

The Modern Surgery Department Chairman

The Job Description as Identified by Chairmen

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Importance: The role of the chairman of a surgery department is critical in academic surgery. However, little is known about the variability of job responsibilities.

Objective: To evaluate chairmen's responsibilities, methods of support, determinants of job performance success, and concerns.

Design: Internet-based survey.

Setting: Electronic survey system.

Participants: Seventy-two chairmen.

Main Outcomes and Measures: Survey data on job responsibilities, methods of support, determinants of job performance success, and concerns.

Results: Of 168 chairmen who received the survey, 72 (43%) responded. The mean age of chairmen was 57 years (range, 44-78 years). Of 72 chairmen who responded, 69 (96%) were men, 67 (93%) were white, 65 (90%) were professors, 11 (15%) held a previous chair, 35 (49%) have advanced degrees, and 19 (26%) are program directors. Respondents are responsible for an average of 8.7 divisions, 60 (83%) spent 1 to 10 hours per week in the clinic, 45 (63%) performed surgery 1 to 10 hours per week, 54 (75%) took less than 6 call days per month, 44 (61%)

published 1 to 6 papers per year and attended a mean (SD) of 4.3 (1.7) essential meetings per year, and 48 (67%) took 1 to 3 weeks of vacation annually. Chair salary support includes (from least to most) faculty tax, grants, endowment, school, and hospital. Compensation correlates with age, additional degree, specialty, location, contract, and tenure but not clinical hours. Reported compensation was consistent with data from the Association of American Medical Colleges, but 24 (33%) felt undercompensated. Incentives for job performance were given for clinical productivity (34 chairmen [47%]), department performance (50 [70%]), institutional performance (27 [38%]), and personal accomplishment (14 [19%]). Of 72 chairmen, 30 (42%) were concerned about personal liability related to the job, 15 (21%) had purchased personal liability insurance, and 20 (28%) have defended a lawsuit related to nonclinical responsibilities.

Conclusions and Relevance: Academic surgery department chairmen have a wide array of responsibilities that have changed from historic standards. Success in the role of chairman may improve by appreciating the responsibilities, time allocation, methods of support, and concerns of other chairmen.

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THE DEPARTMENT CHAIRMAN has an important leadership role in every academic surgery department and medical school. Autobiographic observations of the chairman's job responsibilities have been published and presented.¹⁻³ Several authors,²⁻⁵ reflecting on their tenure as chairmen, have focused on faculty academic affairs, student affairs, budgetary requirements, research, and alumni and community relations. These observations of responsibilities are not unique to chairmen of surgery departments, and most are noted as the responsibilities of any academic chairmen.^{6,7} Personal interpretations of important attributes of successful academic chairmen have also been published.^{1,5,8,9} The personal opinions and gen-

eral assumptions of the responsibilities of the surgery chairman have emphasized the changing role of a surgery department chairman (for at least the past 30 years) and have discussed, with varying degrees of lament, the increasing corporate control of a modern surgery department.

See Invited Critique at end of article

Although there is general agreement that academic surgical departments are experiencing tremendous change, rife with uncertainty about the future of funding, expectations, and priorities, to our knowledge, there has not been a study to evaluate the basic duties and details of a surgery department chairman's position today. In fact, no "standard" for the job of sur-

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Table 1. Data on Surgical Specialties of 64 Surgery Department Chairmen

| Specialty | No. (%) of Chairmen |
|--------------------|---------------------|
| General | 18 (28.1) |
| Cardiothoracic | 6 (9.4) |
| Oncology | 18 (28.1) |
| Pediatric | 1 (1.6) |
| Minimally invasive | 1 (1.6) |
| Transplant | 5 (7.8) |
| Trauma | 8 (12.5) |
| Vascular | 5 (7.8) |
| Other | 2 (3.1) |

gery department chairman exists, and little has been published in this regard, at least in comparison with leadership positions in other industries.

