Centers

Key informants characterized the relationship between an academic medical center's community obligation and its overall missions in very different ways. Most respondents recognized research as an important mission but some saw it as conflicting with serving the community, as one medical student stated

Putting up these research silos where you focus on research that is not at all remotely related to what… surrounds you…ultimately is not the function of an academic medical center.

Another concern reported by a different medical student was that any effort to shift patient case mix towards better-paying specialties was primarily to cross-subsidize research: "…the desire to keep throwing up all these research towers and recruit researchers…that's sort of driving why profit has become such a huge issue."

Respondents voiced concerns about negative effects of emphasizing tertiary care mission on medical education, primary care research, and overall patient wellbeing. One medical center administrator noted the limited use of overly extreme specialization: "a heart transplant does not come as a pure medical problem without simple comorbidities." Several informants discussed partnerships with other medical institutions to cope with shrinking in-house primary care; medical students and residents could rotate and learn "bread and butter" medicine. Yet, according to this administrator, dispersing students also has drawbacks:

a central part of education really depends on you running into your colleague in the same year when you're doing surgery, that person is doing a hypertension clinic…

A variety of responses were elicited from questions about how the financing of academic centers was relevant to their missions. All informants acknowledged the importance of economics in health care delivery. One medical center administrator had a very simple answer to a script question about whether medicine was a business,

I mean all professions are businesses, right? I mean remember they started from medieval guilds…And it has always been thus, doctors have for 25 centuries charged for their services, and if they didn't how would they eat?

No one claimed making money was in itself the primary goal of academic medical centers, though some believed the economic principle of competitive advantage should determine the missions of the center and that it was vital to have a surplus for reinvesting. Another medical center administrator also emphasized finances and explained that fiscal matters had to be tempered with other considerations:

…To allow the business to drive the principles is the death sentence for the profession. I think that everything that we do in a capitalistic society is ultimately a business transaction. But if that's what our lives were about, ha, I think that would be a very hollow, thin, meaningless existence.

Others thought that the financial goal of these centers should be survival in the face of bankruptcy, not making profit. A medical center doctor questioned whether profit was being ethically invested:

Can we afford to build a gazillion dollar new hospital or can we just keep the hospital as it is and take care of as many people who need the care as possible?

Concern Regarding the Nation's Health Care System

Queries regarding obligations to the underserved often elicited comments regarding how the current health care market is ineffective at distributing health care. Several wanted a complete transformation of this system; others, such as the following medical center doctor, directed anger towards the government for failing to reimburse academic centers for the full costs of care: "You know the government has decided how much to allocate towards reimbursement of Medicare and Medicaid. It's not something that's under control of ourselves personally." Payment schemes that reward specialty care over primary also bothered many interviewees. The same doctor failed to see the

Table 2. Major themes and illustrative quotes

Theme	Illustrative quote
Obligation to Surrounding Community	
Ensuring access	"We have an ethical obligation to make sure that they're getting that care and that that care is available before we start turning them away to build a new hospital."
Obligation defines purpose	"I think that the communities are why these centers should exist, um, in the first place. And I fear that academic medical centers have really stepped away from this ethical obligation. I believe they have."
Obligation limited by finances	"It cannot be the case that the [academic medical center] has to treat every single uninsured patient that walks/knocks on its door. It can't be the case. I mean we would never expect, you know, that if you had a house in [a local neighborhood] that um every homeless person that knocked on your door you'd have to welcome into your house and give them a meal and a bedroom."
Obligation of communication	"That helicopter flies over us all the time. You look up and you go, mm hmm, someone's getting deluxe medical care. If you are in a community that's desperately underserved, you look and you go, 'hmm, that's nice, that's for somebody else not me, but gee I live right here.' The obligation is to have a conversation that reaches the residents who have those fears, those feelings, those misapprehensions, or those correct perceptions, whatever they might be."
Missions of Academic Medical Center	
Competitive advantage	"[A community hospital] can't generate new medical students, they can't generate, you know, new articles in *Science* and *Nature*. We can, alright, so our obligation is defined by what we can do best."
Clinicians engaged by clinical care mission	"Our interview today was delayed because I went downstairs to see one of my patients who had a cardioangiogram a few minutes before…That man and his wife had been patients of mine…for 35 years, and when I am in the office with a patient like that or any of my patients, I don't think about 3 missions or 4 missions, I think about 1 mission."
Clinical care ancillary to research/education	"If you were to take away the research and the education and, then there's no point in the [academic medical center], there just wouldn't be a point being there… the university would close the hospital in a second."
Should not be defined by finances	"…What drives an institution to focus on tertiary care? If it's the bottom line, then that's a concern. Because, knowledge is something that doesn't have a price to it, as far as I'm, as far as I've ever known. And, you know, helping, assisting, teaching shouldn't have a price to pay."

logic behind such schemes. "They'd rather pay $10 000 for a special hip replacement as opposed to giving me $10 000 to manage this complex patient."

