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# The academic chair: Achieving success in a rapidly evolving health-care environment

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time is dedicated to clinical activities<sup>5</sup>. The remaining 55% to 60% is spent on departmental operations (budgeting, staffing, and financial management), personnel recruiting, mentoring, and contributing to institutional programs<sup>5</sup>.

As physicians, and specifically surgeons, formal professional education, research expertise, and clinical experience often are inadequate to foster these necessary abilities, and our academic leaders frequently are ill-prepared for the challenges faced in leadership roles. Unlike our military and corporate colleagues, academic physicians receive little or no formal training in valuable skills such as executive leadership, change management, business administration, and strategy. The need for these abilities and mature business acumen have become paramount to successful leadership in contemporary health-care organizations<sup>2-4,6-10</sup>. At the 2017 American Orthopaedic Association (AOA) Annual Meeting, attendees were asked if they “feel that business and administrative experience are important aspects of becoming a successful chair in an orthopaedic department”; 94% of those surveyed responded that they either “agreed” or “strongly agreed” with that statement.

Recent health-care changes that have reduced reimbursement and expanded patient access have disproportionately affected academic medical centers. Medical schools and hospitals are experiencing the impact of powerful market forces and a shift in power away from providers and toward payers. Currently, physicians have less influence in the marketplace and less autonomy in their clinical practices and research endeavors<sup>9,11-13</sup>. Grigsby et al. recognize that modern “medicine has become an industry governed by free market competition, where, to a large extent, the bottom line has increasing importance.”<sup>13</sup>

The recruiting and hiring processes to fill academic leadership roles has been slow to adapt and recognize the skills that are necessary to be a successful chairperson in the contemporary academic health-care system<sup>14,15</sup>. The average cost of a search to fill a chair position is \$63,000, and it is exponentially more expensive if an executive recruiting firm is utilized<sup>12</sup>. The recruiting and hiring process takes an average of 11.9 months<sup>12</sup>, and yet the mean tenure of a chairperson is only 3.7 years<sup>3</sup>. The process often fails to produce capable and successful leaders, with medical school deans regularly reporting dissatisfaction with the outcomes of chairmanship searches<sup>7,12,14,15</sup>. These failures in leadership frequently can be traced to the selection process itself. This is largely due to a misalignment between the goals of the typical search committee and the skills that are required to be a successful department chair in a modern academic health-care system. As noted in the article by Palmer et al., academic leaders “typically come to their positions without any leadership training, without prior executive experience, without a clear understanding of the ambiguity and complexity of their roles, without recognition of the metamorphic changes that occur as one transforms from an academic to an academic leader, and without an awareness of the cost to their academic and personal lives.”<sup>15</sup>

Once an orthopaedic vacancy or future vacancy is identified, the dean of the medical school convenes a search committee. The committee is charged with (1) attracting the most accomplished candidates to the position, (2) recruiting from

departments at reputable or accomplished medical schools, (3) developing a long list of potential candidates, and (4) ultimately delivering the names of 3 to 5 final candidates (with or without prioritization) for in-person interviews and final consideration. This committee typically is made up of 10 individuals. It comprises a committee chairperson, 4 to 5 department chairs, the hospital system chief executive officer (CEO) (or an assigned proxy), an ethicist, and 2 to 3 at-large seats. The committee may or may not have representation from the department of orthopaedic surgery. If orthopaedic representation exists on the committee, these individuals are charged with educating the committee about the national and local challenges in orthopaedic surgery, informing on the specific leadership qualities that are needed by the department at that particular time, and identifying important memberships in societies, traveling fellowships, and authorship in leading orthopaedic journals of the potential candidates. Due to the concern that departmental representatives serve as a conduit of confidential search information back to the department and to avoid potential confidentiality breaches, many institutions have instituted a policy of no departmental representation on their search committees.

Traditionally, search committees have focused on identifying surgeons who are considered leaders within their discipline<sup>12,14,15</sup>. They usually seek out surgeons with numerous publications in the most highly respected journals, evidence of focus and commitment to an important clinical or basic science area, prosperous grant funding, and effective extramural fundraising. As a litmus test for leadership aptitude, they have historically relied on those with national and international reputations, academic awards and honors, and positions of leadership in specialty and subspecialty societies. With regard to the search process, Fisher stated that, historically, “chairs are chosen because they have been successful. They have run successful clinical programs, successful laboratories, successful program projects, successful residency programs.”<sup>16</sup>

However, at a surprising rate, medical schools and academic hospital systems have witnessed that an accomplished curriculum vitae (CV) and prior success as an academician do not correlate with success as a chairperson at an academic medical center or in a surgical department. Thus, it should be concluded that the persistent use of criteria based solely on academic achievement is outdated and shortsighted.

