UNDERSTANDING SUCCESS PROFILES OF HIGH-PERFORMING ACADEMIC MEDICINE CHAIRS: THEIR ATTITUDE AND APPROACH TOWARD LEADERSHIP DEVELOPMENT

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TABLE OF CONTENTS

EXECUTIVE SUMMARY

While the tripartite missions of patient care, research and education are still vital to success in the academic medical chair role, additional tasks that have distinct business orientation have increased. Grigsby, et. al. (2004) suggested that the perception of the chair role being an honorific position bestowed upon someone who has demonstrated personal excellence across the three missions is long behind us. There has been great turmoil in the healthcare industry as the payment structure for healthcare has changed over recent decades. This has required chairs to develop new visions and strategies to maintain viability and professionalism of academic medicine.

In effort to gain greater understanding of the competencies associated with academic medical chair success, the perceptions of professional leadership development activities, and how such activities may influence success in the role, I partnered with global organizational consulting firm, Korn Ferry.

Review of the literature suggest many competencies associated with success in the role of a high-performing academic medicine chair. However previous publications do not exclusively query medical school deans and high-performing chairs or use a research-driven competency model that uses common language to describe leadership qualification. In effort to describe the success profile for chairs at academic medical centers, a survey was issued to U.S. medical school deans and high-performing chairs that they nominated. Eight Deans and 16 Chairs participated in the project. Respondents were asked to consider what high-performance looked like in their organizations and then to rate the importance of each of 38 competencies described in the Korn Ferry Leadership ArchitectTM Competency Mapping model. The highest ranked competencies were reported to be:

- Instills Trust
- Develops Talent
- Builds Effective Teams
- Drives Vision and Purpose
- Demonstrates Self-Awareness
- Ensures Accountability
- Communicates Effectively
- Drives Engagement
- Interpersonal Savvy

Survey results were moderately correlated to Korn Ferry data for Mid-Level and Top-Level managers, but there were several competencies that were ranked higher in the results than in the comparison groups. This suggests that these competencies are more important to success as an academic medicine chair than to the broader manager groups. These are: Demonstrates Self-Awareness; Values Differences; Develops Talent; Organizational Savvy; Courage; and Interpersonal Savvy, all of which are part of the People and Self Factors within the KFLA model.

Qualitative data was collected through a series of interviews to confirm the survey results. When asked about the competencies essential for success, Deans and Chairs mentioned or describe several of the top ten ranked competencies, including the ones that ranked high in the survey but not as high in the benchmark data. Several mentioned Emotional Intelligence as a vital competency which is related to Demonstrates Self-Awareness, Values Differences, and Interpersonal Savvy. Many of the interviews describe the efforts to Develops Talent and Build Effective Teams, and the importance of Organizational Savvy to accomplish these goals.

Literature review also identified the modes of Professional Leadership Development used by these Chairs. Many medical school organizations have robust Leadership Development Programs in their schools, while others utilize external programs and executive coaches. Interviews confirmed a lack of preparedness for the Chair role as well as a variety of approaches to professional leadership development ranging from self-directed learning to participation in internal leadership development programs to external courses and workshops. Further, the ever-changing nature of the position suggests that on-going professional development will prove useful to new chairs. Cost, in both dollars and time required, are the most reported barriers to pursuing professional leadership development. Chairs acknowledged that training in leadership is different than the training they received as physicians, especially as it relates to the soft skills around emotional intelligence. Learning of those skills requires episodic exposure and opportunity to practice the skills, which ultimately leads to change in identity to that of a leader.

Specific recommendations to the collaborating partner include:

1. Partner with academic health systems that do not have robust leadership development programs to develop curriculums for their institutions.
2. Offer executive coaching to services to academic medicine chairs, even if they already have a robust leadership development program at their university.
3. Strengthen the validity of the data by inviting all deans of U.S. medical schools to nominate three high-performing chairs and strengthen the return on investment measures.

Practitioners in the professional services industry may use the findings of this project to alter the leadership development services they offer to academic medical chairs to reflect the unique aspects of the job, especially the competencies determined to be higher ranked by Deans and Chairs than those in the benchmark data. The expressed need for skills around Emotional Intelligence suggest these competencies are very important to the success of a Chair and reflect the nature of academic medical centers as human services organizations rather than traditional business enterprises.

INTRODUCTION AND CONTEXT

Having worked closely with multiple department chairs in academic medical centers for over 30 years, I have experienced both a change in the role of an academic medical chair and variety in the approach toward professional development as they assume the leadership role. In effort to gain greater understanding of the competencies associated with position success, the perceptions of professional leadership development activities, and how such activities may influence success in the role, I partnered with global organizational consulting firm, Korn Ferry.

KORN FERRY

Korn Ferry works with clients to design their organizational structures, roles, and responsibilities. They help them hire the right people and advise them on how to reward, develop and motivate their workforce. They also help professionals navigate and advance their careers. They have 8,600 colleagues serving clients in more than 50 countries. They offer five core solutions:

- Organizational Strategy
- Assessment and Succession
- Talent Acquisition
- Leadership Development
- Rewards and Benefits

Korn Ferry's work with academic medical centers has historically mostly been in talent acquisition, having led many medical school dean and department chair searches, as well as larger physician recruiting strategies. However, their work in leadership development in academic medical centers has been more limited. By establishing favorable working relationships during the recruiting phase, Korn Ferry is well-positioned to engage these clients in leadership development activities. Representatives of Korn Ferry sensed that new chairs frequently seem reluctant to pursue leadership development activities and executive coaching. A major aim of this project will be to better define a success profile for chairs of academic medicine, such that Korn Ferry can successfully demonstrate value of leadership development services. To accomplish this, the competencies that form the Korn Ferry Leadership Architect™ will be used, which will be further discussed in the Methods section.

> *"Great leaders are born, but they can also be made. Effective leadership development helps organizations engage their people, unlock potential, and experience unprecedented growth. Yet, many organizations suffer from lack of confidence in their future leadership strategy. Our leadership development programs are precisely targeted by industry, strategy and leadership level to help our clients develop the next generation of leaders – smart, dynamic professionals prepared to lead their organizations into the future with confidence."*
>
> *Korn Ferry's Website*

ACADEMIC MEDICAL CENTERS

According to the Association of American Medical Colleges (AAMC), there are 118 integrated academic medical center hospitals in the United States (Rowe, 2014). Although such institutions account for just 5% of U.S. hospitals, they account for nearly 25% of clinical care based on total hospital revenue (Advisory Board, 2015). While some universities have spun their teaching hospitals off to be financially independent or managed by outside hospital chains, others have kept them as part of the academic institution (Feldman, 2013). As such, the job of a department chair is complex due to the responsibilities for education, research, and patient care as well as serving in administrative roles for the academic medical center (Fairchild, 2004). In 2019, there were 3,387 department chairs at medical schools (AAMC Faculty Roster, 2019) (Attachment 1).

While this is not a large number in terms of a target market for professional services firms, the turnover rate suggests a need for engagement with professional leadership development. In their 29-year study of first-time chairs at U.S. medical schools, Rayburn, et. al. found that first-time chairs in clinical departments account for 8.5% of all chairs (Rayburn, 2009). Turnover in these positions is reported at nearly 25% each year (Gmelch, 2019). Also, the ever-increasing complexity of the job suggests that even tenured chairs could benefit from on-going professional development.

LITERATURE REVIEW

UNDERSTANDING PHYSICIAN LEADERSHIP COMPETENCIES

The starting point of this effort was to understand previous studies of physician leadership competencies. The topic of leadership in academia has been studied and is well discussed in the literature. Different studies use different terms to describe the competencies necessary for success in the role of academic medicine chair. The following table presents the competency terms used in studies reviewed for this project.

Table #1

COMPETENCIES IDENTIFIED FROM LITERATURE REVIEW

Author	Year	Key Competencies for Performance
Seagren	1993	skills associated with dealing people
		communication
		strategic and lateral thinking
		transformational leadership
Rowley	1997	Intelligence
		Initiative
		self-assurance
		"helicopter trait"
Souba	2003	business and administrative experience
		institutional competence
		emotional competence
		Resilience

COMPETENCIES IDENTIFIED FROM LITERATURE REVIEW		
		organizational fit
		strong communication skills
		ability to build and lead teams
		results orientation
		developing others
McKenna, et. al.	2004	interpersonal and communication skills
		professional ethics
		social responsibility
		influencing others
		administrative responsibility
Grisby, et. al.	2004	promoting collaboration
		building and supporting culture
		accountability
		institutional orientation
		ability to have frank conversations regarding performance
Taylor, et. al.	2008	knowledge (role-related)
		expertise in one's field
		emotional intelligence (self-awareness, self-regulation, motivation, empathy, and social skills)
		vision
		organizational orientation
Detsky	2010	vision
		management style
		knowledge
		people skills
		organizational orientation
		personal development
Dine, et. al.	2011	skills to work in teams
		communication skills
		personal attributes
Hargett, et. al.	2017	acting with personal integrity
		communicating effectively
		acting with professional ethical values
		pursuing excellence
		building and maintaining relationships
		thinking critically

Nearly 30 years ago, Seagren examined the changing role of the academic department chair in the arenas of leadership, influence and faculty development and acknowledged the squeeze experienced by these chairs between the demands of upper administration and the expectations of faculty, staff, and students (Seagren, 1993). Seagren also speculated that academic leadership needed to be a more shared phenomenon than most profit-focused enterprises, an early understanding that human services organizations may require different competencies for leaders. Rowley proposed the question are academic leaders born or made (Rowley, 1997)? Her work explored traits deemed to be important toward success in the role: intelligence; initiative; self-assurance; and what she called "the helicopter trait" – the ability to understand a situation at different levels of detail. This small list may have encompassed the requirements associated with the role in the 1990's, but the academic medical center experienced great change as we moved into the twenty-first century.

While the tripartite missions of patient care, research and education are still vital to success in the academic medical chair role, additional tasks that have distinct business orientation increased during the early 2000's. Department chairs must be equipped to deal with an ever-changing environment and the cultural revolution in academic medicine (Shuck, 2002). Grigsby, et. al. (2004) suggested that the perception of the chair role being an honorific position bestowed upon someone who has demonstrated personal excellence across the three missions of patient care, research, and education is long behind us. There has been great turmoil in the healthcare industry as the payment structure for healthcare has changed over recent decades. This has required chairs to develop new visions and strategies to maintain viability and professionalism of academic medicine. A survey-based study conducted in 2004 by McKenna, et. al. described physician leadership competencies as perceived by the physician leaders, physician educators, and medical students (McKenna, et. al., 2004). They presented the following competencies as the most important for physician leadership roles: interpersonal and communication skills; professional ethics and social responsibility; influencing peers to adopt to new approaches in medicine; and administrative responsibility in a healthcare organization. McKenna and Grisby both recognize the increasing nature of the business and administrative components of these roles. McKenna continued to suggest that "coaching or mentoring from an experienced leader" and on-job experience (e.g. a management position)" as the most effective methods for developing physician leadership competencies (McKenna, et. al., 2004). Grisby described several new qualifications for an academic department chair. "The new qualifications of the department chair include, but are not limited to, promoting collaboration, building and supporting a culture of peer accountability, having an institutional orientation, and demonstrating the ability to have frank, face-to-face discussions with faculty members regarding detailed aspects of performance." (Grisby, et. al., 2004, p. 573). In addition to the traditionally accepted characteristics of a department chair, Souba discussed several characteristics of a future-oriented chair. These include: business and administrative experience; institutional competence; emotional competence; resilience; fit within the organization's values and guiding principles; strong communication skills; able to build and lead a team; results orientation; and develops others (Souba, 2003). Taylor, et. al. conducted a qualitative study at Cleveland Clinic by interviewing 10 aspiring leaders, 8 mid-level leaders, and 7 senior leaders. Through their interviews they compiled a list of competencies necessary to succeed in leadership roles: Knowledge (role-related); expertise in one's field, emotional intelligence (which they described as self-awareness, self-regulation, motivation, empathy, and social skills); vision; and organizational orientation.

The study of academic medical chair competencies for success continued during the most recent decade. Detsky's 2010 essay begins with acknowledgement that leaders at academic medical centers are often chosen based on success in the core activities of patient care, research, and education rather based on demonstrated leadership and management skills. After 21 years in a leadership role, he covers six themes that he deems important to success: vision; management style; knowledge; people skills; organizational orientation; and personal development (Detsky, 2010). Dine, et. al. used focus groups to describe physician leadership at an academic medical center. They concluded that skills necessary to work with a team, along with communication skills and some personal attributes are key to success (Dine, et. al., 2011). The 2017 Hargett, et. al. study at Duke University used 92 faculty and trainees to rank 22 leadership competency statements. They report the following top six: acting with personal integrity; communicating effectively; acting with professional ethical values; pursuing excellence; building and maintaining relationships; and thinking critically.