Furthermore, little is known about the level of job-related stress or job satisfaction of surgery department chairmen. Given the importance of the position, knowing details about the current requirements for the position and about job-related stress and job satisfaction could assist medical schools in providing the resources and environment necessary to improve selection, reduce turnover, enhance effectiveness, and increase long-term commitment. To better understand the complexities of the chairman's position, we designed a detailed survey to identify and define the responsibilities and characteristics of a modern surgery department chairman.

METHODS

We composed and delivered our survey using a commercially available electronic survey system (SurveyMonkey). The survey consisted of 62 questions divided into 2 sections: demographics, clinical activity, professional travel and vacation, research, and perceptions of liability.

The e-mail addresses of surgery department chairs in the United States were obtained from publically available records. There is no single comprehensive database of the nation's surgery department chairs. Sources used included the American College of Surgeons online database of surgery departments¹⁰ and the American Medical Association's FREIDA Online database of accredited residency programs.¹¹ If any information (eg, names of chairmen or e-mail addresses) was missing, a telephone call was made to the department administrator requesting the contact information. An e-mail was sent to each chair with a link to the survey. Follow-up survey requests were sent 2 additional times over the course of 1 month. Data were collected via the survey website and converted into a spreadsheet format.

RESULTS

DEMOGRAPHICS

Of the 168 chairmen who received the survey, 72 (43%) responded. The mean age of respondents was 57 years (range, 44-78 years). Of the 72 chairmen who responded, 69 (96%) were men, 67 (93%) were white, 65 (90%) were appointed at the professor level, and 45 (63%) had received tenure. Hospital affiliations were given as follows: community hospitals (4 respondents [6%]), uni-

Table 2. "Average" Surgery Department Chair

Characteristics

| |
|---|
| White male |
| US residency |
| Fellowship trained |
| Board certified |
| Tenured professor holding an endowed chair |
| First chair position |
| In position for 8.3 y |
| Has annually renewable contract |
| Takes calls for own patients >10 nights/mo |
| Takes calls for unassigned patients 1-2 times/mo |
| 1000-4000 RVUs/y |
| Takes 2-4 wk of vacation |
| Travels 3 wk/y for meetings |
| Attends the ACS, local ACS, and regional surgical meetings yearly |
| Publishes 3-4 manuscripts per year |
| Has no grant funding |

Abbreviations: ACS, American College of Surgeons; RVUs, relative value units.

versity-affiliated community hospitals (22 [31%]), public university hospitals (25 [35%]), and private university hospitals (21 [29%]). The geographic distribution of respondents was as follows: 9 (13%) were from the West, 11 (15%) were from the Midwest, 25 (35%) were from the South, and 27 (37%) were from the Northeast. Forty-four respondents (61%) had completed a surgical specialty fellowship. The specialties are shown in **Table 1**.

On average, the surgery chairs had held their current position for 8 years (range, 4 months–27 years). The average age of first becoming a chair was 48 years (range, 37-61 years). It was found that 11 of the 72 respondents (15%) had held a previous chair position. Nineteen of the 72 chairmen (26%) are concurrently also residency program directors. On average, they are responsible for 9.1 divisions (range, 1-17 divisions) of the surgery department. Utilizing the average for continuous variables and the mode for discreet variables (answers based on ranges), we provide the characteristics of the "average" surgery department chair in **Table 2**.

TRAINING

The majority of surgery department chairs (71 [99%]) graduated from US medical schools. All but one was board certified. Most respondents (42 of 72 [58%]) did not have an additional graduate degree. Of the 30 respondents reporting an additional degree, 9 (30%) had a PhD, 5 (17%) had an MBA, 4 (13%) had an MPH, and 12 (40%) had a "other" master's degree.