It is critically important for each organization to define success. This definition will differ depending on the mission and vision of the organization, but should be clearly stated and measurable. For most organizations, this represents a complex mix of patient outcomes, human resource measures, research activity, educational/training milestones, cost containment, health-care productivity, and scholarly activity. Examples of such outcome matrices could be personnel retention, extramural research funding, achievement of clinical quality and safety standards, surgical volume, working relative value unit (wRVU) productivity, dollars saved from cost containment, high-impact-factor peer-reviewed journal publications, and educational milestones (resident in-training scores, milestones, graduation rates, and board pass rates). Specific measures of

academic productivity and scholastic activity of the orthopaedic departmental chair are paramount to defining and driving achievement<sup>17</sup>. Many orthopaedic centers undertake impactful clinical and basic science research. However, with regard to National Institutes of Health (NIH) research funding, orthopaedic surgery ranked behind general surgery, ophthalmology, obstetrics and gynecology, otolaryngology, and urology in terms of the amount of extramural grant funding that was received<sup>18</sup>. Furthermore, the majority (71.1%) of primary investigators on orthopaedic studies funded via NIH mechanisms are headed by PhDs, not MDs or clinicians. Additionally, the majority of NIH funding is clustered in a few centers, with only 31% of total orthopaedic departments represented and 3% of national academic faculty funded<sup>19</sup>.

To achieve improved outcomes and successfully identify candidates with the appropriate motivation, desire, and skill set, recruitment methods recently have evolved in 3 ways. First, the interview format has been developed to focus on leadership qualities by searching for individuals who possess integrity and can provide meaning, generate trust, and communicate values. These characteristics and skills should no longer be viewed as desirable individual qualities, but as fundamental requirements of the chairmanship position. Secondly, potential candidates are given structured questions in advance so that they can provide thoughtful and prepared plans for departmental strategic vision. Examples of such questions are “How do you think the field of orthopaedic surgery will evolve over the next 5 to 10 years, and how should this department prepare to adapt to this evolution?” and “How do you ensure the academic mission in this changing health-care environment?” Lastly, committees have committed substantial time and resources to perform rigorous due diligence regarding all finalists for consideration. It is no longer adequate to simply contact other leaders in the field and leaders at the candidate’s current institution. The due diligence should be all-encompassing, and inquiries should be made to other chairs, peers (faculty members), and individuals who directly report to the candidate, such as secretaries, nurses, students, and residents. This 360° feedback gives the institution valuable insight into each individual’s interpersonal, communication, and managerial skills.

New efforts have been devoted to identifying some of the essential skills that are necessary for the successful leadership of academic departments. In a poll conducted at the 2017 AOA Annual Meeting, registrants overwhelmingly identified strategic planning, resilience, and communication as the most critical competencies for effective departmental leadership. Jeff Lobas, MD, EdD, investigated the capabilities among leaders in academic medicine and the conditions for organizational success. The study involved collecting and analyzing CVs, administering 2 survey instruments that explored self-efficacy and job content, and conducting 3 structured interviews with randomly selected academic chairs<sup>5</sup>. He identified 12 factors that are associated with departmental success: leadership congruency, leadership skills, emotional intelligence, communication skills, departmental vision, a strong executive leadership team, professional development, renewable resources, business acumen, personnel management, managing change, and defining

success<sup>5</sup>. Grigsby et al. identified comparable qualities and attributes in their study, “The Future-Oriented Department Chair,” and these attributes can be grouped loosely into emotional competency, resiliency, leadership, communication, results orientation, and personnel development<sup>13</sup>.

Emotional intelligence and its concomitant skills are the most essential competencies for leaders to flourish in their academic careers. Emotional competency includes mature interpersonal skills, self-awareness, the ability to inspire others, and the ability to adapt to change. This finding is supported by research in fields outside of medicine. Emotional intelligence has been linked to bottom-line organizational performance in terms of productivity and profit. In leadership positions, 90% of the competencies necessary for success fall into the category related to competency in emotional intelligence.

Resiliency is defined as the ability to deal with failure, reflect, and then take thoughtful, decisive action. Clinical departments experience substantial change on a daily basis. Effective leaders must be able to prepare their organization for change by providing effective departmental strategy, defining individual and personal goals for success, and ensuring proper resources to achieve common goals. They must become subject matter experts in change management, be adaptive to external market pressures, and be open to innovation.

