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On Being a Chair of Medicine in 2012

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Shortly after becoming a chair of medicine in 2002, I chanced upon an article by Barry S. Coller, MD, PhD, entitled "Reflections on Being a Chair of Medicine, 1993-2001" that was published in Association of Professors of Medicine (APM) Perspectives in ***The American Journal of Medicine***.[1,2] The article served as a blueprint for me as I shouldered the new responsibilities of being a chair. After a decade as a chair, I am relinquishing my position to undertake new challenges. As I was cleaning out my desk I again found myself reading Coller's thoughtful discourse. It caused me to reflect on my own tenure as chair. Clearly, academic medicine has changed over the past decade and so, too, has the role of the chair of medicine. Some critics have argued that being a chair of medicine in the era of health care reform requires greatly different skill sets than were required even a decade ago. I would posit that while many of the challenges are new, most of the tenets put forward by Coller are just as important today; although the order of priorities may be different and new skill sets are required. To provide new chairs of medicine with the same type of information that Coller provided a decade ago, I put forth what I think are the 10 most important concepts that a new chair should keep in mind when undertaking the challenge of leading a department of medicine in 2012.

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DEVELOP A VISION

Coller pointed out the critical need to develop and clearly communicate a vision for the future of your department. I would take the notion of vision one step further and suggest that the department also should develop what Jim Collins[3] refers to as a core focus: the single over-riding element that drives the department. The creation of a core focus has numerous benefits. From a business perspective, it provides a platform for making the difficult decisions faced by department chairs on a daily basis. Resources can be allocated more effectively, faculty and staff have a clearer understanding of how to apportion their time, and limited finances can be appropriated rationally to areas that best support the core focus.

In an ideal world, a department should develop its core mission collectively as part of a formalized strategic planning process. Unfortunately, these formalized processes often take place after a new chair has been selected, abrogating the ability to link the chair's new financial package with the development of the new vision. Therefore, it is important that new chairs perform an adequate amount of due diligence before accepting the position and develop their own vision for their department to ensure some relationship between their financial package and their goals for the future development of their department.

Because we live in such uncertain times, the strategic planning process should be an ongoing exercise—not simply a formal process that occurs once every 5 years or whenever new leadership is put in place. Indeed, the department leadership should undergo a continuing effort to ensure that the department's core focus remains unchanged, that all of the stakeholders remain committed to the department's shared vision for the

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future, and that there is a close alignment between goals and incentives. Any decision to deviate from the department's core focus should be made strategically and with the complete support of the faculty.

RECRUIT OUTSTANDING PEOPLE

One of the first lessons I learned from Edward Benz, MD, when he recruited me to be the Chief of the Division of Cardiology at University of Pittsburgh School of Medicine, was that the success of a division chief or of a chair is predicated on the quality of people who are recruited. However, it is not just recruitment, but also the retention of faculty and staff that plays a key role in the success of a department. I believe that a chair should take the sole responsibility for the recruitment of division chiefs. While a chair may defer some of the responsibility for selecting candidates to a search committee, the chair must spend a substantial amount of time with the recruits and develop his or her own assessment of each candidate's strengths and weaknesses and their ability to fit into the departmental team. Entrusting this responsibility to a search committee can be time saving but counterproductive.

The chair should not limit his or her recruiting to division chiefs or center directors. Rather, the chair also should support the recruiting efforts of the divisions. The chair can often provide the candidates with a historical perspective of the division and the department as well as an understanding of the overall goals of the department and can reinforce the vision provided by the division chief. A chair's participation is especially important for new division chiefs who have limited experience with recruitment.

One of the hardest jobs that a chair faces is replacing a division chief because of performance. It is especially difficult when the chair recruited the division chief in question. However, a division chief who is underperforming can have an adverse affect on the faculty they supervise as well as on the department. The chair must approach a change in leadership with honesty and transparency and work to create a transition that is respectful of the outgoing division chief. The associate dean for faculty affairs can often be an important resource in making these difficult administrative decisions.