One medical center administrator called society's regard of specialty care and love of technology a "poverty of affluence," because investing so much in the latest procedures and devices does not necessarily provide the maximum benefit to society. Another medical center doctor believed uneven profit margins influence medical students deciding which field to pursue, creating motives that may contradict with the country's health care needs:

The problem now, is that the margin for primary care is probably like 3%, and the margin for complex care is probably like 5 or 6%. So where are people [students] gonna go?

Respondents commonly blamed society as a whole for the misplaced incentives faced by academic centers. A medical center doctor charged society to "step up to the plate" in providing sufficient health care access for all, saying "that doesn't necessarily mean an academic medical center's health care system, but it does mean something more robust than a federally qualified health center." This doctor also pointed out that the federal government currently pays federally qualified health centers higher rates than academic centers to see primary care patients, thereby discouraging academic centers from providing

Table 2. Major themes and illustrative quotes (cont)

Theme	Illustrative quote
Larger Health Care System	
Technology overvalued	"The poverty of affluence is that we are a society, we are a country that is attracted to technology, and technology turns out to be very expensive. And technology is not always in our best interests. And that is what we pay for as a society."
Misplaced incentives	"The whole goal is, you know if [a patient] has to be admitted, get them out as fast as possible; from the second they're admitted there are people watching to make sure they get out. … and its not about the people, you know it's all about the money, it's depressing."
System prevents quality	"I think it sucks to owe 200 grand and then work in the 42nd best health system in the world. I think that we're really not providing the care that we have been trained to provide, and that is, you know, I just may not be able to practice the way I want to practice here."
Society fails to ensure health care for the poor	"The larger community problems, um, are completely a result of the social dynamics of the city and region at large, um, I mean the people that used to live here in the 1940s, you know, left and took their money with them…Just because those people left the [academic medical center] behind doesn't mean its just the [academic medical center's] problem, it's still society's problem to figure out how to deal with poverty in America."
Inefficient spending	"I think that we as a nation have to be prepared for a sense that's emerging that $2.5 trillion may be enough. It may be what we're restricted to. Spend it more wisely."
Operational Strategies for Medical Centers to Pursue	
Maximize internal efficiency	"It's the responsibility of the hospital or of the [academic medical center] to be as efficient as possible and to collect as much as possible, so that they are able to provide more care to more underserved patients and maximize the amount of patients we can provide care to."
Improve health policy	"I really think people, besides making these changes, like limiting the number of Medicaid patients to [allow the hospital to] stay open, at the same time there should be people at the same institution writing the new policies that are going to get passed, that are going to change the system and make it better for everybody"
Compete among centers	"…There is never a choice of 'will I make payroll or will I go out of business.' There is always a choice relative to the other people you're competing with. So you probably applied to more than 1 medical school, you may have gotten into more than 1 medical school, you decided to come to this one vs some other set, right? There's a competitive situation."
Business partnerships	"…At the end of the day, the progress in the make is through business deals. Um, and not through everybody sitting at the table and grinning at each other going 'isn't it terrible, here are the problems.'"
Self-interest	"Enlightened self-interest is never a bad thing."

primary care. This respondent felt that the current system of federally qualified health centers was an inadequate solution for the urban poor, citing the lack of tertiary care available to these patients. Several respondents also commented on the lack of integration in the US health care system and how this inefficiency was particularly detrimental in areas with fewer resources.

Operational Strategies for Academic Medical Centers in Underserved Communities

Nearly all respondents offered opinions regarding strategies that academic centers might take to shape their relationship with underserved communities. A medical center doctor suggested that academic centers must tend to the health and efficiency of their business to be of greater benefit to their patients:

Box. Semistructured Interview Guide

1. First, a few questions about your training and your career.
   a. Can you tell me about your specialty and how you chose it?
   b. How long have you been in (academic) medicine?
   c How long have you been at (current employment)?
   d. How is your time allocated between research, teaching, clinical care, and administration or other responsibilities?