An essential factor for success is open, honest, and skillful communication. Congruency in expectations and alignment of goals among the department chair, the medical school dean, and the CEO of the teaching-hospital system require constant communication and transparency. There often exists a natural tension between the educational mission of the medical school and the business of the hospital system (patient volume, payer mix, burden of documentation, clinic access/wait times, physician compensation, resident education/autonomy, and physician satisfaction). Thus, it is important for the chair to have open dialogue, trust, and goal alignment with the leadership of both the hospital and the medical school. Most importantly, the chair should be a thoughtful listener who is in tune with the faculty, the residents, and the support staff. He or she should be able to gather feedback, process departmental challenges, and overcome organizational hurdles.

Successful department chairs have mastered a basic set of leadership skills. These include skills such as visioning, strategic planning, change management, team building, personnel management, business skills, and systems thinking. There is a growing consensus that these skills are not only desirable, but required for effective leadership in a modern academic department<sup>8-10,20</sup>. However, traditional medical education and training includes little or no formal training in these aspects of leadership development. Accordingly, there is great debate on how and when academic leaders should obtain these skills. Some have advocated for acquiring additional skills by obtaining formal advanced degrees such as a Master of Business Administration (MBA) degree. These programs range from part-time 24 to 36-month executive programs that are attended in the evenings and on weekends to 1 to 2-year full-time programs. The MBA programs give in-depth training on both the “soft” leadership skills (executive leadership, change

management, strategy, ethics, etc.) and the “hard” business skills (accounting, finance, economics, marketing, etc.). Several dual MD/MBA and health-care MBA programs have emerged that are designed to focus their curricula on issues that are specific to health-care professionals (the University of California-Irvine Paul Merage School of Business, the Indiana University Kelley School of Business, and the Auburn University Raymond J. Harbert College of Business). However, these degree programs are time-intensive and expensive. They incontrovertibly offer excellent training, but often are difficult to complete while maintaining a busy clinical practice.

Alternative options include shorter nondegree executive leadership immersion courses. These are intensive programs in leadership and organizational management that are designed for busy executives and professionals. They are offered at various institutions, but the most well-known and widely attended have been at Stanford University, Harvard Business School, the University of Chicago Booth School of Business, the Northwestern Kellogg School of Management, the Notre Dame Mendoza College of Business, and the Wharton School of the University of Pennsylvania.

For orthopaedic surgeons, additional leadership training opportunities exist within the American Academy of Orthopaedic Surgeons (AAOS) and its subspecialty societies. The AAOS offers a fellows program for individuals who are interested in future leadership in orthopaedics. Additionally, the AOA offers both the Emerging Leaders Program (ELP) and the C. McCollister Evarts Resident Leadership Program (RLP) for resident trainees and young practicing orthopaedic surgeons with aptitude and motivation for career paths that involve potential leadership positions. Less-structured leadership opportunities exist by becoming involved with committees and boards of medical societies, institutional faculty development programs, and personal coaching<sup>7,20,21</sup>. These programs all offer the opportunity for obtaining or refining the business, managerial, and leadership skills that are lacking in current professional surgical training and education.

Another key characteristic identified in efficacious leaders is that they remain results-oriented. They set clear expectations, define success, and provide the necessary resources to achieve departmental goals. The clinical, scientific, and educational activities should align with the strategic vision and remain focused on execution. While faculty, residents, and support staff must be held accountable, achievements should be publicly recognized and celebrated.

The final essential talent of high-achieving leaders is the ability to inspire and help the individuals around them to develop. This can be accomplished with formal mentorship programs, informal coaching, career planning, and educational support. These individuals maximize the talent and the productivity of the residents, the faculty, the research teams, and the staff by

cultivating a collegial and cooperative work environment, empowering creativity and innovation, and providing graded professional autonomy.

Academic chairmanship is not for everyone, and it has become clear that traditional academic achievements and talents may not be enough to effectively run a department. Health-care reforms, market competition, focus on cost containment, and pressure for productivity have necessitated increased attention and time directed toward administrative management at academic health-care centers. Because multiple and often competing constituencies and agendas exist, careful navigation and thoughtful strategies to achieve departmental goals are required. Formal courses and training in executive leadership and business management may be helpful in enhancing knowledge and skills in these disciplines. The objectives of a chair will always include advancing patient care, education, and research. However, the soft skills, revered by the military and the corporate world, are increasingly critical to achieving success. In a modern academic health-care system, true departmental excellence requires capable leaders with mature managerial skill sets and strategic vision. ■

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