There are several shortcomings associated with this list. First, it isn't comprehensive. Second, some are not competencies, rather they are descriptions of one's knowledge of subject matter (e.g. Institutional knowledge, expertise in one's field). The third shortcoming could be described as "bandwidth" as some of the competencies listed are defined too broadly, which leads to some practical difficulties. Broad competencies are difficult to assess, give feedback on, and develop. An example is "People Skills" which leaves readers pondering exactly what that means and how it can be developed. A competency must be sufficiently concrete, observable, and measurable (Korn Ferry, 2016).

EMOTIONAL INTELLIGENCE AS A CORE COMPETENCY

Emotional intelligence is increasingly discussed as an important core competency for healthcare leaders and warrants some attention. Freshman and Rubino's 2002 paper brought the concept of Emotional Intelligence (EI) popularized in the 1990's to healthcare. They describe EI as "proficiencies in intrapersonal and interpersonal skills in the areas of self-awareness, self-regulation, self-motivation, social awareness, and social skills" (Freshman & Rubino, 2002. p. 1). They suggest that the integrated networks of health systems require healthcare administrators to collaborate more than previously needed. Taylor, et. al. conducted an interview study in 2007 if effort to explore leadership competencies in established and aspiring physician leaders. People skills, or "emotional intelligence" surfaced as one of four themes that emerged. The others were around knowledge, vision, and organizational orientation. EI was the most often cited quality of admired leaders (>70% of comments) as well as a "skill" seen as important to acquire when preparing for leadership positions (40-58% of comments, depending on the group) (Taylor, et. al, 2008). They presented their findings to the team that prepares the curriculum for the Cleveland Clinic Leading in Healthcare program which will be discussed in a further section. Mintz and Stoller performed a systematic literature review of articles that addressed a connection between EI and physician leadership. The review of articles from 1990-2012 yielded three results. First, EI is broadly endorsed as a leadership development strategy. Models of EI and leadership development practices vary widely. And EI is considered relevant throughout medical education and practice. They conclude that further research is necessary to develop and nurture EI to enhance leadership skills in physicians (Mintz & Stoller, 2014).

USE OF PROFESSIONAL LEADERSHIP DEVELOPMENT IN ACADEMIC MEDICINE

More recently, Anthony and Antony completed a literature review to further understand the characteristics of an effective academic leader. They asked if academic leadership was special or simple (Anthony & Antony, 2017). They concluded that "academic leaders can come from, and be translated into, leaders with positional power, leaders with expertise power, leaders with networking power and leaders with personality power, but this is no different than any other industry" (p. 635).

A conceptual framework that professional leadership development can improve competencies of leaders leads us to review of the literature describing professional development. Returning to Rayburn's 29 year-long study of first-time department chairs reports participants were initially insufficiently prepared for their roles (Rayburn, 2009). This may be partially attributed to an avoidance of administrative duties by academic physicians. In the academic environment, junior faculty were to avoid administrative duties so they would not be distracting from teaching and research. It is within this traditionally anti-management academic environment that the increased need for physician administrative leadership is creating new career pathways for academic physicians who can work at the interface of clinical medicine, health care finance, and management (Fairchild, 2004). To facilitate career development and to obtain necessary skills, some academic physician leaders obtain MBAs, MPHs, or other similar degrees. However, this is a time-consuming educational strategy that is not generalizable to most physicians (Fairchild, 2004).

With understanding of the competencies linked to successful performance of academic medical chair or physician administrative leader, several research projects attempted to review leadership development efforts regarding said competencies. Aziz, et. al.'s 2005 study described the training needs for department chairs in public universities. They suggest that progress toward an understanding of the key roles of a chair is a good start, but an assessment of the specific knowledge, skills and abilities is needed (Aziz, 2005). Given limited resources and the need to prepare chairs as quickly as possible, it is important to focus on the tasks that are most in need of training to ensure chair success. Rayburn further suggests that transition to the role of chair is complicated and requires orientation beyond their department to include an array of hospitals, research institutes, university structures, as well an orientation to the power structures (Rayburn, 2009).

LEADERSHIP DEVELOPMENT PROGRAMS.

Leadership Develop Programs have emerged at many academic medical centers. Some of the more robust programs are described in the literature.

In 2001, senior administrators at Emory University's Woodruff Health Sciences Center (WHSC) designated leadership as the central element of a new strategic plan, believing that an academic health center requires excellence in leadership at all organizational levels to carry out the tripartite mission. They acknowledge that physician leaders, although highly competent in their areas of expertise, possess limited leadership skills. The leadership team launched a new leadership development program named the Woodruff Leadership Academy (WLA). (http://whsc.emory.edu/wla/)

Through working with the Goizuetta Business School, the WLA set a goal to develop 100 new leaders by 2007. With a cohort size of approximately 25 each year, WLA was small enough to be personalized. The program involved a three-year curriculum with lectures by WHSC leaders about organization history, finance, development, marketing, human resources, and communications. Presentation from local business executives and case studies led by

Goizuetta professors enabled critical thinking, interactive learning, and experiential exercises. Korschun, et. al. published the particulars of the program and led a survey-based study to follow up on the first 70 WLA fellows (Korschun, 2007). Of interest was that attendance was near perfect, and only three fellows left Emory before completing the program. The study concluded that teamwork and relationship building were the most valuable elements of the program. The mentoring component was not uniformly successful. Though only 15% of the graduates were promoted, 56% reported having been given additional responsibilities and 76% reported taking on additional leadership responsibilities at Emory or in their profession (Korschun, 2007).

JOHNS HOPKINS MEDICINE.

LEADERSHIP DEVELOPMENT PROGRAM.

(https://www.hopkinsmedicine.org/fac_development/career-path/leadership/leadership_development_program.html) Johns Hopkins LDP is offered annually to a cohort of no more than 15 faculty and 15 administrative individuals who are chosen to participate based upon nomination and completion of an application process. There are multiple criteria for participation including rank in the organization (Vice President, Professor or Associate Professor, Director or Administrator), demonstration of leadership abilities, and interpersonal skills consistent with leadership excellence. The ten-month program includes ten days of programming that includes self-awareness, executive coaching, strategic planning, negotiating with individuals and teams, among other topics. Participants are required to develop strategic projects which are presented to their learning group. Participants have additional opportunities to shadow management meetings, work with a leader who will serve as an advisor, engage in roundtable discussions with senior leaders, and to engage with program sponsors to share personal challenges. Among the stated goals of the program is to strengthen Johns Hopkins Medicine's long-term organizational viability by developing leaders for the 21st century to foster innovative and sustaining solutions to complex problems.

Hopkins' leadership believes that the success of an academic medical center rests on the ability to recruit, retain, and promote a diverse and talented faculty. They also suggest it important to develop skilled, effective, and diverse leaders to navigate an increasingly complex healthcare environment (Levine, et. al., 2015). In addition to the building of a skillset of leadership competencies, the LDP creates opportunities for faculty to "try on" leadership identities. The creation of safe space for trial runs in leadership roles (Ibarra, 2015) affords faculty opportunity to explore a leadership identity that may be very different from the identity they have a faculty member who spends their time in patient care, research, and teaching. The concept of identity change will be discussed further.

OFFERINGS AND PROGRAMS FOR JUNIOR FACULTY.

The traditional academic notion that only senior physicians should assume administrative roles, and that junior faculty should eschew service jobs to concentrate on clinical care, teaching, and research, no longer fits well with the current academic environment (Fairchild, et. al., 2004). Johns Hopkins Medicine offers a Junior Faculty Leadership Program (JFLP) to faculty members at the Instructor or Assistant Professor level with less than 4 years at rank. The goal of this program is to provide junior faculty with the opportunity to build professional and leadership skills and to think proactively about their future roles as leaders in academic medicine. This program consists of 8 two and a half hour sessions over a 6-month period. In addition to this cohort program, several skill building sessions are offered to junior faculty through the Talent Management and Organization

Development department. Titles include “Effective Meetings in Half the Time”, “Speak Like a Pro”, “Practical Communication Skills Using MBTI Personality Type Theory”, “Becoming a Conflict Competent Leader”, and other similar classes.

DUKE MEDICINE.

DUKE CLINICAL LEADERSHIP PROGRAM (DCLP).

(https://medschool.duke.edu/about-us/faculty-resources/faculty-development/our-programs/duke-clinical-leadership-program) DCLP was founded by the Chancellor for Health Affairs in 2010 to help expand leadership capacity within Duke Health. Mid-career Duke faculty members with clinical responsibilities who have the support of their direct leaders are eligible to apply for this cohort-based program. The program includes six, full-day sessions over six months and addresses topics such as strategy and health policy, funds flow and operations at Duke, negotiation, leveraging leadership styles, managing personnel, and navigating difficult conversations. In addition to classwork, fellows are assigned to group projects designed to focus on team development and effectiveness. (Attachment 2 – Brochure)

MANAGEMENT AND LEADERSHIP PATHWAY FOR RESIDENTS.

Created in 2009, Duke’s Management and Leadership Pathway for Residents (MLPR) was developed for residents with both a medical degree and management training. This program was developed to help catalyze the emergence of a new generation of physician-leaders by combining rigorous clinical training with mentorship and rotational opportunities in management to accelerate the development of clinical leadership and management skills in all facets of medicine (Ackerly, et. al., 2011). The goal of this program was to keep more MD-MBA’s in health care and create a bench of talented physician-executives. Duke has published findings describing the results of the MPLR program’s 15-18 months of project-based rotations under the guidance of senior leaders in many disciplines including finance, patient safety, health system operations, strategy, and others. They reported that a critical factor for long-term success of the MLPR will be the continued career development of graduates after they leave the program (Ackerly, et. al. 2011).

LEADERSHIP TRAINING PROGRAMS IMPACT.

Formal training in the multifaceted components of leadership is now accepted as highly desirable for health care leaders. Despite some programs having existed for nearly 20 years, outcomes research has shown that health care leadership training is most effective when it takes place over time, is comprehensive and interdisciplinary, and incorporates the individual/institutional projects allowing participant immediate practical application of their newly acquired skills (Sonnino, 2016). Enhancing the academic element of administrative and leadership positions in academic medicine will attract the best and brightest academic physicians to serve these important roles (Fairchild, et. al., 2004).

In 2011 Straus, et. al. engaged in a systematic literature review of all relevant studies, quantitative and qualitative, that reported on the implementation and evaluation of a leadership development program for physicians in academic medical centers. They identified 11 articles describing 10 studies. Although they characterized all studies as being at substantial risk of bias, the highest quality ones show that leadership training programs affected participants’ advancement in academic rank and hospital leadership positions (Straus, 2013). They acknowledge the substantial investments organization must make in these programs and suggested that further evaluation of the programs was warranted. Frich, et. al. furthered the review in 2014. They identified 45 papers describing positive outcomes

for programs for resident physicians with no leadership roles or physicians in mid-level management positions. They found that although self-awareness within larger groups or organizations is fundamental to leadership capacity, few programs addressed personal growth and self-awareness. In contrast they found the programs to be centered on imparting conceptual knowledge to physicians as individuals. Their recommendations were to include non-physicians in the programs to foster more team building between physician and non-physician leaders, as well as to add more interactive learning and feedback in effort to develop self-awareness (Frich, 2015). A 2015 survey conducted by the Association of American Medical Colleges (AAMC) reported 93 of 94 respondents provided some form of leadership training and 61 provided a formal internal faculty LDP (Lucas, et. al., 2018). Lucas, et. al. concluded that LDPs were becoming increasingly common, with some programs informed by the leadership literature. However, they suggested that programs could improve "by basing content on a leadership competency model, incorporating multiple approaches to teaching, and implementing more rigorous program evaluation (Lucas, et. al., 2018. p. 229).

STARTING EARLIER.

Some medical schools are adding leadership training to their curricula. In 2014, Webb, et. al. conducted a systematic literature review of all articles between 1980 – 2014 that described curricula with interventions to teach leadership skills to medical students. They classified leadership skills taught into the five Medical Leadership Competency Framework (MLCF): working with others; managing services; improving services with an emphasis on patient safety and quality improvement; personal qualities; and setting direction. The MLCF comes from the Academy of Medical Royal Colleges in the UK and has not been widely observed in the U.S.-based literature. However, this framework provided opportunity to categorize the curricula. Most studies did not demonstrate changes in student behavior or quantifiable results. Among the studies recommendations was to align the curricula with competency model in effort to standardize the evaluation of outcomes, leading to better measurement of student competency and a better understanding of best practices (Webb, et. al., 2014). The matter of introducing leadership into medical school curricula is important and should be further considered.