2. Historically, how do you think academic medical centers came to be in underserved communities?
   a. Can you say more?
   b. Historically, what do you think the impact has been for these academic medical centers to be located in these communities?

3. Do academic medical centers have an obligation to serve the community they are in?
   a. Can you tell me more about this?
   b. Why does this obligation exist (not exist)?
   c. Is there a difference in community obligation between public and private academic medical centers? Why or why not?
   d. What is the extent of this obligation for a private academic medical center? Are there limits to the obligation that such academic medical center may have to the surrounding communities?
   e. What kind of role(s) should the academic medical center serve in the provision of the community's healthcare?
   f. Are there any ways the community has some kind of reciprocal obligation towards the academic medical center? Why or why not?

4. What are the main ways you think this obligation enhances or detracts from the mission of an academic medical center?
   a. Can you say more about this?
   b. Are there ways that greater community-focus strengthens the traditional missions of an academic medical center? Can you say more about this?
   c. How about ways that such a community-focus might detract or compete with the traditional missions of an academic medical center? Can you tell me more?

5. The community around a private academic medical center also includes other healthcare organizations…
   a. First, let's consider other community health care providers, such as hospitals, clinics, and individual providers. What kinds of relationships should academic medical centers have with other local health care providers? In what ways are academic medical centers and local community providers similar and/or different? Can you say more? goals, resources, services, quality, etc.
   b. There are various other organizations that exist in any local community: such as schools, churches, businesses, law enforcement, etc. Do you think the academic medical centers should have a relationship with any of these entities? Can you say more? Why or why not?

6. Academic medical centers have the unique ability to perform high tech care. Some have argued that academic medical centers should focus on tertiary care and leave the provision of primary care to other health care providers. Others have argued that academic medical centers should not have this sort of tertiary care focus. What are your thoughts regarding this?
   a. Can you tell me more?
   b. Are academic medical centers more effective or efficient at providing one level of care over the other?
   c. Do you think academic medical centers should focus on delivering one type of care more than the other? What kind of balance should be sought?
   d. What are the costs and benefits of the balance you propose?
   e. Does this balance impact the academic medical center's role in the community?

It's the responsibility of the hospital or of the AMC [academic medical center]…to collect as much as possible, so that they are able to provide more care to more underserved patients and maximize the amount of patients we can provide care to.

A medical center administrator highlighted the importance of internal communication regarding an institution's principles when commenting on strategic efforts to limit medical center access to patients who were underinsured or uninsured:

If I didn't have an understanding of what are the principles and what's the business plan, then those efforts fly in direct conflict with everything that I'm taught about being a doctor and being an advocate for my patient.

Respondents also widely suggested increasing communication among academic centers, community leaders, and health care providers. Four respondents, a medical student, a medical center doctor, and 2 community administrators spoke of a roundtable discussion or ongoing dialogue with stakeholders, while others such as the following medical center doctor stressed the importance of academic medical centers explaining their actions to those outside their walls to build the community's trust:

But, its up to the powerful one to show that this is a genuine concern and to prove it before the community; I mean there's every reason for the community not to trust an academic medical center.

However, as one community administrator also pointed out, the measurable goal ought to be the formation of business relationships:

What I don't trust is sort of sitting at a table with a number of partners and having some generalities and pieties about change and investments and needs…at the end of the day, progress is through business deals."

Several respondents mentioned partnerships with other local medical institutions as a way to address both the needs of the underserved and the educational mission.

DISCUSSION

This qualitative study of stakeholders' beliefs regarding academic medical centers and their surrounding communities illustrates the complex dimensions of their relationship. Every respondent believed that academic medical centers have some obligation to their surrounding communities but they differed regarding the extent of the obligation as well as how to best unite the service

Box. Semistructured Interview Guide (cont)

7. The amount that academic medical centers are reimbursed for the care of individual patients varies based patient's characteristics such as their type of insurance and level of comorbid illness. For example, academic medical centers are reimbursed less favorably for delivering primary care than specialty care. Despite this, patients in the community around an academic medical center need all types of care.
   a. How much care should private academic medical centers provide to patients with primary care needs at the expense of seeing complex patients whose care would be reimbursed more favorably? How should this balance be determined? What metrics should be used?
   b. Have you encountered efforts to reduce primary care to patients at academic medical centers? Can you tell me more about this?
   c. Are these efforts explicit policies, institutional barriers, or should they be described as something else?