CLINICAL ACTIVITY

In terms of clinical responsibilities, 60 of 72 respondents (83%) spent 1 to 10 hours per week in the clinic, 45 (63%) performed surgery 1 to 10 hours per week, and 37 (51%) took emergency department calls, on average, 5 days per month. Fifty respondents (69%) reported that they knew their relative value units (RVUs). For these 50 respondents, the distribution of RVUs is shown in

Table 3. Annual RVUs Reported by 50 Surgery Department Chairmen

| No. of RVUs | No. (%) of Respondents | Mean (SD) W-2 Wages, \$ |
|-------------|------------------------|-------------------------|
| ≤1000 | 2 (4.0) | 608 461 (198 973) |
| 1001-2500 | 12 (24.0) | |
| 2501-4000 | 18 (36.0) | 584 000 (99 900) |
| 4001-5500 | 3 (6.0) | |
| 5501-7000 | 6 (12.0) | 724 416 (219 450) |
| >7000 | 9 (18.0) | |

Abbreviation: RVUs, relative value units.

Table 3. Gross collections were reported (ie, mean [SD], \$557 796 [\$540 835]).

COMPENSATION

The mean (SD) W-2 compensation was \$611 333 (\$203 938). The mean (SD) base salary was \$523 491 (\$196 984). The distribution of compensation was highly variable. Compensation correlated with age, additional degrees, specialty, geographic location, and tenure, but, interestingly, it did not correlate with clinical effort. Chairs who were also program directors tended to earn less. Chairs with fellowship training earned an average annual salary \$100 000 greater than those without. Compensation was also greater for 43 of the 72 chairs having a formal contract (60%). Sixty-three chairmen (88%) reported that they understood what their compensation was based on. Forty-five respondents (63%) had an annual bonus provision that depended, to varying degrees, on clinical activity (21 of 45 respondents [47%]), department performance (32 [71%]), institutional performance (17 [38%]), and personal accomplishment (9 [20%]). Twenty-four respondents (33%) reported feeling undercompensated, and this group did fall below the average reported compensation.

RESEARCH

Of the 72 respondents, 44 (61%) felt pressure to continue to publish. Interestingly, when evaluated by age, the younger (<50 years) and older (>70 years) chairs felt the most pressure to publish. Most chairs did not have external grant funding (53 respondents [74%]). When asked how many publications they were included in as an author per year, most respondents (42 [58%]) reported 1 to 4 publications, 18 (25%) reported 5 to 8 publications, 4 (6%) reported 9 to 10 publications, and the remainder reported more than 10 publications.

PROFESSIONAL TRAVEL AND VACATION

The chairs reported attending a mean (SD) 4.3 (1.7) meetings that they considered essential each year, which required 3 to 5 weeks of professional travel. Sixty-eight respondents (94%) attended the American College of Surgeons clinical congress each year. In addition, 54 (75%) attended the prominent regional surgical meeting for their area of the country, and 53 (74%) attended the local

American College of Surgeons chapter meeting. The average chair travel budget is \$11 321 (range, \$0-\$60 000). Thirty-five respondents (49%) participated in the American Board of Surgery examination process. Nine respondents (13%) reported being American Board of Surgery directors.

All chairs had personal vacation time. The amount of vacation time taken ranged from 1 to 7 weeks per year: 1 week (4 respondents [6%]), 2 weeks (14 respondents [19%]), 3 weeks (26 respondents [36%]), 4 weeks (17 respondents [24%]), 5 weeks (4 respondents [6%]), and 6 to 7 weeks (7 respondents [10%]).

LIABILITY

Regarding lawsuits, 30 respondents (42%) report concern about personal liability related to their position as chair. Sixty-three respondents (88%) were confident that their employer was committed to defending them in a suit related to their obligations as chair and/or residency program director. However, 15 respondents (21%) reported having independently purchased personal liability insurance. Twenty respondents (28%) have had to defend a lawsuit directly related to nonclinical aspects of their job as chair. Of these 20 respondents, 2 (10%) hired a personal lawyer to assist in representing them.