EXECUTIVE COACHING.

Use of an executive coach is also evident in the literature around leadership development in healthcare. Henochowicz and Hetherington reviewed the state of leadership coaching for physicians and non-medical health care leaders in 2006. They found leadership coaching to be an underutilized resource in health care executive training, especially because coaching helps leaders develop interpersonal and emotional intelligence competencies to successfully run increasingly complex organizations (Henochowicz & Hetherington, 2006). Nocks suggests the rapid advances in treatment, along with the need to meet fiscal goals, makes the rapid pace of change required for organizations to be successful especially true in health care. Nocks suggests that the coaching for executives pays off not only for the leader but for the entire organization. The return on investment is high, with increased morale and employee satisfaction, decreased turnover and improved outcomes (Nocks, 2007). Geist and Cohen (2010) propose that the use of executive coaching in academic medicine may be of benefit for new departmental executive officers. Experience using an executive coach suggests that this was a valuable growth experience for new leaders at the University of Iowa.

Thorn and Raj (2012) explore the use of coaching in academic health centers even further. They reviewed the agendas of academic society meetings to find most classes related to disease, diagnosis, treatment, and prevention. Some classes include elements of

team-based, quality-focused, patient-centered care. The point is there were limited if any classes that address the "being" aspect of the individual – including core values, sense of purpose, beliefs, self-awareness, emotion and habits, character strengths, orientation to failure, learning preferences, motivation, lived experience, and goals. They suggest that all of these are essential components toward effective leadership through individual peak performance. Integration of professional coaches and the subsequent development of coachlike behaviors is an effective strategy for culture change in academic medicine. Faculty afforded opportunities to work with professional coach's report enhanced trust in collegial relationships. This shifts the culture toward one that is dynamic and relational.

While the popularity of coaching has increased in both the practitioner world and academia, evaluation of effectiveness had lagged. DeMeuse, Dai, and Lee published on evaluation measures beyond the return on investment associated with executive coaching. They proposed six key areas related to coaching evaluation (DeMeuse, et. al., 2009):

1. The purpose of coaching evaluation
2. Criteria used to measure coaching effectiveness
3. Rigor of the coaching evaluation
4. Type of coaching implemented
5. Content of the coaching engagement
6. Coaching methodologies

A systematic review of executive coaching outcomes completed by Athanasopoulou and Dopson was published in 2018. By reviewing the literature related to the use of external coaches, they sought out to understand how executive coaching outcomes are researched and what is known about executive coaching outcomes. Like DeMeuse, et. al., they expressed concern about ROI and suggest ways to measure organizational-level executive coaching outcome measures: customer service; project management; productivity and quality. They also suggest less emphasis on the outcomes and more focus on the journey – what executive coaching involves as a practice and in what ways the social context within it takes place matters to this journey (Athanaspoulou & Dopson, 2018).

MENTORING/SPONSORSHIP.

Mentoring has been a core component of the duties of medical faculty. It has been recognized as a catalyst for career success and important in facilitating career selection, advancement, and productivity (Sambunjak, et. al. 2006). Peer coaching has been described as a "developmental relationship with the clear purpose of supporting individuals within it to achieve their job objectives." (Parker, 2008). Taylor, et. al. furthered understanding on the influence of mentorship and role modeling on developing physician leaders (2009). Their study on 25 Cleveland Clinic faculty (14 established leaders and 11 aspiring leaders) resulted in three themes. First, role modeling was differentiated as a valued experience separate from mentoring. Many respondents favored a series of "strategic" interactions with various individuals rather than longitudinal mentoring experiences. Third, emotional and psychological support was considered the most values type of interventional activity (Taylor, et. al., 2009). Gmelch proposed that in-house mentorships are particularly valuable in terms of what they can contribute to skill development (2016). New administrators benefit greatly from having access to someone who can listen to their concerns and help with decisions.

A 2019 paper from Ayyala, et. al. explored how sponsorship functions as a professional relationship in academic medicine by interviewing 11 faculty who completed the Hopkins Leadership Development Program in 2016, along with 12 sponsors. They suggest that sponsorship, which is episodic and focused on specific opportunities, is different from mentorship. Sponsorship, in addition to mentorship, is critical for successful career

advancement. Understanding sponsorship as a distinct professional relationship may help faculty and academic leaders make more informed decisions about using sponsorship as a deliberate career-advancement strategy (Ayyala, et. al., 2019). Experience mentoring a protégé or being a protégé oneself is often instrumental in the succession planning process (Grisby, 2004).

LEARNING IN COMMUNITY

Learning communities provide a space and a structure for people to align around a shared goal. Effective communities are both aspirational and practical. They connect people, organizations, and systems that are eager to learn and work across boundaries, all the while holding members accountable to a common agenda, metrics, and outcomes. These communities enable participants to share results and learn from each other, thereby improving their ability to achieve rapid yet significant progress. Lief, et. al. reported that 21 of 25 chairs reported being insufficiently prepared for the demands of their roles. A comprehensive network of support for eliciting advice and exchanging information, strategy, and emotional support was formed (Leif, 2013). Given the complexities and emotional burden of the chair role, it is necessary for chairs to have a range of supports to succeed in their roles. Their leadership effectiveness can be enhanced by providing transitional process and supports, development, and mentoring, as well as facilitating the development of a community of peers. Some participants discussed creating their own informal community of peers (Lief, et. al., 2013). Lief's further work found academic health science leaders were found to engage in four types of networking activities: role bound, project bound, goal/vision informed, and opportunity driven. These 4 types were influenced by the participants' conception of their role and their perceived leadership work context, which in turn influence their sense of agency (Lief, et. al., 2020). This research will further investigate the role of community in learning about the job of department Chair.

IDENTITY

A perspective on leadership development has emerged that explicitly links leadership to identity. This perspective focuses attention to the importance of a leader's self-concept and focusing on the potential gap between "doing" and "being." Snook, Ibarra, and Ramos' identity-based model positions that leader development unfolds as an identity transition in which people disengage from central, behaviorally anchored identities while exploring new possible selves, and eventually, integrating a new, alternative identity (2010). Quinn and Spreitzer reported on this transformation of self and others when entering the fundamental state of leadership (2005). They suggest that when having to extend oneself in ways they would never have predicted, one experiences some form of personal transformation. This requires reflection on one's motives to be a leader. "Am I internally-driven?" "Am I Other-focused?" (Quinn & Spreitzer, 2005).

Spehar, Frich and Kjekshus furthered this perspective by investigating how clinicians' professional background influences their transition into leadership roles and identity (2014). A central finding was that doctors experienced difficulties in reconciling their role as a health professional with the role as manager. They maintained a health professional identity and reported to find meaning in the clinical work. The practical implications of their project were that health care organizations need to focus on role, identity and need satisfaction when recruiting and developing clinicians to become leaders (Spehar, et. al., 2014).

RESEARCH QUESTIONS

In effort to better understand the competencies most important to successful performance as an academic medical chair, as well as the forms of leadership development in which they engage and barriers that prevent pursuing professional development, the following serve as the research questions for this project:

1. Using the Korn Ferry Leadership Architect™, what does a success profile for leaders in academic medicine look like in comparison to Korn Ferry success profiles for other leaders?

2. What forms of leadership development do department chairs engage in?

3. What barriers prevent these chairs from pursuing professional development as part of their leadership development?

METHODS

A mixed-methods approach was used to gather data necessary to answer the research questions.

Review of the literature suggests some patterns in descriptions and importance of competencies to be a successful academic medicine chair. Each study describes the competencies using different terminology. (Refer to Table #1) In effort to address the shortcomings associated with competencies revealed in the literature review, this study will use a standard vocabulary. It is important to use common language to describe leadership qualification because the accumulation of knowledge is built on a consistent methodology/framework to study and examine leadership. This study will utilize 38 competencies from the Korn Ferry Leadership Architect™ (Barnfield, 2014). This framework comprises (see Attachment 3):

- 4 Factors: Factors are groups of competencies that form a cohesive theme. These competencies share some thematic similarities. Factors can be derived from statistics or content analysis.

- 12 Clusters: Clusters are groupings of related competencies that represent a broader scope of skills and behaviors that contribute to success in the skill.

- 38 Competencies: Competencies are skills and behaviors required for success to be observed.

- 10 Career Stallers and Stoppers: These are grouped in three clusters. Stallers and Stoppers are behaviors generally considered problematic or harmful to career success.

Table # 2

KORN FERRY LEADERSHIP ARCHITECT™ COMPETENCY MAPPING

Factor (4)	Cluster (12)	Competency (38)
FACTOR I: Thought	Understanding the Business	Business Insight (5)
		Customer Focus
		Financial Acumen
		Tech Savvy
	Making the Right Call	*Manages* Complexity
		Decision Quality
		Balances Stakeholders
	Creating the New & Different	Global Perspective
		Cultivates Innovation
		Strategic Mindset
FACTOR II: Results	Taking Initiative	Action Oriented
		Resourcefulness
	Managing Execution	Directs Work
		Plans & Aligns
		Optimizes Work Processes
	Focusing on Performance	*Ensures* Accountability
		Drives Results
FACTOR III: People	Building Collaborative Relationships	Collaborates
		Manages Conflict
		Interpersonal Savvy
		Builds Networks
	Optimizing Diverse Talent	Attracts Top Talent
		Develops Talent
		Values Differences
		Builds Effective Teams
	Influencing People	Communicates Effectively
		Drives Engagement
		Organizational Savvy
		Persuades
		Drives Vision and Purpose

KORN FERRY LEADERSHIP ARCHITECT™ COMPETENCY MAPPING

FACTOR IV: Self	Being Authentic	Courage
		Instills Trust
	Being Open	*Demonstrates* Self-Awareness
		Self-Development
	Being Flexible & Adaptable	*Manages* Ambiguity
		Nimble Learning
		Being Resilient
		Situational Adaptability

Korn Ferry's KFLA Competency Model utilizes a research-based, widely used leadership framework. Its use provides a common language to describe leadership capability and leadership effectiveness. Further, the leadership data that Korn Ferry possesses will provide a reference point to interpret the results of this study.

In effort to describe the success profile for chairs at academic medical centers a survey was issued to U.S. medical school deans and high-performing chairs that they nominated. Respondents were asked to consider what high-performance looked like in their organizations and then to rate the importance of each of 38 competencies described in the KFLA model using a 5-point Likert scale (Attachment 4 – Survey Instrument). The average score for each was calculated to determine a ranking of the competencies. This ranking was compared to the ranking of other leadership profiles in the Korn Ferry database of over 6,000 responses.

Qualitative data was gathered via a series of interviews with medical school deans and the chairs they recommended as high performers in their organization. All interviews were recorded, and transcripts were prepared. The transcripts were analyzed for mention of competencies or descriptions that were similar. Reference to competencies were catalogued and tallied in effort to confirm survey results for most important competencies. Summary tables that organized responses were constructed in effort to identify themes in the responses around the competencies described in the KFLA model. The transcripts of all interviews were further reviewed for responses related to the other research questions and relevant quotes were listed.

The methods used in this study are consistent with methods used in previous studies that evaluated academic medical chair job competencies. Wolverton, et. al.'s 2005 study at University of Nevada Las Vegas began by interviewing two academic deans and then following with open-ended survey to 20 faculty identified by their deans as prospective chairs. Identification of skills they felt less prepared for enabled professional development programs to be adjusted (Wolverton, et. al., 2005). Souba, et. al.'s 2003-4 study included semi structured qualitative interviews with 18 U.S. medical school deans. They sorted responses

and concluded that integrity, the most essential leadership value, was positively correlated with humanistic values and negatively correlated with results. Vision, also highly valued, was correlated strongly with performance-oriented values, but correlated negatively with humanistic values. Hopkins, et. al. (2015) used interviews with 28 physicians identified as emerging leaders at Cleveland Clinic. They then used a competency model to inductively characterize theme. Hargett, et. al. (2017) also used a concept mapping approach to develop a competency model for effective leadership in healthcare. They used cards with the competency on them to develop a cluster analysis. They followed with focus groups and consensus meeting to confirm their findings with additional qualitative data.