PERSPECTIVES VIEWPOINTS

- Leading a department of medicine in 2012 requires a diverse set of skills including an ability to compromise, a talent for recruiting, and a willingness to be transparent.
- Today's challenges can be mitigated by developing a vision, recognizing that our role is the serve the interests of our faculty and giving our division chiefs authority to go along with their responsibilities.
- Two things a chair must assiduously avoid are to accept the status quo and to concede on issues that compromise one's core values.

PERFECT THE ART OF COMPROMISE

Many current chairs grew up at a time when department of medicine chairs were iconic figures who ruled their departments with an iron fist, induced fear in any learner or junior faculty member who crossed them, and often had an enormous impact on American medicine. They often controlled enormous fiefdoms that included large numbers of faculty and staff, great expanses of clinical and research space, and large practice plan budgets. As "physicians-in-chief" of their associated hospitals, the chairs also controlled the clinical enterprises of the hospital.

Medical schools and teaching hospitals today are quite different. Medicine is far more complex, and the inpatient clinical arena requires daily attention to detail. The delivery of outstanding patient care requires the seamless integration of a multidisciplinary team of nurses, social workers, pharmacists, home health programs, and physicians from a variety of medical and surgical specialties. Physicians must be able to effectively transition the care of a hospitalized patient to a provider in the community and a support group in the home. Successful research also requires the formation of collaborative and interdisciplinary teams that come together to solve scientific questions across institutional and departmental silos. In this new clinical and research environment, department chairs must learn how to work collaboratively and collegially with the members of these different teams and must learn to compromise, as resources, responsibilities, and authority is often distributed to different departments and centers.

ALWAYS SERVE THE INTERESTS OF THE FACULTY

Chairs must focus their primary efforts on ensuring the success of the faculty, an endeavor that requires a multitude of skills. First, the chair must serve as a mentor. Young faculty need guidance in choosing mentors for their research, help in identifying agencies that will sponsor their work, and supervision as they develop their own programs. New faculty members have the best chance of success when they are coupled with an appropriate mentor from day 1 – but because academic careers rarely follow a straight course, it becomes the chair's responsibility to show young faculty

the many pathways that can lead to success. Senior faculty members also need support and mentoring as they have opportunities to take on leadership roles, face difficult career decisions when their research funding expires, or need advice about their transition into the later years of their careers.

Second, the chair must work assiduously to recognize the accomplishments of the faculty, both within and outside the institution. Even the simplest means of communication can have an enormous impact on the morale of the faculty. One of the most successful ventures during my tenure as a chair was a simple quarterly newsletter that recognized the accomplishments of the faculty and learners.

Third, the chair should shield both division chiefs and faculty from the entropy that often encompasses medical schools and teaching hospitals. The chair must spend time negotiating with various stakeholders, including the hospital president and the dean, to protect division chiefs from the slings and arrows of academia. When the chair of another department complained publicly that the division of infectious disease was not providing timely consults on postoperative patients, I gathered information from national data banks to support the contention that it was becoming difficult to retain infectious disease specialists because neither the hospital nor the surgical subspecialties provided support for the recruitment or retention of infectious disease experts.

BE TRANSPARENT

A department chair must be transparent about how departmental resources are allocated. It is impossible to keep everyone happy all the time. However, the chair cannot be faulted for making difficult administrative or economic decisions if those decisions are transparently aligned with the strategic goal of the department. The level of transparency should not be restricted to how funds are allocated from the department to the divisions, but faculty also should have a clear understanding of how divisional resources are distributed. The chair should not assume that division chiefs share information about resource allocations with their faculty; chairs should communicate directly with the entire faculty when the department is faced with a financial crisis.

When resources are limited, conflicts often arise between the diverse specialties that populate a department of internal medicine. These conflicts can often be tempered by ensuring that everyone understands how limited resources are allocated and how that allocation is guided by the core goals of the department. When economic constraints require budgetary cuts, the chair should eschew making across-the-board cuts that adversely affect all divisions. Rather, the chair should seek to make cuts strategically, limiting or even eliminating funding for programs that are not consistent with the strategic goals of the department while maintaining funding for programs viewed as being of greatest need and importance.