DISCUSSION

Our study surveyed surgery department chairs in an attempt to delineate the job descriptions of the chairs from their own perspective. In the simplest terms, we wanted to answer the following question: what does the surgery department chair do all day? Although there have been surgery department chairs who published personal observations, to our knowledge, this is the first attempt to assess, more globally, the allocation of time for the various responsibilities of a surgery department chair, how compensation is determined, and what their concerns are.^{1,2,12,13}

Shuck,¹² who wrote of his personal experience as a chair, included a survey of surgery department chairs that was first done in 1981 and then repeated 20 years later in 2001. He reported demographic data about the chairs but not specifics about the duties of the position.¹² He found that, during his time as chair (from 1980 to 2001), the mean age of chairs around the country had increased (from 44 to 49 years of age) and that their tenure had decreased (from 9.4 to 7.1 years). In our survey, we found that the trend of an increasing average age of surgery department chairs is continuing, with the current average age in our cohort being 57 years. However, the length of tenure in the position appears to have stabilized (at a mean of 8.3 years in our cohort). The diversification of specialties represented has continued. Shuck¹² noted that, over the 21-year period, the number of specialties represented increased from 2 in 1980 (general and cardiothoracic) to 4 in 2001 (general, cardiothoracic, vascular, and pediatric). The present study identified chairs from 10 different subspecialties. This likely is a function of the continued subspecialization seen in medicine overall and is probably not unique to the surgery department chair.

Our study evaluated the distribution of a chair's workload during a typical workweek. The complexities of the job and the variations in local medical centers make definitive statements regarding standards challenging. However, our study does indicate that most chairs maintain a clinical practice that, on average, consumes approximately 25% of the typical workweek. The RVU data support this because most chairs produce between 1000 and 4000 RVUs per year. Using Medical Group Management Association data¹⁴ for all surgical specialties reported by chairs in the survey, we found that the distribution of RVUs places the "average" surgery department chair in the 0 to 25th percentile.

Interestingly, there was no direct correlation between the number of RVUs and W-2 salary. In fact, in our study, some of the chairs with lower RVUs reported the highest incomes.

The academic duties of a surgery department chair may be the most difficult to define. Perhaps this stems from the multiple constituencies that can be placed beneath the umbrella of "academic responsibilities," including curriculum and teaching, faculty, residents, students, development (fund-raising), alumni, school/university/community relations, and research.^{4,5,15,16} In support of academic responsibilities, 34 of 72 respondents (47%) were paid from an endowed chair. The mean annual endowed compensation was \$107 823 (maximum reported, \$300 000). Tenure may be considered an institutional commitment to the academic component of a chair's duties, and 45 respondents (63%) had tenure.

Despite the traditional emphasis on the accomplishment of personal research, only 18 of the 72 respondents (25%) had outside grant funding. Forty-four chairmen (61%) did feel pressure to publish, and 60 (84%) were included as an author on at least 1 publication annually. Although our survey did not explore the extent of research in more detail, it is likely that the information reported indicates that chairs are more probably research mentors as opposed to principal investigators.

The data from our study provide important insight into the responsibilities and concerns that affect the surgery department chair. Our study confirms and emphasizes the realities of changing responsibilities from what might be the traditional view of the job of the surgery department chair. There is agreement that a successful chairman must be a creative strategic planner.^{8,16} This is consistent with the opinions of others who have emphasized the importance of the surgery department chairman as a leader as opposed to someone focused on his or her own personal career development. The chair must divide his or her time between maintaining a certain amount of personal credibility as an academic surgeon and leading the surgery department both internally and as a component of the broader institution. Personal credibility includes not only involvement in patient care and research but also in regional, national, and even international surgical organizations. In our study, surgery department chairs felt that attending 1 to 10 surgical meetings (mean, 4.3 meetings) per year was "essential." Although our study did not specifically address the details of the workload distribution, using RVU data and salary support data, we estimate that most chairs spend about 25% of their time on clinical activities, 10% to 25%

of their time at meetings, conferences, and organizations (including the board meetings), and the remainder of their time involved in department and medical center business and academics.