For this project, the characterization of a department chair being high performing was a difficult starting point. As discussed, the requirements of the job are multi-factorial and methods to document performance are equally as varied. Together with Korn Ferry, we considered various metrics to qualify a chair as high-performing: financial performance metrics of an organization: rankings on national surveys: levels of research and publications: and others as possible performance metrics to proximate "high-performing". However, these data are not readily available for all chairs nor are they collected in standardized ways. The only way to identify a high-performing chair was to have the deans nominate participants they felt met that standard. Upon finding a dean willing to participate, they were asked to provide the names of three high-performing chairs in their organization. Though we would ask the deans about performance measures during the interview portion, it was agreed that the deans would know who the high-performing chairs within their schools were. The nomination of high-performing chairs was a pivotal step in the data collection process. At the beginning of the data gathering, targets of 10 deans and 30 chairs were established.

DEANS

In effort to get deans to participate, a list of deans was constructed and included names of deans known to me personally, names of deans known to professional colleagues at other academic medical centers, and names of deans known to Greg Postel, former Executive Vice President for Health Affairs at University of Louisville and Senior Client Partner at Korn Ferry. This created a convenience sample of nineteen deans that were invited to participate.

Table #3

MEDICAL SCHOOL DEANS INVITED TO PARTICIPATE

Duke University	University of Cincinnati
East Virginia Medical School	University of Louisville
Emory University	University of Miami
Johns Hopkins University	University of Michigan
Meharry Medical College	University of Mississippi
Oakland University	University of Oregon
Ohio State University	Vanderbilt University
Stanford University	Virginia Commonwealth University
Thomas Jefferson University	Wake Forrest University
University of California, Davis	

Despite being a convenience sample, there was attempted to get a diverse sample of public and provide institutions with geographic diversity. Contact was made via email either directly from me, or through one of my colleagues at other medical schools. (Attachment 5 – IRB Documents: Please refer to "Identification of Prospects – Communication to Deans") They were sent a personalized link to the survey using the Qualtrics XM platform (Qualtrics, Provo, UT) provided by Vanderbilt University. The survey provided space to provide the names of the high-performing chairs; however, all but two of the deans that agreed to participate responded to the email without completing the survey.

Early during the data collection phase of the project, the COVID-19 pandemic began. This required complete attention of the deans as they were facing challenges of hospital surge, suspension of elective care, closure of campuses, among many other challenges. These priorities restricted deans from engaging in this project. As mentioned, the study was designed with the deans in the gate-keeper role because they had to provide the nomination of high-performing chairs. Target participation goals were subsequently reduced to five deans and 15 chairs. After medical centers settled into stable operations, there was opportunity to re-engage with potential participants. Response rates for deans are summarized in the following table:

Table #4

DEAN RESPONSE METRICS

Invited	Completed Survey	Interviewed	Nominated High-Performing Chairs	Participated in at Least One Possible Way	Participated in All Three Possible Ways
19	2	6	6	8	1
	10.53%	31.58%	31.58%	42.11%	5.26%

Of the eight deans that participated in at least one way, six provided the names of three high-performing chairs in their organizations. Only two completed the survey. Six participated in a telephone or video-conference interview. The interviews were framed around five areas (Attachment 5 – IRB Documents: Please refer to "Script for Interview Meetings with Deans)

The first two questions relate to Research Question 1.

1. *How do you define success?* This question was asked in an open-ended way to gather initial thoughts.

2. *What competencies do you associate with chair success?* Again, this was asked in an open-ended way, but if they identified competencies via the survey or during the interview, further discussion was had as to why they thought those competencies were important.

The next question relates to Research Questions 2 and 3.

3. *How do you prepare / develop chairs for leadership?*

4. *What leadership qualities will be needed for future chairs?* This was also asked in an open-ended way, but when appropriate the KFLA competencies were discussed.

5. *Do you anticipate changing your leadership development programs based on future needs and if so, how?* This question was also designed to reveal what obstacles are faced in terms of leadership development and to gain insight into how deans anticipate this changing in the future.

CHAIRS

Six deans provided the names of three high-performing chairs, for a total of 18 possible subjects. The 18 chairs are associated with the following six medical schools.

Table #5

MEDICAL SCHOOLS INVITED TO PARTICIPATE
Meharry Medical College
Oakland University
University of Cincinnati
University of Louisville
University of Miami
University of Michigan

This provides equal sampling of both private and public medical schools. Meharry Medical College is a private, Historically Black College/University located in Nashville, Tennessee. William Beaumont School of Medicine is part of Oakland University, a private university located in Rochester, Michigan. The Miller School of Medicine at the University of Miami, located in Miami, Florida, is also a private institution. The University of Cincinnati School of Medicine, located in Cincinnati, Ohio, the University of Louisville, located in Louisville, Kentucky, and the University of Michigan in Ann Arbor, Michigan are public universities.

Email invitations (Attachment 5– IRB Documents: Please refer to "Communication to Chairs"), along with personalized links to the Qualtrics survey, were sent to each of the 18 chairs. Response rates are presented in the following table.

Table #6

CHAIR RESPONSE RATES

Invited	Completed Survey	Interviewed	Participated in at Least One Possible Way	Participated in Both Possible Ways
18	14	10	16	8
	77.78%	55.56%	88.89%	44.44%

The high response rate may be indicative of the high-performing nature of the chairs and the good working relationship with their dean that nominated them. Of the 16 responses, 12.5% were female, which is lower than the percentage of female department chairs (19%) (AAMC data table, 2019).

Interviews were conducted with ten chairs from five different medical schools. The topics discussed related to each of the research questions (Attachment 5 – IRB Documents: Please refer to Script for Interview Meetings with Chairs).

The first two questions relate to research question 1.

1. *What competencies most contribute to your success as a leader and why?* This was asked in an open-ended way, but if they identified competencies via the survey or during the interview, further discussion was had as to why they thought those competencies were important.

2. *What motivates you to be a high performing leader?*

The next series of questions related to research questions 2 and 3.

3. *Did you feel well-prepared and why? If not, why not?*

4. *How did you prepare for your leadership role and how did professional development effect your career?*

The remaining questions were asked to gain deeper insight into perceptions of leadership development activities.

5. *How did your development as a leader differ from your training as a physician?*

6. *What were some pivotal moments in your leadership experience what are your takeaways?*

7. *As you have developed identity as a leader, what caused the change*?

The next two questions were asked to gain insight into the existence of learning communities and their perceived importance to leadership learning.

8. *Do you feel the support of your leader and/or institution in your development as a leader?*

9. *Do you feel a sense of community among your peer chairs? Within your organization? Within your specialty society? Through formal or informal ways?*

The final questions relate to the evolving nature of the job and how leadership training may need to be adjusted to develop competencies necessary for future success.

10. *How do you see the role of department chair in an academic medical center changing? Positive ways? Challenges?*

11. *What are the leadership qualities needed in leading the change/in the future and why?*

12. *Do you have suggestions for leadership development for future-oriented chairs?*

RESULTS AND DISCUSSION

QUANTITATIVE RESULTS

The results of the surveys were combined into one data set (Attachment 6). The mean score for each competency was calculated and a ranking of the competencies according to those means was prepared to indicate the competencies' relative importance to success in the position of academic department chair.

Table #7

Competency	Mean	Rank	Competency	Mean	Rank
Instills Trust	5.00	1	Collaboration	4.38	16
Develops Talent	4.81	2	Decision Quality	4.38	16
Builds Effective Teams	4.63	4	Attracts Top Talent	4.38	16
Drives Vision and Purpose	4.63	4	Drives Results	4.31	20.5
Demonstrates Self-Awareness	4.63	4	Manages Complexity	4.31	20.5
Ensures Accountability	4.56	6	Strategic Mindset	4.31	20.5
Communicates Effectively	4.50	8.5	Being Resilient	4.31	20.5
Drives Engagement	4.50	8.5	Directs Work	4.31	20.5
Interpersonal Savvy	4.50	8.5	Manages Conflict	4.31	20.5
Courage	4.50	8.5	Action Oriented	4.25	25
Plans and Aligns	4.44	12.5	Balances Stakeholders	4.25	25
Resourcefulness	4.44	12.5	Situational Adaptability	4.25	25
Organizational Savvy	4.44	12.5	Manages Ambiguity	4.19	28
Values Differences	4.44	12.5	Persuades	4.19	28

Competency	Mean	Rank
Navigates Networks	4.19	28
Cultivates Innovation	4.13	30
Self-Development	4.00	31
Optimizes Work Processes	3.94	32
Customer Focus	3.88	33.5
Financial Acumen	3.88	33.5
Business Insight	3.81	35
Nimble Learning	3.63	36.5
Global Perspective	3.63	36.5
Tech Savvy	3.44	38

Our first research question was how the success profile for an academic medicine chair compares to the success profile of some other categories in the Korn Ferry data, so the ranking data was compared to two categorizations provided by Korn Ferry. The Mid-Level category includes positions with titles including manager and director. The Top-Level category includes positions with titles associated with a c-suite. These categories were chosen as comparisons due to the nature of the academic medical chair job. In many respects they share similar functions with MID level such as operations and some strategy. However, comparison to the top-level category is warranted because they do serve as leaders of their departments that function as somewhat independent business units with sole accountability. In Attachment 6, the average score for each competency is reported in the columns Mid-Level Importance and Top-Level Importance. In effort to measure the association between these data, Pearson's correlation coefficients were calculated. Correlation coefficients were calculated for each data set. The importance of each competency for academic medical chairs correlates to the importance of each competency for all Mid-Level at 0.58 and to all Top Level at 0.57. This suggests a moderately positive correlation.

In effort to identify differences between the ranking of competencies for academic medical chairs and the benchmark data from Korn Ferry, the difference between ranking was calculated.

These six competencies were highly ranked as important for academic medical chairs but rank much lower in the Korn Ferry Mid-Level and Top-Level rankings, suggesting that these competencies are more important for academic medical chairs than for other respondents in the Korn Ferry database.

Table #8

Competency	Rank	Mid-Level Rank	Top-Level Rank	Difference to Mid-Level Rank	Difference to Top Level Rank
Demonstrates Self-Awareness	4.0	34	34	30.0	30.0
Values Differences	12.5	36	36	23.5	23.5
Develops Talent	2.0	14	19	12.0	17.0
Organizational Savvy	12.5	27	28	14.5	15.5
Courage	8.5	23	23	14.5	14.5
Interpersonal Savvy	8.5	18	20	9.5	11.5

Four of these competencies are part of Factor III: People: Values Differences; Develops Talent; Organizational Savvy. Two of these competencies are part of Factor IV: Self: Demonstrates Self-Awareness; and Courage. Recognizing the competencies deemed more important for academic medical chairs suggests opportunities for professional development around these areas. Further, these competencies relate to the competencies described in the literature, especially in terms of people skills.

Table #9:

Competency Described in Literature	Competency Described in KFLA Term
Skills associated with dealing people	Interpersonal Savvy
Communication	Communicates Effectively
Strategic and lateral thinking	Strategic Mindset
Initiative	Action Oriented
Self-assurance	Demonstrates Self-Awareness
Business and administrative experience	Financial Acumen
Institutional competence	Organizational Savvy
Emotional competence	Self-Development
Resilience	Being Resilient
Ability to build and lead teams	Builds Effective Teams
Results orientation	Drives Results
Developing others	Develops Talent
Influencing others	Persuades
Building and supporting culture	Drives Vision and Purpose
Accountability	Ensures Accountability
	Manages conflict
	Manages ambiguity
	Drives engagement
	Interpersonal savvy
	Being resilient
Emotional intelligence (self-awareness, self-regulation, motivation, empathy, and social skills)	Values differences
	Demonstrates self-awareness
	Builds effective teams
	Organizational savvy
	Instills trust
	Situational adaptability
	Collaborates

The purpose of this table is to again highlight the variety of terminology in the leadership literature when describing competencies. It is important to highlight that Emotional Intelligence does not have as straight-forward, one-to-one translation to a KFLA term. In fact, in their Research Guide and Technical Manual they suggest that 12 Competencies are necessary to define EQ (Korn Ferry, 2016). These appear in Table #9. Seven of these are ranked 12.5 or higher in the survey results, suggesting that "Emotional Intelligence" is highly important for success.

These seven competencies were ranked less important for academic medical chairs but rank much higher in the Korn Ferry Mid-Level and Top-Level rankings, suggesting that these competencies are less important for academic medical chairs than for other respondents in the Korn Ferry database.

