A Double Merger: Biomed at Brigham and Women's Hospital

Sue Schade, chief information officer (CIO) at Brigham and Women's Hospital (BWH) in Boston, oversees both information technology and biomedical engineering—but with a twist: Her director of biomedical engineering also reports to the director of biomedical engineering at Partners Health Care System (PHS), the parent organization of BWH. This structure—unique even within the Partners system—has been in place for more than five years and, in Schade's opinion, has been a success.

Sue Schade

BI&T: *How did this joint supervision of biomedical engineering come about, and what are its advantages?*

Sue Schade: About six years ago, the leadership team here decided that biomed needed to be docked locally, so it was brought under the CIO at BWH. Within the hospital it made sense, because it allows information systems (IS) and biomed to collaborate more easily. Our biomed director knows the issues at BWH and manages our budget, but he also has the Partners' biomedical engineering staff as another resource for expertise when he needs it.

The system has worked very well for us, but we could go further with it. Our biomed director sits in on IS management team meetings, so everybody on the IS team knows him and works with him. People working on joint projects have a lot of exposure to each other.

BI&T: *Are there leadership challenges with this structure?*

Schade: The fundamental challenge from biomed concerns the cultural differences between the two groups and a lack of respect for, or understanding about, the clinical engineering discipline. It is important to make sure we're all going in the same direction and to clarify roles and who "owns" what. For example, how do we reconcile technology that is logical for biomed to own but that has components that should be in IS? It has to be done on a case-by-case basis, and requires a lot of coordination.

BI&T: *Is there overlap in the reporting arrangement?*

Schade: At BWH, the biomed director currently has a solid line reporting relationship to the PHS director for biomed, and a dotted line to me. Operational issues at BWH go through me, and the BWH biomed budget is managed by the BWH director and reviewed regularly with me. The PHS director assists with budget planning and oversight.

BI&T: *How has the IT profession—and with it the role of CIO—evolved since you've been in the field?*

Schade: It is a continuous evolution as both technology and healthcare change. My role has become more strategic. It is less focused on technology and more on leadership. And there's a lot more outreach. We're doing a lot of network development with other healthcare organizations in the region and working with other CIOs to make sure healthcare facilities are on the right track. In other words, it is no longer a position limited to the four walls of the hospital.

BI&T: *What advice do you give to new IT professionals about the clinical side of the work? And, what do you tell new clinical engineers and biomeds they need to know about IT?*

Schade: For IT professionals, they have to understand that the clinical engineering group works with systems that directly touch patients. IT traditionally is more removed, so their work doesn't have quite the critical, time-sensitive component. But with the convergence of medical devices and IT, the IT professionals are becoming closer to the patients. They need to think of biomed as part of the team, not a separate entity.

For new biomeds, I stress respect. There may be frustration that IT doesn't understand the clinical aspects of an integrated device, but there is going to be overlap. Each group has its own role, but they can't operate independently anymore.

BI&T: *What can the healthcare field learn from IT practices in other industries?*

Schade: Even though healthcare has some specific challenges, there's so much that's relevant to all industries. Beginning with the basics—networks and servers—we should look at some of the cost-effective ways other industries have dealt with basic infrastructure. We have to balance patient safety and patient care appropriately. If you restrict data too much, then the people who need it to take care of patients might not have the access they need. ■