The greatest challenge that a chair will face is to lead the department when there is an absence of transparency in the dean's office or in the hospital. There is little that the chair can do to mitigate this circumstance, but as Coller pointed out in his reflections in 2002, the chair should never blame financial downturns on the dean or on the hospital. To do so convinces the department's faculty members that the chair is impotent and precludes the chair's ability to lead.

GIVE DIVISION CHIEFS RESPONSIBILITY AND AUTHORITY

Shortly before taking my position as chair, I had a conversation with Eugene Braunwald, MD. He shared with me an important insight: being a chair of medicine was rewarding only if you could be a manager and not a middle manager. A manager has the opportunity to participate in the decision-making process; contribute to the institution's strategic plan; manage the finances, space, and clinical activities of the department; and interact with other chairs, service line leaders, hospital administrators, and practice plan administrators on a level playing field. A middle manager merely takes instructions from the dean, the hospital president, and the practice plan director, and has little or no input into the strategic goals of the institution. In my experience, a chair who is a manager sees the position as a rewarding and satisfying experience. By contrast, chairs who simply serve as middle managers find little satisfaction in the role of chair and are often frustrated as they try to build or effect change.

Regardless of how the chair fits into the administrative culture of the medical school or medical center, the chair should not expect division chiefs to be middle managers. Chairs should give their division chiefs both the responsibility and the authority to achieve the goals that they have collectively set. Division chiefs must actively participate in the creation of the department's budget, the allocation of space, and the department's strategic plan. Division chiefs must be held accountable for all aspects of their divisions, including clinical and research productivity, support of the educational mission, use of space and other resources, and, most importantly, the quality of the clinical care provided.

Chairs should also appoint and empower outstanding vice chairs, especially in larger departments. These appointments provide an opportunity to groom future leaders and can help retain emerging superstars. A constructive management structure at the departmental level may mitigate, at least in part, a flaw in the management structure of the health system or the school of medicine.

The chair should align incentives for the individual divisions with the core goal of the department. When the team shares a common core value and is willing not just to espouse it but to live it, the department works as a constructive unit and can have an enormous impact within the hospital.

DON'T FORGET THE TEACHING MISSION

It is very easy for a chair to forget that an important mission of the academic department is to train the next generation of physicians. It often occurs because hospital administrators only care about volume and margin, practice plan directors focus on access to care and efficiency, and deans focus on research portfolios and indirect cost recovery. Yet if we forget the importance of providing students with the best possible educational experience, we will be abrogating our responsibility for the future of medical care in the United States.

In view of the enormous economic pressures that take up most of a chair's day, how can a chair contribute to the education of students and postgraduate learners? First, select a highly qualified educator to serve as vice chair for education and fund that individual's protected time through departmental resources. Second, publicly and privately recognize the accomplishments of the educators in the department and ensure that they are fairly compensated for their activities. Third, include residents on every task force and committee to ensure that they actively participate in the decision-making processes of the department. Fourth, encourage the use of town hall meetings, small group lunches, and celebratory occasions as opportunities for the chair and the faculty to spend time with the residents in a social environment. And finally, select a single activity that is important to the residents and make it your own. I decided to shoulder a large part of the responsibility for supporting the efforts of our residents to attain fellowship opportunities. Meeting with second-year residents to discuss career planning gave me a unique opportunity to get to know them on a personal level.

NEVER ACCEPT THE STATUS QUO

If a day has gone by without a threat to the well-being of your department, you probably have not been paying attention. The economic and regulatory environment is continuously changing and evolving; departments of internal medicine, because of their size and diversity, sit in the middle of most of these changes. As such, we must continuously reinvent ourselves to continue to fulfill our core mission. There is no right answer and no magic formula, but the process of learning must be ongoing. We must continuously discover and invent new ways to improve.

Most physicians abhor change; even those physicians who do not often feel ill prepared to motivate others to change. I found several opportunities quite useful in facilitating the ability of our department to effectively cope with the challenges we faced. First, I encouraged each new division chief to attend a formal management program to learn the basic concepts of organization, strategy, and management from experts in the field of business. Second, we utilized the consultative expertise of teams available through health care management consulting groups to work with groups of faculty to effect changes in processes of care and teach us how to become better agents of change. And finally, we encouraged the active participation of department leaders in Six Sigma and LEAN training programs sponsored by the hospital.