Table #10

Competency	Rank	Mid-Level Rank	Top-Level Rank	Difference to Mid-Level Rank	Difference to Top Level Rank
Decision Quality	16.0	7	5	-9.0	-11.0
Manages Complexity	20.5	10	9	-10.5	-11.5
Collaboration	16.0	4	4	-12.0	-12.0
Action Oriented	25.0	9	10	-16.0	-15.0
Business Insight	35.0	28	16	-7.0	-19.0
Drives Results	20.5	1	1	-19.5	-19.5
Customer Focus	33.5	5	8	-28.5	-25.5

It is noteworthy to discuss the two competencies that were ranked much lower in our results than in the benchmark data. It is remarkable that Customer Focus was so much lower in our results given the focus on patient care. Physicians struggle to describe patients as customers. (Hutton, 2011). Perhaps the variety of customers: patients, payers, students, sponsors, also make this competency less important in our results. Drives Results is also much lower ranked in our results. Again, good clinical outcomes are a primary motivation for physicians; however, the competency Drive Results suggests maximizing financial performance, which is less important to physicians in academic medicine than it is to their business administrator colleagues. (Valleta, 2013). The dynamic tension within academic medical centers between humanistic values and performance-based values, as described by Souba (2006), describes human services organizations that are less oriented toward business and financial performance. This is reflected in the competencies that were higher and lower ranked than in benchmark data.

QUALITATIVE RESULTS

As described in the Methods section, the transcripts of all interviews were reviewed and analyzed for reference to the KFLA competency terms or similar descriptions. Summary of the transcripts of the dean interviews (Attachment 7) and the transcripts of the chair interviews (Attachment 8) revealed the following patterns which contributed toward answering our research questions.

1. COMPETENCIES OF HIGH-PERFORMING DEPARTMENT CHAIRS:

The interviews include mention of many of the top ten competencies that were identified in the survey data. Table #11 reports the frequency that Deans and Chairs mention competencies by name or describe them and presents the relevant quotes.

Table #11

Competency	Rank	Dean Results	Chair Result
Instills Trust	1	2 of 6 Deans mentioned	4 of 10 Chairs mentioned
		"I would put integrity at the top. Without integrity the chair will not have the trust of his department."	"Try to make decisions that are better for the organization or group instead of what is better for your personal agenda."
		"Chairs model and should only accept excellence. You can't lower the bar."	"I would rather know the answer is 'no' rather than put energy into something that isn't going anywhere. I many not like it, but I can tolerate it and just know that we are doing to more on and go onto my next constraints and work from there. Being honest instills trust."
			People need to know they can trust you. Sometimes you have good answers to tell them, sometimes you have bad, but you're not going to just lie with all that positivity."
			"Authenticity is something that is very important to people, then you have trust. People need to be able to trust the words you say."
Develops Talent	2	2 of 6 Deans mentioned	5 of 10 Chairs mentioned
		"Chairs to need to be gardeners. That is, they plant seeds and reap fruit. As Dean, I want everyone on my team to reflect this."	"Allow people to use their talents and helping them make sure they recognize their blind spots."

		"It's really developing people in the department and developing relationships across the department."	"We've had a lot of new hires and lot of young faculty members that find their pathway to success and working with them early along to, you know, develop a series of goals and find ways to utilize their talents."
			"Lift others and help others be successful."
			"The value of organization is due to its people. I believe in developing people and investing in them."
			"Get the best people. Resource them to help them define their future. You don't even have to ask them to work. If you say to people, you are super talented, tell me what you want to do and help me clear the path for you, I will resource you along the way, and you stay true to your word. It is what they want to be doing!"
Builds Effective Teams	4	3 of 6 Deans mentioned	4 of 10 Chairs mentioned
		"In my experience, the most common reason chairs lose their job is because they can't manage people and they can't manage themselves."	"To utilize individual strengths of individual teammates, they start that certainly build you up because they have a skill set that you may not have, and you can rely upon them."
		"Someone who firmly embraces and supports the notion that the whole needs to be greater than the sum of the parts."	"Listening to people but then also understanding how to deploy their talents strategically in a way that gives us all the things we need."
		"You need someone who can lead, orchestrate the team, putting the team together."	"Surround yourself with the smartest people and then treat them the way you want to be treated."
			"Acknowledge the necessity of teams, so teamwork."

Drives Vision and Purpose	4		2 of 10 Chairs mentioned
			"And I feel like if you invest in your people and develop their capabilities and help them meet their goals, you will have a success in other parts of your mission."
			"Passion and vision. I think the job of a leader is to try to make an organization, try to make the people carry on tasks and empower them to work at their top capabilities. One of the things that people like and are drawn into, passion. People are drawn to people that are very excited and believes in what they are doing and has a clear vision of what they are trying to accomplish.
Demonstrates Self-Awareness	4	2 of 6 Deans mentioned	3 of 10 Chairs mentioned
			"Authenticity. It is a natural thing for me so I'm lucky."
		"It's not their intelligence quotient. It's their emotional intelligence quotient. So, thinking about 360 degrees, they need to be able to get along with those above them as well."	"I want to make a stamp. To leave a legacy."
			"Reflect on yourself."
Ensures Accountability	6	1 of 6 Deans mentioned	2 of 10 Chairs mentioned
		"Chairs need to evaluate everyone. The evaluations drive performance and the chairs are measured by me through the actions of their team."	"I have a high index for accountability. We must, like, in other words like think about, we have a bottom line. It's like a trade off right when you come into my organization. I will help develop you and help you achieve your goals, but we also have to be accountable and good fiscal stewards."

			"Metrics. You know instantly if you are achieving results even under tough circumstances."
Communicates Effectively	8.5	2 of 6 Deans mentioned	5 of 10 Chairs mentioned
		"Emotional Intelligence is the quintessential element. Chairs must be able to deliver bad news with empathy."	"a high level of communication obviously with professionalism with it. We are in a state in which things are so dynamic, so quick, information is travelling so quickly, and the business platform of academic medicine is also shifting on a very rapid basis…and it requires a well-oiled machine with regard to communications and that bidirectional communications, and I think it's open and honest communication that really transmits information that both favorable and unfavorable."
		"Parts of the business education involve difficult conversations, which we offer a course here at the medical school co-taught by professor here."	"Related to communication would jump out the most. I can tell you I learn every day and make mistakes, every day with communication. I look back at how I communicated two years ago versus now and it's different, you know, I'm a little bit more measured and how I see things and hopefully my emotional IQ is up a little bit."
			"Being an effective communicator with high emotional intelligence."
			"Part of the solution is energizing. You know, once you have a strategy and getting people excited about it. So, communication skills."
			"Communicate up and communicate down. You don't have to be an extrovert, but you need an ability to communicate clearly."

Drives Engagement	8.5	2 of 6 Deans mentioned	1 of 10 Chairs mentioned
		"They need to be a servant leader, so they need to be attending to the faculty, so the faculty are excelling at whatever pathway they choose, whether that's a clinical pathway, research pathway, or educator."	"State your vision and the 'why' to be able to work. Then you know the plan of implementation."
		"Promote a culture of collaboration."	
Interpersonal Savvy	8.5	1 of 6 Deans mentioned	3 of 10 Chairs mentioned
		"The one I sort of lump with a lot of things into and is hard to measure is E.Q. So, where we have chairs that struggle the most, they are not able to quite embrace suggestions, criticisms, etc. from the department, or anybody else. Basically, they have trouble not following their own course. I think of E.Q. as the ability to change the course depending on circumstances as very important."	"People interaction is the most important."
			"Listening. It goes without saying."
			"So undeniably it is all about how you treat people."
Courage	8.5	1 of 6 Deans mentioned	
		"Chairs must exhibit tenacity/determination. If it doesn't work, re-frame it, hypothesize, get up. You could call this 'grit'."	

Deans and Chairs were both asked to suggest competencies they deemed necessary for Chairs to be successful. Each group referenced nine of the ten highest-ranked competencies from our survey results. Eight of these are part of Factor III: People or part of Factor IV: Self. Only Ensures Accountability is not part of one of these factors, rather is part of Factor II: Results. The conversations were most robust about developing people and the importance of effective communication. Emotional intelligence was mentioned in three of the interviews. Recall the competencies that were higher ranked in our survey results than in the benchmark result (Table# 7). Referencing these competencies serves as confirmation of the survey results and confirms that some of the People and Self competencies are more

important to success than the Thought and Results competencies that are higher ranked in the comparison data. As such, professional development around these competencies would be valuable to developing successful academic medical chairs.

Recall that Customer Focus was ranked lower in the survey results than is found in benchmark data. This topic was not directly discussed; however, Deans did suggest that patient satisfaction scores was a possible metric for chair evaluation which suggests that academic medical centers due, in fact, focus on customers.

2. TYPES OF ENGAGEMENT IN LEADERSHIP DEVELOPMENT ACTIVITIES

Chairs universally expressed limitations of their feeling prepared for the roles, whether they engaged in some professional development or not, like Leif's results. "I was prepared emotionally to embrace it, but not well prepared with what I needed to know." "I guess in some ways I feel like I had some opportunities to prepare myself for leadership and to learn some skills along the way." The interviews provided answers to our second question regarding what types of professional development are utilized by academic medical chairs.

OFF-SITE LEADERSHIP DEVELOPMENT ACTIVITIES

Several programs offered external to their own organizations were suggested by interviewees. Several Deans and Chairs describe satisfaction with their experience in two frequently mentioned off-site programs. Some information about these programs is provided here.

THE PROGRAM FOR CHAIRS OF CLINICAL SERVICES AT HARVARD T. H. CHAN SCHOOL OF PUBLIC HEALTH (https://www.hsph.harvard.edu/ecpe/programs/program-for-chairs-of-clinical-services/) which brings together chairs of major clinical departments in teaching hospitals and health systems and an experienced interdisciplinary faculty for two weeks of intensive and systematic study of some of the critical leadership and management issues facing chairs, their departments, and teaching hospitals. Major elements of their curriculum include: Institutional Strategy; Health Policy; Financial Analysis and Control; Operations Management; Organizational Issues; and Leadership Challenges.

EXECUTIVE LEADERSHIP IN ACADEMIC MEDICINE offered by Drexel University

Established in 1995, the Hedwig van Ameringen Executive Leadership in Academic Medicine® (ELAM) (https://drexel.edu/medicine/academics/womens-health-and-leadership/elam/) program offers an intensive one-year fellowship of leadership training with extensive coaching, networking and mentoring opportunities aimed at expanding the national pool of qualified women candidates for leadership in academic medicine. The curriculum of this program is designed to address four fundamental competencies: Strategic Finance and Resource Management; Personal and Professional Leadership Effectiveness; Organizational Dynamics; and Communities of Leadership Practice.

Where the Harvard course is designed for those already appointed chair, this program differs in that it targets aspiring leaders. The ELAM program has been specially developed for senior women faculty at the associate or full professor level who demonstrate the greatest potential for assuming executive leadership positions at academic health centers within the next five years. ELAM suggests that placing more women in positions of senior leadership at academic health centers will provide important new perspectives for decision making and help speed the curricular, organizational and policy changes needed to ensure a more effective representative and responsive health care system.

The ASSOCIATION OF AMERICAN MEDICAL COLLEGES (AAMC), offers several professional development classes for leadership. (https://www.aamc.org/professional-development/leadership-development) Most of their programming involves multi-day, in-person seminars. They have programs targeted toward early-career faculty, mid-career faculty, and executive levels. They have a class for Associate Deans or Department Chairs who have been in the position for three years or less. This program offers skill building in Leadership, People and Team Management, Financial Decision Making, and Communication in community with colleagues for meaningful networking.

High satisfaction with these programs was expressed. "ELAM is a huge opportunity to develop a chair." "We are requiring all of our new chairs within their first year, to go to either the Harvard program or an AAMC program. Just about everyone who has gone through finds it to be helpful."

Other external professional development options mentioned include actual degree programs like MBA or MHA, leadership development programs offered from specialty medical societies, and seeking external mentors who have served in capacity of department chair. "I did my master's in health services administration…it was having a seat at the table and I was just gradually stepping into other leadership roles as well."

INTERNAL LEADERSHIP DEVELOPMENT ACTIVITIES.

Some chairs participated in leadership development programs offered by their own institutions like ones discussed in the previous section: Emory, Johns Hopkins, and Duke. Specifics of the programs mentioned by the interviewees will not be discussed in effort to protect confidentiality. Some internal LDPs were described as robust learning opportunities and some acknowledge that their university needs to re-vamp the programs. Recognizing the need for business acumen, the Business Schools at some of the programs contributed to the curriculum development. As a result of the effects of health reform, financial pressures, and resource constraints, many chairs are being asked by their institutions to become more extensively involved in institutional decision-making with regard to programs, staffing, operating and capital budgets, and other issues, such as the restructuring of the clinical enterprise. These responsibilities are in addition to their traditional concerns within their own departments. At the same time, chairs need to further consider the relationship between institutional priorities, departmental decisions, and collaboration with other services.

