Chair of a Department of Medicine: Now a Different Job

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Abstract

The job of chair of a department of medicine, once seen as the apex in the career of an academic internist, has lost much of its allure, in part because of increasing administrative and financial obligations that require more of the time and effort of chairs than formerly. This is the impression the author gathered from interviewing 44 current and former chairs, deans, division chiefs, and hospital directors.

He was told that chairs have lost some of their independence as departments have become increasingly dependent on the support of the executives at their university hospitals who, as the source of funds and facilities, can even specify which clinical services the chairs may develop. Conflict over the assignment of resources between dean and hospital CEO, which one interviewee stated can produce "incredible tensions," can complicate efforts of chairs to build clinical and research strength within their departments according to their own preferences. The growing administrative and financial duties of the job have forced some chairs to decrease their dedication to the classic responsibilities of teaching medical students and house officers.

Recruiting outstanding leaders for departments of medicine challenges search committees and deans more than in the past because many suitable candidates do not choose to be considered and prefer to lead institutes, centers, or specialty divisions. The author suggests, however, that schools—by providing chairs with adequate administrative support and authority—can structure the job to improve its attractiveness and allow chairs more time to engage in traditional academic pursuits.

Editor's Note: Commentaries by G. Sheldon and J. Ende appear on pages 914–915 and 916–917.

There was a time when becoming chair of a department of medicine in a prominent medical school was the dream of many academic internists and was seen as the apex of their careers. No longer. It's "not a fun job," "increasingly difficult," "more and more onerous," and "much less attractive." These are some of the comments of 44 people—21 current and former chairs, 9 deans, 6 medical center CEOs and hospital directors, and 4 division chiefs at 22 leading academic health centers—whom I informally interviewed from February to September 2012. I asked them to describe the changes that they had observed in the character and appeal of the job of chair of a department of medicine (see also Coller[1,2] and Feldman[3]) and compared their observations with my own experiences both during and after I was chair at the University of Maryland from 1984 to 1997. Most of the interviews were conducted over the telephone; some were in person. I took notes during the interviews but did not record them. Although in this commentary, I discuss chairs of departments of medicine, some of the observations may apply to the chairs of other clinical departments as well. Because my personal views coincide with what most of the interviewees said, I combined their impressions and mine in the report that follows.

Medicine chairs were once among the scholarly leaders in their medical schools. Now they're "harried middle managers rather than leaders," in the opinion of one experienced former chair. The job has become more administrative and less academic as the financial and managerial roles of chairs have increased and the size of departments of medicine has grown. Whereas chairs formerly controlled most of the resources of their departments, they are now increasingly dependent on the support of the executives at their university hospitals who, as the source of funds and facilities, can specify which clinical services the chairs may develop.

The dean, whom chairs traditionally saw as their chief, has become as dependent on subventions from the hospital as the chair has and, subsequently, cannot provide further support once the recruitment package has been spent. To control costs, some deans exercise greater control over departmental expenses than in the past and require chairs to obtain permission before hiring faculty and allocating sizeable expenditures. Furthermore, chairs' plans can be trapped in controversy over priorities between the dean and chief executive officer (CEO), a conflict that one interviewee said can produce "incredible tensions," a clash that I can attest is extremely taxing.

Directing the clinical service in medicine at the university hospital and outpatient clinics has become a more time-consuming and complicated responsibility for chairs. Regulations regarding oversight and compliance are much more complex, and although performing these duties is often delegated, the hospital leaders turn to the chair when problems arise. Reducing length-of-stay is a constant challenge for chairs of medicine and other services. Chairs are now responsible for the provision of care for patients on medical services without house staff, which is necessary because of the reduction in work hours for residents. Many departments, including ours at Maryland, solve this with a hospitalist service, although this becomes another responsibility for the department's leadership.