While chairs of medicine no longer have the institutional power that they once had, creating leadership within the department and creating a business-like environment in which the physician workforce feels empowered to make decisions and effect change can make the department of internal medicine an imposing force within the structure of the health system. This new model of management has been referred to as distributive leadership; the complexities of the current environment are approached by gaining input from individuals with standing in the core missions of research, education, and clinical delivery systems.

PURSUE RESEARCH OR OTHER ACADEMIC ENDEAVORS

At a meeting of the Association of Professors of Medicine that I attended shortly after I became a chair, a former chair gave me one of the most important pieces of advice that I have received. He admonished me to "continue to pursue research." This advice was of critical importance for several reasons. First, you will find that your research is one of the few areas of your life over which you will have virtually total control. You can decide which experiments to do, how to do them, and when to do them. The few hours each week spent reviewing data or manuscripts with your research team also provides an opportunity to recharge, re-energize, and put the day-to-day problems in better perspective. Continuing to pursue academic interests also allows you to continue to interact with a community of scholars, a welcome respite from the daily grind of interactions with third-party payers, regulatory agencies, and clinical administrators.

Spending time in an academic pursuit also is important because no chair position lasts forever. Maintaining your academic profile facilitates the ability of a chair to find the next position or to return to full-time academics at the conclusion of a leadership position. Some chairs believe that an equally important insurance policy for being able to have a post-chair career is to maintain an active practice in their medical specialty. I think this decision is shortsighted. I have found it dif-

ficult to serve the full needs of my patients while at the same time fulfilling my responsibilities to a large group of faculty, learners, and staff. As a chair, it is the latter group and not the former group that are my first responsibility. I have limited my patient encounters to providing second opinions for complex cases and overseeing the delivery of care by residents or fellows.

REFUSE TO CONCEDE ON ISSUES OF CORE VALUES

Although the art of compromise is of critical importance, a chair should never concede when issues involve his or her personal core values. To do so threatens the very underpinning of the chair's authority as well as the ability to lead. Compromising core values also impedes the chair's ability to educate the next generation of physicians. Educators have coined the term "hidden curriculum" to define the untoward consequences that occur when a clinical instructor teaches a student how to respond in a particular situation but then acts in a very different way when faced with the same challenge. The untoward effects on the education of students and postgraduate learners of the hidden curriculum are magnified many times when a chair fails to adhere to the core values that the chair and the faculty have collectively established for the department.

The core values of my department have always been to provide outstanding care for patients while providing an exceptional educational experience for learners, goals that are intuitively simple and straightforward. Unfortunately, maintaining this core focus is not without challenges. Our residents were interacting with an overwhelming number of attending physicians during each rotation because the voluntary faculty members did not want to relegate the care of their patients to a hospitalist. This situation was difficult for everyone. The department wanted to ensure the educational experience of the residents, the volunteers wanted to be able to teach and care for their patients, and the hospital wanted to maintain its market share. It is these types of conflicts between a chair's core values and the values of the medical school or hospital that are difficult to resolve and are a common cause of a chair stepping down.

Being a chair of medicine can be a rich and rewarding experience. In fact, you should approach the opportunity of being a chair as a chance to make a difference while at the same time having a lot of fun. Few other occupations provide the opportunity to oversee the care of patients with a variety of human diseases, create an educational environment that ensures that the next generation of physicians will be highly skilled, and support innovative and disease-related clinical and translational research that may change the future of medical care while at the same time spending most working moments with a group of bright, interesting, and dedicated people. Today's chairs do face fiscal and regulatory restraints that challenge the ability to succeed in the tripartite mission. Far too often, chairs also face structural and administrative deficiencies in medical schools and teaching hospitals that make some tasks seem daunting, if not impossible. I hope that these reflections on almost a decade as a chair will prove helpful, especially to new chairs that are embarking on what will be an exciting and challenging adventure.

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