SELF-DIRECTED LEADERSHIP DEVELOPMENT ACTIVITIES.

Some chairs described self-directed activities as part of the leadership development process.

MANAGEMENT BOOKS.

Several describe a commitment to reading of management literature and enjoy reading the work of successful leaders like Lou Gerstner's achievements bringing IBM back from financial insolvency. Also mentioned were the books published by Robert Quinn at the University of Michigan (https://www.amazon.com/Robert-E.-Quinn/e/B001H6MQSK) One article, The Future-Oriented Department Chair (Grisby, et. al., 2004) was mentioned by at least three of the people interviewed as being as relevant today as it was in 2004. As previously discussed, this article proposed that the characteristics of traditional department chairs have been replaced with other key skills and abilities that are fundamental to the success of the future-oriented chair and, ultimately, the department.

Unless the individual possesses these skills, she or he will be unable to craft a strategic vision to which everyone in the department is committed and contributes (Grisby, 2004). To develop and retain these leaders, they suggest that leadership training, mentoring, and effective performance evaluations are all necessary. Adding new leadership skills can result in improved organizational performance, if for no other reason than to build the leader's confidence (Grisby, 2004). The characteristics they list in this article correspond to the KFLA competencies that were high in the ranking results of the survey and confirmed in the interviews.

EXECUTIVE COACHING

Use of executive coaches is another mode of professional development that may be considered as a self-directed pursuit. Those who used executive coaches reported a level of support as they transitioned from the physician world where they were trained to be independent thinkers, skeptical scientists, and self-reliant professionals to a world where they need to build and lead teams, need to make decisions for not only themselves, but for the organization, and where blind spots can derail. Also, the trust relationship between client and coach can serve as a model for the trust that new leaders need to build with their faculty and staff (Boyce, 2010). Respondents report approaching their new leadership responsibilities with humility, acknowledging they had much to learn. The chairs that participated in the interviews did not convey a desire to lead from above or display stereotypic physician arrogance (Berger, 2002).

Despite these training opportunities, they also expressed need for more preparation around business acumen, managing professionalism/performance issues, and getting their team to accept differences in style from their predecessor. It is important to mention that some interviewees reported that they had engaged in no leadership development activities prior to their roles. In these cases, it is presumed that the hiring deans saw leadership potential and innate leadership qualities in the candidates.

It was reported that pivotal moments in their leadership journey illuminated the lack of preparation. Managing multiple agendas, dealing with conflict, making difficult decisions, how to be a stabilizing force during crisis were all mentioned as pivotal moments that afforded opportunities for learning. “Dealing with HR problems have been most challenging, but after experience you can build trust.”

The chairs interviewed acknowledge that leadership development is different than their training to become a physician. These quotes from interviewed chairs acknowledge this: “Being a physician is highly objective. Leadership is more relationship based.” “As a surgeon I could be more autonomous, but in my leadership role the work is much more team-based.” Similarly, “the core of being a physician is the relationship 1:1 with the patient. Leadership is about the team.” “The things I learned to become a doctor become muscle memory. Now you need to invest time in leadership education.” “The most relevant part of medical school training to leadership is having difficult conversations and perhaps some parts of crisis management are transferable to leadership.”

3. BARRIERS TO PURSUING LEADERSHIP DEVELOPMENT

Several barriers to pursing leadership development were discussed during the interview.

COST.

Off-site courses and executive coaching contracts are expensive. The Harvard program's tuition is $9,500 plus living expenses. Executive coaching agreements average approximately $15,000. The time away from other responsibilities of their jobs was reported as an opportunity cost of the effort.

PROGRAM NOT OFFERED AT THEIR SCHOOL.

Chairs reported an increased willingness to invest the time in leadership development if the program were local and could be worked in around other job responsibilities. However, academic medical centers must incur significant expense to develop and conduct a robust leadership development program at their own school.

Chairs expressed that they seek to find support from their deans, peer chairs at their organization, and national peers via their medical societies.

Other Insights

When asked about identity change the responses were varied. Two chairs expressed only feeling like a leader when people acknowledge/remind him of such but acknowledged that people look up to them. Several mentioned perceived change in standing. "I went from being everyone's friend, but now it's a little different." The major theme was that this group perceives themselves as servant leaders. These quotes support that position: "I prefer to lead beside people than from above." "I'm very fulfilled when others meet their goals and become successful." "It's important to revel in others' success."

CHANGING ROLE OF CHAIRS

Several chairs talked about the days of the "triple threat" weaning, if not already gone. This shift from the classic chair being a force in research, teaching, and patient care toward leading teams, being resilient, and developing others is completely aligned with the competency shift described in The Future-Oriented Department Chair (Grisby, et. al., 2004) article. Emotional intelligence came up a lot. The need for even more skill development for these competencies will be necessary more and more.

Despite statements that an MBA are not necessary, there were themes around business acumen, especially need to understanding health systems and service lines. This again relates back to identity beyond one is self and as part of an organization. One chair suggested, "Being a future thinker, citizen of a broader universe."

FUTURE TRAINING NEEDS

As mentioned, financial acumen was suggested as increasingly important for a future chair. The business side of healthcare has been absent from medical school curricula though is being inserted as revealed by the literature (Webb, 2014). No one expressed interest in achieving mastery of accounting. Rather they wanted to understand financial statements, identifying patterns and trends, and especially learn more about forecasting. One cautionary comment was made. "Protect what make us "academic" or we will become just another large health system." This suggests that academic medical centers see themselves more as human service organizations than traditional business enterprises.

LIMITATIONS

SAMPLE SIZE.

The small sample of academic medicine chairs in this study invites potential scrutiny of the findings. The requirement that chairs be deemed "high-performing" by their dean and nominated for participation limited possible chair participants. However, this same requirement likely increased the quality of the participants. Consider the 2017 Hargett, et. al. study at Duke University where 92 participants ranked 22 leadership competency statements. The difference there was that the participants were medical students, residents, attendings, and non-physician professionals. None were in leadership positions at the level of a chair. In fact, at least half were early in their training career and had no opportunities for significant leadership roles. In contrast, this project includes not only those at the chair level, but the top performers in their organizations as identified by their superiors.

RETURN ON INVESTMENT.

Avolio, Avey, and Quisenberry's 2010 article "Estimating Return on Leadership Development Investment" suggests that one of the key goals of their research was to change the way organizational leaders think about their investment in leadership development. Oftentimes, organizations are more willing to invest in leadership development when sufficient extra funds are available. Their view is that leadership development interventions should be proven valid and that providers should be able to offer demonstrated return on investment. We have seen in the literature that traditional ROI calculations are not optimal when considering returns on professional development (Mackie, 2007; DeMeuse, 2009; Athanasopoulous, 2018). Future effort from Korn Ferry should attempt to examine all the components that go into calculating ROI in terms of the types of outcomes, including improvement of organizational metrics. The intangible benefits need to be presented to potential clients in meaningful ways.

SUMMARY OF FINDINGS

In Summary, the KFLA success profile of academic medical chairs is moderately correlated to the success profiles of Mid-Levels ($r = 0.58$) and moderately correlated to the success profiles of Top Levels ($r = 0.57$). However, some competencies were more highly ranked in the success profile for academic department chairs: Demonstrates Self-Awareness; Values Differences; Develops Talent; Organizational Savvy; Courage; and Interpersonal Savvy, all People and Self Factors. There were other competencies that were regarded toward the least important in the success profile for academic medical chairs and are highly ranked in the benchmark profiles: Decision Quality; Manages Complexity; Collaboration; Action Oriented; Business Insight; Drives Results; and Customer Focus, competencies in the Thought and Results Factors.

As reported during the interviews, the following methods of professional development have been used in preparation of leadership roles as academic medical chairs.

- External leadership development programs like the Harvard course and ELAM.
- Internal leadership development programs offered by their own university
- Programs offered by AAMC and their specialty medical societies
- Executive coaching
- Reading
- Forming a network of peers to share ideas

The barriers to preventing pursuit of leadership development activities were cost, both dollars and time, and lack of access within their own universities. Understanding the return on investment beyond quantifiable ways also limits openness to making professional leadership investments.

RECOMMENDATIONS

Korn Ferry's goal of better understanding the success profile for academic medical chairs is to use the information to tune their offerings to better align with the needs of the target market.

RECOMMENDATION #1: PARTNER WITH ACADEMIC HEALTH SYSTEMS THAT DO NOT HAVE ROBUST LEADERSHIP DEVELOPMENT PROGRAMS TO DEVELOP CURRICULUMS FOR THEIR INSTITUTIONS.

Korn Ferry's success in the leadership develop space can be extended toward programming for academic medical centers. Given the moderately positive correlation with success profile for mid-level professionals and top-level professionals in the database, much of the content exits within the current programming targeted toward these groups. It will be essential to acknowledge the differences between the academic medicine chairs and other employee groups for the following reasons:

1. The data identified competencies for academic medicine chairs that are different than benchmark groups. From the results, Demonstrates Self-Awareness, Values Differences, Develops Talent, Organizational Savvy, Courage, and Interpersonal Savvy all land much higher in the success profile of an academic medicine chair. Korn Ferry must acknowledge these differences when proposing leadership development programming to this audience. Four of these competencies are part of Factor III: People: Values Differences; Develops Talent; Organizational Savvy. Two of these competencies are part of Factor IV: Self: Demonstrates Self-Awareness; and Courage.

> *Look inward before looking forward. Leaders must understand themselves and their own goals before meaningful sustained change can occur. – Korn Ferry website*

2. The literature review and interviews confirm the importance of many of these competencies as they are related to emotional intelligence. While EI is not a KFLA competency itself, the definition from Freshman and Rubino (2002) put forth Self-Awareness, Self-regulation, Self-motivation, Social Awareness, and Social Skills as the competencies key to healthcare leaders and the 12 competencies that Korn Ferry associates with EI. Previously viewed as unmalleable personality traits, there is greater acceptance that these competencies are skills that can be developed (Freshman, 2002). Again, these competencies would align with those in the KFLA competencies within Factor III: People and Factor IV: Self.
3. Themes around "people skills" were identified in the interview responses to discussion about how future leadership development should be designed to meet the competencies needed for success in the future.

For these reasons, the leadership development programs for academic medicine chairs need to have more emphasis on these competencies.

While many academic medical centers offer leadership development programs to aspiring leaders on their faculty, the ones that do not are potential clients for Korn Ferry to engage with. Recall Lucas' 2015 finding that 61 of 94 respondents to an (AAMC) survey indicated they were provided a formal internal faculty LDP (Lucas, et. al., 2018). Korn Ferry can also be instrumental in improving the efficacy of programs beyond the traditional return on investment calculation.

Korn Ferry can use a range of approaches from highly configurable standard, scalable solutions, and eLearning modules, to deeply customized leadership development experiences. They should keep in mind the barriers that chairs face when considering professional leadership development. Utilizing eLearning and on-site sessions will enable institutions to keep costs manageable after the initial investment in curriculum development. Based on the types of programs already offered, it seems that immersion programs for some, but most have longer curriculums with episodic learning sessions conducive to allowing participants immediate practical application of their newly acquired skills (Sonnino, 2016). This allows for time to ponder the material discussed and learn by doing back in their departments.

It's about the organization. A positive impact on individual participants should deliver dramatic results in organizational strategy. – Korn Ferry Website

RECOMMENDATION #2: OFFER EXECUTIVE COACHING TO SERVICES TO ACADEMIC MEDICINE CHAIRS, EVEN IF THEY ALREADY HAVE A ROBUST LEADERSHIP DEVELOPMENT PROGRAM AT THEIR UNIVERSITY.

The perceived benefits of executive coaching are espoused in the literature (Henochowicz, 2006; Nocks, 2007; DeMeuse, 2009; Boyce, 2010; Thorn, 2012; Athanasopoulou, 2018). Also, the ten competencies identified as most important to academic medicine chair success mostly fall into People and Self Factors which lend themselves to development of emotional intelligence.

- Instills Trust
- Develops Talent
- Builds Effective Teams
- Drives Vision and Purpose
- Demonstrates Self-Awareness
- Ensures Accountability
- Communicates Effectively
- Drives Engagement
- Interpersonal Savvy
- Courage

However, the use of executive coaching is not widespread in leadership development programs for academic medical chairs (Straus, 2013). This creates opportunity for Korn Ferry to enhance its "Executive Coaching for Academic Medicine Chairs" program as complement to existing LDPs and a key component to new ones. The development of these soft skills requires on-going feedback, observation, and collaboration.