A lack of consistency in defining the job of an academic chair is one factor in the concern over the method of selecting academic chairs.^{1,6,9,15} The ideal characteristics of a surgery department chair today are not clear, and the "traditional" concepts of what guarantees success have been and are changing. As such, academic department leaders have been, and often continue to be, chosen for what they have done as individuals and not for how they fulfill the specific job requirements of a chair.^{17,18} This is in contrast to typical leadership positions in other industries for which high-level leaders are selected on the basis of a predetermined skill set, including how effectively they create an environment that allows subordinates to be effective in achieving the strategic goals, mission, and vision of the company or business unit.

This may seem self-evident, but it is at odds with the traditional methods and criteria used by academic medical schools to rank and recruit candidates for a chair position. As Souba¹⁷ has discussed, the traditional selection criteria have focused on individual accomplishments (such as RO1 grants) and number of first-author publications, which may or may not correlate with leadership skills focused on the success of others, of the department, and of the institution as a whole.

As with any survey of this type, our study is limited by the response rate (43%) and by the unpredictability of who is motivated to complete the survey and why. However, because the geographic distribution of respondents was broadly representative and because salary data were consistent with other sources,¹⁴ we believe that the results reflect a representative sample of surgery department chairs in the United States.

In conclusion, our study confirms that a surgery department chair position is complex, with multiple responsibilities. One aspect that is consistent with tradition is that the surgery department chair usually maintains a clinical practice, which in 2012 consumes, on average, approximately 25% of the workweek. In contrast, research was not a high priority for chairs. Our study suggests that surgeons considering a career in departmental leadership and search committees trying to identify the ideal candidate for a surgery department chair should focus on leadership skills as opposed to individual-oriented accomplishments. For academic medical center leadership, the realities of the responsibilities assigned to a surgery department chair should be acknowledged to clarify prioritization and to help choose and properly support the best person for the job.

A follow-up to our study could examine in more detail what constitutes a chairman who is acknowledged as a success. As Jim Collins noted in his assessment of successful business leadership, *Good to Great*,¹⁹ leaders who demonstrated the greatest management success over time had humility as a core personal trait underpinning their achievements. These leaders put the company first, rather than their own glory. Perhaps that is how we should determine who will most likely be an effective surgery department chair in the future.

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INVITED CRITIQUE

The Real Job

Recruit, Mentor, and Protect

Dr Slakey and his coauthors¹ provide some interesting and useful demographic data regarding the job of a surgical chair. This information is gleaned from a survey sent to all surgical chairs in the United States and returned by 43% of them. Some encouraging news is that most chairs are well paid, with their income dependent on factors other than clinical productivity. Somewhat discouraging, however, is the lack of diversity, with only 4% of chairs being women and only 7% nonwhite.

In my opinion, what the survey does not address is the essence of what the job is really about. I had never seriously contemplated this myself until my hospital administrator, who paid one-half of my base salary, requested for the purpose of accountability that I keep a daily log of my hospital activities that were related to my role as chair of the surgery department. I considered that keeping track of the endless meetings I attended on behalf of the hospital was a rather mundane and useless task, and this led me to ponder what my essential functions as a chair were. I could come up with only three. First, I was responsible for recruiting exceptional surgeons who would keep the hospital's beds full and, through their academic activities, call attention to our hospital as an outstanding health care institution at the local, state, and na-

tional level. Second, I would do all that I could to help advance these surgeons' careers and keep them functioning effectively on a daily basis. In other words, I would spend a considerable amount of time mentoring. Finally, in an era when institutions, especially medical schools, are strapped for revenue, an essential component of the job is protecting the department's resources. This needs to be done in a nonbelligerent, sometimes compromising, but firm manner that allows the surgery department chair to remain a key institutional leader.

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1. Slakey DP, Korndorffer JR, Long KN, Clark T, Hidalgo M. The modern surgery department chairman: the job description as identified by chairmen [published online April 17, 2013]. *JAMA Surg.* 2013;148(6):511-515.