8. Now, let's consider the differing reimbursement rates from various third party payers. Patients without insurance and on government programs don't reimburse academic medical centers as well as private health insurance plans. Yet, a huge proportion of surrounding communities' inhabitants lack private insurance
   a. Should academic medical centers limit the amount of care they provide to patients whose care is less well reimbursed by third party payors? How should this be done? What metrics should be used?
   b. Have you encountered efforts to limit access of such patients to academic medical centers? Can you tell me more about this? Uninsured, Medicaid, Medicare
   c. Are these efforts explicit policies, institutional barriers, or should they be described as something else?

9. Now, a very broad and open-ended question. Some think that medicine today is a business, while others disagree with this depiction of the profession. How do you feel?
   a. How do you feel when financial concerns are mixed with medicine, for instance in the above example of impoverished patients? Can you say more?
   b. Does dealing with finances affect your ability to practice medicine as you see fit? Why or why not?
   c. Do you think academic medical centers have a unique role in terms of fitting into the medical marketplace? Why or why not?

goals of the medical profession with the fiscal realities of the institution. Previous research has shown that academic faculty physicians have widely begun to recognize institutional barriers to accessing care for the medically indigent; one study found evidence of this at 116 out of 121 academic health centers surveyed.[3] Our findings are important because less is known about various stakeholders' general views about the relationship between academic medical centers and the underserved communities around them.

Although the ultimate impact of The Patient Protection and Affordable Care Act remains unclear, efforts to increase workforce supply, enhance access, improve efficiency, and shore up the primary care infrastructure will all have important effects on academic medical centers and their surrounding communities. It will take years and tremendous changes in the health care system to accomplish these and other objectives of the recently legislated health care reform. The views represented herein illustrate the complexities that academic medical centers and their surrounding communities will face during this process, including the imprecise definitions of what it means to be actively engaged in the community's health and the delicate tension among expanding access, fulfilling multiple missions, and maintaining fiscal viability.

As expected, although there were a variety of opinions even within stakeholder groups, there were some noteworthy consistencies as well. The medical center administrators were more fluent with the medical center's budget, and some highlighted the challenge of helping other stakeholder groups fully appreciate the challenges faced in remaining fiscally viable. By contrast, many medical students and clinicians were less comfortable discussing financial aspects of the medical center's management. As one medical center clinician explained:

…That man and his wife had been patients of mine…for 35 years, and when I am in the office with a patient like that or any of my patients, I don't think about 3 missions or 4 missions, I think about 1 mission.

Some medical students and clinicians believed that motivations underlying the center's management were more grounded in economics than what may be in the community's best interests. Community administrators fell between both extremes, having some sense of the financial challenges facing academic centers in the current US health system, while questioning the soundness of some medical center policies.

Our findings have several implications. First, despite different views among key informants, several participants emphasized the importance of open discussions and frank dialogue regarding the academic medical center's mission and obligation to the community. Such dialogue is crucial to help foster trust, build mutual confidence, and establish relationships that are sensitive to the contexts of specific institutions and communities. Conversely, the absence of such dialogue may hinder successful partnerships and contribute to an absence of organizational cohesion or culture. Second, in addition to such dialogue, partnerships with nonclinical and clinical community leaders were often suggested as necessary steps to sharing the burden of caring for the underserved. Other academic medical centers have exemplified this approach, in some cases through collaborations with federally qualified health centers to increase reimbursement for and sustainability of primary care.[7] As has been suggested by a previously conducted qualitative study survey of community members involved in 5 different academic partnerships, active community involvement in prioritizing needs, as well as a mutual division of tasks, is often crucial to these relationships.[9] These partnerships may be aided by coherent organizational process within the medical center. As one academic medical center administrator in our study suggested:

[It is] very important with a nonpublic academic medical center to have a set of principles around how they define their obligation to the community…those principles then need to be translated into a business plan for how they can sustain their multiple mission areas.