Berglas (2002) warned of the "the very real dangers of executive coaching, and those warnings remain relevant today. Berger warns of the lure of seemingly quick and easy answers. Some new chairs reported a willingness to seek guidance from any seemingly knowledgeable source. Berglas also stressed the importance of expertise. Korn Ferry needs to remain mindful to position themselves as highly capable, knowledgeable experts that will

bring their deep experience from many industries, as well as their research-based competency model, to the academic medicine environment.

When developing tactics for recommendations 1 and 2, Korn Ferry should be mindful of the concepts of Identity and Learning Communities. Chairs reported that identity change developed over time. Experience fostered confidence that furthered their identification as leaders. The concept of learning communities is important. While chairs report mixed feelings regarding community with the chairs at their institutions, the communities formed through professional societies and cohorts in leadership development programs were long-lasting.

RECOMMENDATION #3: STRENGTHEN THE VALIDITY OF THE DATA BY INVITING ALL DEANS OF U.S. MEDICAL SCHOOLS TO NOMINATE THREE HIGH-PERFORMING CHAIRS AND STRENGTHEN THE RETURN ON INVESTMENT MEASURES.

Our sample of 14 chairs provides some basis for analysis; however, it does not represent a significant sample which may be questioned by academics. While the literature review and interviews support the differences in top-ranked competencies, it would be better to have a larger sample. By contacting deans and not asking for any time-commitment for surveys or interviews, only to nominate three chairs to complete the survey, I suggest it is possible to increase the sample size. Then, emails could be sent to the chairs asking them to complete the same Likert scale type survey to rate the importance of each competency. A larger sample will strengthen the validity of the work and make it more defensible when comparing to other studies attempting to identify the competencies of academic medical chairs.

By improving understanding of return in leadership development investment, in both quantifiable and intangible ways, academic medical chairs may seek greater support from their universities to invest in them. Emphasis should be placed on moving of institutional metrics when a cohort of leaders are developed, rather than focusing solely on measuring impact in one department.

CONCLUSIONS

Moving into leadership positions in academic medicine requires proficiency in specific competencies in effort to be successful or high performing. This project has survey results from U.S. medical school deans and high-performing department chairs to determine a success profile using the Korn Ferry Leadership ArchitectTM Competency Mapping model. While the success profile for an academic medicine chair is moderately correlated to the success profiles of Mid-Level and Top-Level leaders in the Korn Ferry database, several competencies identified among the top competencies for the job were higher in the profile than to the comparison groups: Demonstrates Self-Awareness; Values Differences; Develops Talent; Organizational Savvy; Courage; and Interpersonal Savvy. This suggests that these competencies are more important to success as an academic medicine chair than to broader leadership groups.

Qualitative data confirmed the results of the surveys. Emotional Intelligence, while not a separate Korn Ferry competency, was suggested as necessary for success. Other Korn Ferry competencies that relate to Emotional Intelligence were high-ranking in the success profile of academic medicine chairs: Demonstrates Self-Awareness; Communicates Effectively; and Interpersonal Savvy were top ten in the success profile and relate to Emotional Intelligence.

Interviews also furthered the understanding of academic medical chair perceptions of professional leadership development activities. Chairs reported a variety of exposures to leadership development. External activities like degree programs or training programs offered at other universities or professional societies, are valued by chairs, but some report challenges to find time to attend and challenges with cost. Internally offered Leadership Development Programs are appealing in terms of making it easier to participate due to the sessions being spread out over a longer period, which is effective for learning people skills. Some chairs reported value in working with executive coaches as they transition into leadership roles.

There is opportunity for Korn Ferry to enhance their training programs in response to success profile for academic medicine chairs. This could be in terms of programming offered to medical schools and health systems following chair recruitments or by executive coaching programs to align with the competencies that were higher ranked for academic medicine chairs than in general leadership groups.

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APPENDICES

1. AAMC 2019 Faculty Roster
2. Brochure for Duke Leadership Development Program
3. Korn Ferry Leadership Architect Model
4. Qualtrics Survey
5. IRB Documents
6. Data File
7. Summary of Dean Interviews
8. Summary of Chair Interviews

Trends: Department Chairs by Chair Type and Sex, December 31 Snapshots

The table below displays counts and percentages of permanent, interim, and acting department chairs at all U.S. medical schools by sex from 1977 to the present using December 31 snapshots. In order to provide unduplicated counts of chairs, the table shows the most recent chair appointment for an individual that was open on December 31 in each snapshot year. As a result, individuals who held chair appointments in multiple departments simultaenously in a given snapshot year are only counted once in that snapshot year. Comprehensive data on department chairs are available from 1977 onwards.

	Permanent Chairs				Interim/Acting Chairs				All Chairs Combined			
	Women		Men		Women		Men		Women		Men	
Snapshot Year	N	%	N	%	N	%	N	%	N	%	N	%
1977	60	3%	2,286	97%	0	0%	4	100%	60	3%	2,290	97%
1978	66	3%	2,350	97%	0	0%	5	100%	66	3%	2,355	97%
1979	72	3%	2,350	97%	0	0%	8	100%	72	3%	2,358	97%
1980	69	3%	2,357	97%	0	0%	8	100%	69	3%	2,365	97%
1981	67	3%	2,364	97%	0	0%	8	100%	67	3%	2,372	97%
1982	71	3%	2,248	97%	0	0%	8	100%	71	3%	2,256	97%
1983	67	3%	2,300	97%	0	0%	12	100%	67	3%	2,312	97%
1984	69	3%	2,324	97%	1	5%	18	95%	70	3%	2,342	97%
1985	78	3%	2,342	97%	1	6%	17	94%	79	3%	2,359	97%
1986	83	3%	2,342	97%	0	0%	15	100%	83	3%	2,357	97%
1987	86	4%	2,317	96%	0	0%	17	100%	86	4%	2,334	96%
1988	95	4%	2,316	96%	0	0%	17	100%	95	4%	2,333	96%
1989	103	4%	2,337	96%	0	0%	18	100%	103	4%	2,355	96%
1990	102	4%	2,337	96%	0	0%	23	100%	102	4%	2,360	96%
1991	114	5%	2,323	95%	0	0%	27	100%	114	5%	2,350	95%
1992	119	5%	2,356	95%	0	0%	34	100%	119	5%	2,390	95%
1993	129	5%	2,374	95%	0	0%	33	100%	129	5%	2,407	95%
1994	135	5%	2,348	95%	2	5%	37	95%	137	5%	2,385	95%
1995	147	6%	2,368	94%	3	6%	48	94%	150	6%	2,416	94%
1996	164	6%	2,377	94%	4	7%	55	93%	168	6%	2,432	94%
1997	178	7%	2,384	93%	5	8%	55	92%	183	7%	2,439	93%
1998	187	7%	2,376	93%	8	11%	65	89%	195	7%	2,441	93%
1999	197	8%	2,383	92%	9	10%	78	90%	206	8%	2,461	92%
2000	216	8%	2,391	92%	13	11%	103	89%	229	8%	2,494	92%
2001	226	9%	2,403	91%	11	9%	110	91%	237	9%	2,513	91%
2002	230	9%	2,355	91%	16	9%	166	91%	246	9%	2,521	91%
2003	259	10%	2,325	90%	31	14%	185	86%	290	10%	2,510	90%
2004	266	10%	2,345	90%	26	13%	177	87%	292	10%	2,522	90%
2005	272	10%	2,340	90%	22	12%	162	88%	294	11%	2,502	89%
2006	279	11%	2,316	89%	29	14%	183	86%	308	11%	2,499	89%
2007	298	11%	2,323	89%	40	20%	165	80%	338	12%	2,488	88%
2008	319	12%	2,371	88%	40	19%	171	81%	359	12%	2,542	88%
2009	346	13%	2,394	87%	47	23%	158	77%	393	13%	2,552	87%
2010	359	13%	2,426	87%	52	25%	158	75%	411	14%	2,584	86%
2011	375	13%	2,428	87%	53	23%	174	77%	428	14%	2,602	86%
2012	392	14%	2,485	86%	56	26%	162	74%	448	14%	2,647	86%
2013	428	15%	2,490	85%	53	25%	157	75%	481	15%	2,647	85%
2014	447	15%	2,496	85%	68	30%	157	70%	515	16%	2,653	84%
2015	485	16%	2,473	84%	64	25%	193	75%	549	17%	2,666	83%
2016	513	17%	2,483	83%	70	26%	200	74%	583	18%	2,683	82%
2017	521	18%	2,452	82%	73	24%	232	76%	594	18%	2,684	82%
2018	546	18%	2,412	82%	81	25%	248	75%	627	19%	2,660	81%
2019	561	19%	2,415	81%	76	24%	245	76%	637	19%	2,660	81%

Note: This table excludes 30 chairs with missing sex data.

Source: AAMC Faculty Roster, December 31, 2019 snapshot.

Group Projects

Each DCLP fellow participates in a group project focused on an issue identified by Duke Health leaders. **Projects provide an opportunity for leaders to engage a group of creative thinkers in understanding and proposing solutions to a challenge they are currently facing.** Program fellows use this opportunity to apply classroom knowledge while developing skills in effective teamwork. Projects afford fellows an avenue to engage with senior leaders on issues of importance to them, and to develop awareness of how to move an idea through a highly matrixed organization. Each project group provides the nominating entity with an analysis of the problem and proposed solutions.

Examples of past projects that have been implemented include:

- Exploration of feasibility and process for a Duke Academy for Innovation and Research in Education. After further evaluation and development, this 2012 project contributed to the formation of the Duke Academy for Health Professions Education and Academic Development (Duke AHEAD).
- Analysis of Duke's K Award mentoring structure. This situation analysis proposed the formation of internal grant review programs for NIH career development and other awards. These programs were developed in 2010 and still operate as the Path to Independence Program and K Club.

New in 2019, the **Thomas Gorrie Clinical Leadership Impact Award** recognizes the most successful project team with a cash prize.

Eligibility

The Duke Clinical Leadership Program is designed for mid-career faculty members with clinical responsibilities who are interested in or preparing for a clinical leadership role. Course costs are covered by the Office of the Chancellor. Faculty must be able to attend all six program days in order to apply.

Application Process

Program participants are chosen through a competitive selection process. Applications are accepted in the fall and require a letter of support from the applicant's departmental or unit leadership. Faculty will be notified of the application process via e-mail.

"My participation in DCLP came at the perfect time in my career, as I was transitioning to a leadership position and the sessions seemed perfectly focused on the issues I was facing in my division."

– April Stouder, MHS, PA-C
2018 Program Participant

Learn More

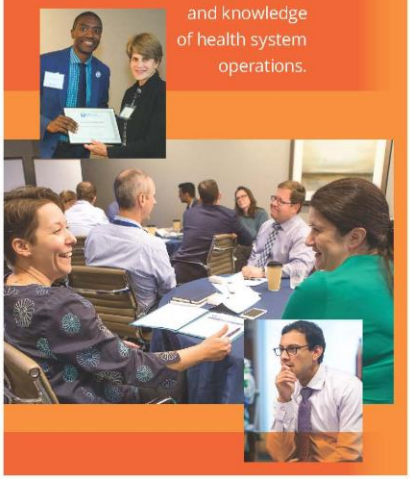
For more information about DCLP, contact the Duke University School of Medicine Office for Faculty.

Vice Dean for Faculty Ann Brown, MD, MHS
Phone: (919) 684-4139
E-mail: facdev@dm.duke.edu
Web: http://facdev.medschool.duke.edu

DukeHealth

Duke Clinical Leadership Program

Providing mid-career clinical faculty an opportunity to expand their leadership skills and knowledge of health system operations.



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Duke Clinical Leadership Program

The Duke Clinical Leadership Program (DCLP) was founded in 2010 by the Chancellor for Health Affairs to help **expand capacity for leadership within Duke Health and broaden opportunities for professional development.** The program is part of a suite of professional development programs managed by the School of Medicine Office for Faculty. The DCLP learning environment gives current and future clinical leaders the opportunity to grow their understanding of healthcare operations while honing their leadership skills.