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The clinical sway of chairs often reaches beyond the confines of the university hospital, since many academic health centers have merged with or bought community hospitals and have established ambulatory care sites off campus staffed with full-time members of the department. Although the administrative and clinical direction of such sites can be partially, though not completely, assigned to medical or administrative members of the department, the chair is ultimately responsible for the quality of the medical care that his or her colleagues deliver at these sites. I can sympathize with the chairs who complained about the time required to meet and negotiate with the leaders at these hospitals and clinics.

Chairs in research-intensive medical schools have traditionally been selected from the specialty divisions, few from divisions of general internal medicine or other primary care divisions, despite the growing importance of primary care programs in academic health centers. Hospital leaders understand the importance of primary care physicians to staff off-campus sites and refer patients for specialty care, procedures, and admission. Although chairs may prefer to build the research and clinical strengths of specialty divisions, they may find the hospital insisting that primary care become a higher priority, thus, in effect, choosing where chairs should invest in developing their faculties.

As divisions have grown and developed their own resources, division chiefs have become more independent of their departments. Chairs, preoccupied with their increasing burden of administrative and financial activities, find that they can no longer influence activities of their divisions as in the past. The directors of institutes and centers,[4,5] many of which contain clinical and research activities traditionally associated with departments of medicine, may report directly to the dean or the CEO, thereby bypassing the chair, an irritating issue that I experienced when chair. Directing institutes, centers, or specialty divisions—some of which have grown to a size similar to that of departments of medicine in the past—may have greater appeal than taking on the multiple responsibilities, many with limited academic reward, that the chairship now requires. To the extent that this is true—and several of the former chairs interviewed said that they would prefer such a job over a chair position now—many potential candidates with classic accomplishments, making them excellent candidates, may reject recruitment offers.

The growth of the administrative and financial duties of the chairship has reduced the time many chairs can devote to traditional academic roles. Scholarly contact between chairs and house officers, for example, has decreased. The large size of house staffs and the schedules under which trainees now work have interrupted the close relationship that formerly existed between them and those chairs who chose to emphasize this traditional feature of their jobs. Similarly, chairs who enjoy teaching medical students find less time for this time-honored activity.

As the administrative responsibilities of the job have grown, many chairs find it difficult or impossible to continue the research that helped to make them candidates for the job. Some chairs who no longer have the time or the inclination to perform experiments may still meet with their laboratory colleagues once or twice a week to review the progress of the research performed by junior faculty, postdoctoral fellows, and students. Although one chair reported spending 50% of his time on research, this dedication to the laboratory is unusual. I found that, as a chair whose research is clinical, research could be continued, although not as efficiently as before taking on the responsibilities of being chair.

The irony of the selection process, particularly in a research-intensive medical school, is that the curriculum vitae (CV), with its emphasis on publications and competitive grants, may not describe those characteristics most needed in a chair of medicine now. Search committees and deans often start by looking for a scholar, but as the process proceeds, the priorities change, an experienced chair told me. With the hospital CEO or his delegate participating in the search, the group may begin to favor candidates with significant administrative and financial skills over those with impressive numbers of publications in competitive journals. Committees may see the MBA degree as more predictive of a successful chairship than an extensive CV.

The duties of leaders of departments of medicine have not, however, discouraged all competent academic internists from taking on the responsibilities of the job. Several current and recent chairs told me that, although the job has changed, it is no less attractive. With the support of their deans, some have been able to structure their departments with a sufficient number of qualified colleagues who can assume many of the administrative and financial responsibilities and thereby allow the chair more time and energy to fulfill the traditional academic duties of being chair, an arrangement that I strongly favor. Deans and CEOs should also consider delegating the authority to chairs that the chairs need to perform their jobs effectively. For example, chairs should be able to recruit division chiefs and faculty according to their visions of what will best advance the missions of their departments without overbearing interference from deans and CEOs.

Departments of medicine require leaders with the highest academic and personal accomplishments and standards. I advise candidates for chairs of all clinical departments, not only of medicine, to consider most carefully what being a chair entails before accepting, lest they subsequently find the job unpalatable, thereby limiting their tenure as chairs and afflicting their institutions with another search and its associated expense and administrative turmoil.

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References

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