Bigger Chairs at Smaller Tables

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Abstract

As noted in the commentary by Kastor, chairs of academic clinical departments in medical schools now find themselves beleaguered by issues and responsibilities—and in reporting relationships—that are beyond the traditional scope of those positions. The situation is particularly acute in departments of medicine. This commentary suggests that departments of medicine have become too large and that chairs are no longer able to focus on the more traditional missions of the department of medicine, most notably direct clinical care and teaching. An argument is made for limiting the scope of departments' clinical and research programs, thereby enabling academic chairs to regain the level of prominence and satisfaction that has traditionally been associated with those distinguished positions.

Editor's Note: This is a commentary on Kastor JA. Chair of a department of medicine: Now a different job. Acad Med. 2013;88:912–913.

Now and then, on internal medicine attending rounds, I will remind my team of students and residents of the *Four Rules of Medical Therapeutics*,[1] which I dutifully attribute to Robert F. Loeb, MD. "*Rule 1*," I announce: "If what you are doing is working, keep doing it. *Rule 2*, If what you are doing is not working, do something different. *Rule 3*, If you don't know what to do, do nothing. And *Rule 4*," I add, "is never call the surgeons." (Although Loeb actually said, "Never make the treatment worse than the disease."[2]) I almost always get a good laugh. I used to then ask, "Has anyone ever heard of Dr. Loeb? You know, Loeb, the chair of medicine at Columbia from 1947 to 1960, preeminent clinician, almost won a Nobel Prize—that Loeb, from the textbook, Cecil and Loeb?" Blank stares all around; probably the same stares I would get if I asked them about Stead, or Hurst, or Seldin, or Petersdorf. It would not trouble me if it were only that my students are unaware of these giants of decades ago. After all, time passes. What does trouble me is that they do not have any giants, or heroes, of their own. Chairs of medicine used to be heroes. Why is this no longer the case?

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For one thing, ours is not an age of heroes, not in sports, not in politics, and, alas, not in medicine. Writing about the 1970s and 1980s, Ludmerer[3] notes:

> The disappearance of heroes from medicine reflected in part the cynicism of an American society that had been through the trauma of the Watergate affair and the Vietnam War. However, it also reflected the fact that academic medicine had grown too large and fragmented for "heroes" to emerge.

Since then, it has only gotten worse. Today's would-be heroes—typically chairs of medicine for those of us in that field, and of whom Kastor[4] paints a somewhat gray picture—are more harried than heroic. Chairs of medicine today may find themselves in charge of upwards of 300 faculty, clinical enterprises generating hundreds of millions of dollars, and research portfolios in the hundreds of millions as well. In addition, they are responsible for growing clinical volume and ensuring quality across several hospitals and ambulatory sites, and (oh, yes!) education programs for students, residents, and fellows. All of this occurs in the highly competitive, corporate environment of health care delivery, reporting to deans who are beholden to CEOs or, in effect, reporting to CEOs directly. Suffice it to say, the onerous issues Kastor's interview subjects describe are hardly a surprise.

But neither are they necessary. Law schools operate successfully based principally on tuition dollars, endowment, philanthropy, and sometimes state support. Business schools, likewise, depend on revenue from tuition, endowment, and philanthropy, and perhaps fees from other educational programs and a small amount of research funding. Medical schools have long been the envy of the other professional schools for their capacity to provide trainees with realistic and practical experience. But medical schools, now subsumed within academic health systems (AHSs), have grown financially dependent on clinical practice, as have the AHSs—hence, the pressure to expand clinical practice, and the need for academic departments, including departments of medicine, of course, to expand and grow. Have academic departments of medicine become too large, with a scope of activities that is too dispersed, and responsive to forces that may direct chairs' attention away from the academic mission? Although departments of medicine, like some corporations, may be "too big to fail," the job of a chair of medicine may be too big to succeed. Part of the solution may be, as Kastor[4] suggests, for the chair to delegate responsibilities to others, but that may not be enough.

In addition to considering strategies for more effective delegation, the conversation should also include the following two questions: First, must the clinical service directed by the chair be so large? Instead, the department could be responsible only for as many patients as needed to maintain the education program and support key faculty. The clinical volume and growth required to support the AHS and maintain clinical market share would still be part of the AHS, but not the responsibility of the department of medicine.

And second, must departments' research programs be so large? Yes, to the extent that robust research programs enable departments to attract outstanding faculty and trainees; but no to the extent that a good deal of research these days is unrelated to the department's clinical and teaching missions, and may be better

situated in an organizational structure of centers and institutes related to, but not the responsibility of, the department and the chair.

Where would all this downsizing leave the chair? Still at the head of the table, of course, but hopefully more gratified and fulfilled, functioning more as a leader than a manager, in a position that may be smaller in terms of dollars and FTEs, but bigger in terms of control over what is important for her or his department. Chairs might even have some more time to walk about (or stalk, as did the giants of yesteryear). They might even have more time to teach students, conduct their own research, mentor faculty, and see patients on the wards. Would that be attractive to candidates considering becoming chairs of medicine? Probably not to all of them. But, then, not everyone can be a giant.

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