Third, few participants limited their discussion to academic medical centers, and half directly connected the challenges facing these centers to inefficiencies and inequities in the broader health care system. Many of these respondents emphasized that the current system places a disproportionate burden on institutions such as private academic centers that may have greater resources than their community hospital counterparts. Reports from other private academic medical centers have also referred to programmatic challenges because of this unequal distribution of social burden, including difficulty with funding and sustainability.[9]

Our study had several limitations. First, as a qualitative study of key informant interviews, our 19 interviewees were nonrandomly preselected and therefore views expressed in this study may not be representative of stakeholder groups from which individuals were sampled, particularly medical students and faculty physicians. Second, although we attempted to have respondents focus generally about the relationship between all private academic medical centers and their underserved communities, responses to these general questions were invariably informed by individuals' experiences at a few or single medical center. Third, as with all qualitative research, our findings may have been influenced by our own frame of reference, perspectives, and prior experiences. However, we attempted to minimize the impact of this through methods commonly employed in qualitative research,[18] including through the use of triangulation and

reflexivity, as well as continuing key informant interviews and analyses until theme saturation was reached.

CONCLUSION

Despite recent promise of health care reform, many academic medical centers continue to struggle to balance what at times may be competing missions and obligations.[19] Our results suggest the breadth of views that are present regarding these challenges and may be of interest to a variety of stakeholders involved in the relationship between academic centers and their surrounding, often underserved, communities.

REFERENCES

1. McNulty MF, Sheps CG, Knapp RM. Role of Teaching Hospital in Community Service. *J Med Educ*. 1970;45:403-410.

2. Health Professions Education for the Future: Schools in Service to the Nation: Report of the Pew Health Professions Commission. Durham, NC: The Pew Health Professions Commission; 1993.

3. Weissman JS, Moy E, Campbell EG, et al. Limits to the Safety Net: Teaching Hospital Faculty Report on their Patients' Access to Care. *Health Aff*. 2003;22:156-166.

4. Moy E, Valente E Jr., Levin RJ, Griner PF. Academic Medical Centers and the Care of Underserved Populations. *Acad Med.* 1996;71:1370-1377.

5. Garson, Jr A, Blumenthal D. State-federal Partnerships for Access to Care. *JAMA*. 2007;297:1112-1115.

6. Simonet D. Cost reduction strategies for emergency services: insurance role, practice changes and patient accountability. *Health Care Anal*. 2009;17:1-19.

7. Michener JL, Champagne MT, Yaggy D, Yaggy SD, Krause KM. Making a Home in the Community for the Academic Medical Center. *Acad Med.* 2005;80:57-61.

8. Calleson DC, Seifer SD, Maurana C. Forces Affecting Community Involvement of AHCs: Perspectives of Institutional and Faculty Leaders. *Acad Med*. 2002;77:72-81.

9. Wolff M, Maurana CA. Building Effective Community-Academic Partnerships to Improve Health: A Qualitative Study of Perspectives from Communities. *Acad Med.* 2001;76:166-172.

10. Hubbell K, Burman ME. Factors Related to Successful Collaboration in Community-Campus Partnerships. *J Nurs Educ.* 2006;45:519-522.

11. Guerra FA, Crockett SA. Overcoming the Hurdles to Providing Urban Health Care in the 21st Century. *Acad Med*. 2004;79:1148-1153.

12. Levine DM, Becker DM, Bone LR, Hill MN, Tuggle MB, Zeger SL. Community-Academic Partnerships for Underserved Minority Populations: One Solution to a National Crisis. *JAMA*. 1994;272:309-311.

13. Foreman S. Montefiore Medical Center in the Bronx, New York: Improving Health in the Urban Community. *Acad Med.* 2004;79:1154-1161.

14. Garfield R. Community Health Promotion via Local Minority Youth: A Mode for Academic Medical Centers. *Am J Publ Health.* 1996;86:1475-1477.

15. Gusmano MK, Fairbrother G, Park H. From the Field- Exploring the Limits of the Safety Net: Community Health Centers and Care for the Uninsured. *Health Aff.* 2002; 21(6):188-194.

16. Silberberg M, Yarnall KS, Johnson F, Sangvai D, Patel R, Yaggy SD. Neighborhood clinics: an academic medical center-community health center partnership. *J Health Care Poor Underserved*. 2007;18:516-22.

17. Relman AS. Medical Professionalism in a Commercialized Health Care Market. *JAMA*. 2007;2982:2668-2670.

18. Malterud K. Qualitative research: standards, challenges, and guidelines. *Lancet*. 2001;358:483-488.

19. Wartman SA. Toward a virtuous cycle: the changing face of academic health centers. *Acad Med*. 2008;83:797-799. ■