"I greatly appreciated the multidisciplinary perspective the DCLP team brought to my project. The final presentation was extremely helpful in our thinking about advancing family medicine across Duke Health." – Anthony Viera, MD, Chair of the Department of Community and Family Medicine; 2018 Project Proposer

Program Goals

- Provide a management toolkit that will enable participants to lead and grow their units with increased efficacy and efficiency
- Provide education and training that will allow participants to enhance their career trajectories
- Enrich the institution through engagement and innovation to improve its culture of supporting leadership
- Provide cross-fertilization from disparate divisions/departments
- Build collegiality among Duke Health's next generation of leaders
- Enhance team performance skills through group project activities of significance to the organization

Program Structure

DCLP consists of six day-long meetings over six months and concludes with a graduation ceremony. **Each meeting is highly interactive and includes time for group project work.** Additional time may be needed outside of the classroom to complete the projects. The program addresses critical leadership topics such as:

- Leveraging different leadership styles
- Managing self and others
- Difficult conversations
- Finance
- Negotiation
- Institutional strategy

As part of the participation in DCLP, fellows are given a 360-degree evaluation, as well as follow up coaching from an executive coach. During the coaching session, fellows discuss topics such as professional challenges, opportunities, goal setting, leadership skill development, and work-life integration.

DukeHealth

Korn Ferry Leadership Architect™ Competency Mapping

Factor (4)	Cluster (12)	Competency (38)
FACTOR I: Thought	Understanding the Business (A)	Business Insight (5)
		Customer Focus (11)
		Financial Acumen (17)
		Tech Savvy (35)
	Making the Right Call (B)	*Manages* Complexity (8)
		Decision Quality (12)
		Balances Stakeholders (32)
	Creating the New & Different (C)	Global Perspective (18)
		Cultivates Innovation (19)
		Strategic Mindset (33)
FACTOR II: Results	Taking Initiative (D)	Action Oriented (2)
		Resourcefulness (27)
	Managing Execution (E)	Directs Work (15)
		Plans & Aligns (25)
		Optimizes Work Processes (38)
	Focusing on Performance (F)	*Ensures* Accountability (1)
		Drives Results (28)
FACTOR III: People	Building Collaborative Relationships (G)	Collaborates (6)
		Manages Conflict (9)
		Interpersonal Savvy (20)
		Builds Networks (21)
	Optimizing Diverse Talent (H)	Attracts Top Talent (4)
		Develops Talent (13)
		Values Differences (14)
		Builds Effective Teams (34)
	Influencing People (I)	Communicates Effectively (7)
		Drives Engagement (16)
		Organizational Savvy (23)
		Persuades (24)
		Drives Vision and Purpose (37)
FACTOR IV: Self	Being Authentic (J)	Courage (10)
		Instills Trust (36)
	Being Open (K)	*Demonstrates* Self-Awareness (29)
		Self-Development (30)
	Being Flexible & Adaptable (L)	*Manages* Ambiguity (3)
		Nimble Learning (22)
		Being Resilient (26)
		Situational Adaptability (31)

High Performing Chair Survey

Start of Block: Default Question Block

Your Dean has indicated you are considered a high-performing Chair.
For each of the competencies listed in the table below, please rate the importance of each competency to the leadership role as department chair with 5 being most important and 1 being least important.

	1 (1)	2 (2)	3 (3)	4 (4)	5 (5)
Ensures Accountability: Holding self and others accountable to meet commitments. (1)	○	○	○	○	○
Action Oriented: Taking on new opportunities and tough challenges with a sense of urgency, high energy, and enthusiasm. (2)	○	○	○	○	○
Manages Ambiguity: Operating effectively, even when things are not certain or the way forward is not clear. (3)	○	○	○	○	○
Attracts Top Talent: Attracting and selecting the best talent to meet current and future business needs. (4)	○	○	○	○	○
Business Insight: Applying knowledge of business and the marketplace to advance the organization's goals. (5)	○	○	○	○	○

Collaboration: Building partnerships and working collaboratively with others to meet shared objectives. (6)	○	○	○	○	○
Communicates Effectively: Developing and delivering multi-mode communications that convey a clear understanding of the unique needs of different audiences. (7)	○	○	○	○	○
Manages Complexity: Making sense of complex, high quantity, and sometimes contradictory information to effectively solve problems. (8)	○	○	○	○	○
Manages Conflict: Handling conflict situations effectively, with a minimum of noise. (9)	○	○	○	○	○
Courage: Stepping up to address difficult issues, saying what needs to be said. (10)	○	○	○	○	○

Customer Focus: Building strong customer relationships and delivering customer-centric solutions. (11)	○	○	○	○	○
Decision Quality: Making good and timely decisions that keep the organization moving forward. (12)	○	○	○	○	○
Develops Talent: Developing people to meet both their career goals and the organization's goals. (13)	○	○	○	○	○
Values Differences: Recognizing the value that different perspectives and cultures bring to an organization. (14)	○	○	○	○	○
Directs Work: Providing direction, delegating, and removing obstacles to get work done. (15)	○	○	○	○	○

Drives Engagement: Creating a climate where people are motivated to do their best to help the organization achieve its objectives. (16)	○	○	○	○	○
Financial Acumen: Interpreting and applying understanding of key financial indicators to make better business decisions. (17)	○	○	○	○	○
Global Perspective: Taking a broad view when approaching issues, using a global lens. (18)	○	○	○	○	○
Cultivates Innovation: Creating new and better ways for the organization to be successful. (19)	○	○	○	○	○
Interpersonal Savvy: Relating openly and comfortably with diverse groups of people. (20)	○	○	○	○	○

Navigates Networks: Effectively navigating formal channels and informal networks inside and outside the organization. (21)	○	○	○	○	○
Nimble Learning: Actively learning through experimentation when tackling new problems, using both successes and failures as learning fodder. (22)	○	○	○	○	○
Organization Savvy: Maneuvering comfortably through complex policy, process, and people-related organizational dynamics. (23)	○	○	○	○	○
Persuades: Using compelling arguments to gain the support and commitment of others. (24)	○	○	○	○	○

Plans and Aligns: Planning and prioritizing work to meet commitments aligned with organizational goals. (25)	○	○	○	○	○
Being Resilient: Rebounding from setbacks and adversity when facing difficult situations. (26)	○	○	○	○	○
Resourcefulness: Securing and deploying resources effectively and efficiently. (27)	○	○	○	○	○
Drives Results: Consistently achieving results, even under tough circumstances. (28)	○	○	○	○	○
Demonstrates Self-Awareness: Using a combination of feedback and reflection to gain productive insight into personal strengths and weaknesses. (29)	○	○	○	○	○

Self-Development: Actively seeking new ways to grow and be challenged using both formal and informal development channels. (30)	○	○	○	○	○
Situational Adaptability: Adapting approach and demeanor in real time to match the shifting demands of different situations. (31)	○	○	○	○	○
Balances Stakeholders: Anticipating and balancing the needs of multiple stakeholders. (32)	○	○	○	○	○
Strategic Mindset: Seeing ahead to future possibilities and translating them into breakthrough strategies. (33)	○	○	○	○	○
Builds Effective Teams: Building strong-identity teams that apply their diverse skills and perspectives to achieve common goals. (34)	○	○	○	○	○

Tech Savvy: Anticipating and adopting innovations in business-building digital and technology applications. (35)	○	○	○	○	○
Instills Trust: Gaining the confidence and trust of others through honesty, integrity, and authenticity. (36)	○	○	○	○	○
Drives Vision and Purpose: Painting a compelling picture of the vision and strategy that motivates others to action. (37)	○	○	○	○	○
Optimizes Work Processes: Knowing the most effective and efficient processes to get things done, with a focus on continuous improvement. (38)	○	○	○	○	○

End of Block: Default Question Block

Understanding Success Profiles of High-Performing Chairs of Academic Medicine; Their Attitude and Approach to Professional Development

Identification of Participants - Communication to Deans:

Deans of Medical Schools will be contacted using a combination of phone calls, emails, and letters. Recognizing the limited time for Deans to participate in this project, we will utilize existing professional relationships in effort to encourage participation. Some Deans are known personally by the researcher and he will contact them. Other Deans have historical relationships with Korn Ferry and will be contacted by members of their Academic Practice team.

Following is the text they will be used invite participation:

Dear Dean _____,

Great to connect with a colleague in Academic Medicine.

Having worked in Academic Medicine for over twenty years at John Hopkins and now almost ten years at University of Miami, I can tell you firsthand how critical leadership development is for all of us to meet the challenges of today's healthcare landscape.

I'm sure you'll agree. Leadership development these days is just so critical given rising costs of healthcare, the need for patient centric models of service and the increasing complexity of treatment. Challenging to say the least.

Still, what I have been unable to really understand is what kind of leadership attributes are key for Department Chair success in our unique Academic Medical Center tri-partite setting. Perhaps you are curious also?

That's the reason for this email. To ask for your help in learning about this critical issue.

I am enrolled in a doctoral program at Vanderbilt University in Leadership and Learning in Organizations. As part of my capstone doctoral project and in collaboration with Korn/Ferry, I'm conducting a research study to understand the competencies and capabilities of the best peak-performing chairs in our industry.

My heart felt intent is to try and find the critical components for building the academic medical center leaders of tomorrow, by interviewing 30 Chairs across the US and building out a framework model that I plan to share with all participating deans. My thinking here is simple, perhaps we can address this leadership challenge together and get a foothold in meeting the challenges we frankly are all facing.

What 3 or 4 department chairs in your organization do you consider to be high-performing and what competencies differentiate their performance? Would you identify them to me so that I can have some time to speak with them? The process should take no longer than thirty minutes.

I would also ask for you to take a short survey that will help to direct the research. I assure you that all information will remain 100% confidential, simply the names of institutions will be shared and of course

the outcome and key learning will be distributed to you and others that participate. Please consider completion of the survey, even if you can't spare the time for an interview with me.

However; if willing, I would most appreciate your participation in an interview with me regarding these topics and I can assure you this would take less than a half hour of your valuable time.

I would appreciate so much your institutions contribution because of your reputation as a dean and your institution's contributions to the field.

Thanking you in advance for considering this, I am,

Sincerely,

Tony Etzel
Vice Chair Department of Otolaryngology at University of Miami

A link to the survey instrument will be sent to them with the communication.
(Attachment A).

If they agree to participate in an interview, a phone or video meeting will be scheduled at a convenient time.

Script for Interview Meetings with Deans:

I sincerely thank you for making time in what I know is a busy schedule for this interview. Before we get started, please allow me to introduce myself and tell you a little about my project.

My name is Tony Etzel, and my career has been in academic medical center administration, working in partnership with Department Chairs. My first Administrator role was with Charlie Cummings at Johns Hopkins, then also worked with Lloyd Minor (at Stanford), John Niparko (who went to USC), and for the past nine years I've worked with Fred Telischi at University of Miami. Having worked with these any many other Chairs during my career, I've seen a variety of approaches to professional development as Chairs transition into leadership roles. As a doctoral student at Vanderbilt, I am researching what makes an academic medical center chair successful, as well as how they approach professional development. I am partnering with Korn/Ferry and using their KF4D as a tool to describe the competencies needed to be a high-performing Chair. Thank you for completing the survey. Now, I'd like to ask you some questions about your experience.

With your permission, I would like to record our meeting. This is for the purpose of accuracy and only I will hear the recording. While the name of your medical school will appear in my report, all of your responses will be confidential. No quotes will be attributed to specific participants without expressed permission. In the survey, you identified three department chairs in your organization that you feel are high performing in their roles. I have or will be reaching out to them.

Guiding Interview Questions:

1. How do you define success? What metrics do you consider when measuring their success?

2. What competencies do you associate with their success? (Open ended) Based on your responses to the survey, you indicated _____ were most important. Why do you feel this way?

3. How do you prepare / develop chairs for leadership (today)?

a. Educational programming

b. Off site development

c. On site development

d. Executive Coaching

e. Formal coursework (i.e. MBA)

4. The job of Department Chair continues to change in part due to changing context. I think of increased centralization in academic medical centers and the role of the Chair changing. What leadership qualities will be needed for future chairs? (Open ended.) How about from the list we discussed? Do you see any of these as more necessary for future chairs?

5. Do you anticipate changing your leadership development programs based on future needs? If so, how?

Using the information collected from the Deans, I will reach out to the high-performing Chairs.

Communication to Chairs:

Dear Dr. _____:

I am the Administrator for the Department of Otolaryngology at University of Miami and previously worked in various roles at Johns Hopkins. I am also a doctoral student at Vanderbilt University completing my Capstone Project in Leadership and Learning in Organizations in conjunction with Korn/Ferry. Having partnered with many successful Chairs during my career, I am researching how Chairs at academic medical centers develop into leaders. Your Dean, Dr. _____, has told me that you are considered a high-performing, successful Chair at _____ and has indicated that you would be willing to participate in an approximately 30-minute interview with me. Your Dean has provided me with contact information for your assistant and I would like to schedule some time on your calendar for a phone or video meeting in the coming weeks. I hope that my research findings will provide support to Chairs, especially new ones, as they transition into leadership roles.

In addition, I will send you via email a link to a very brief survey that asks your opinion as to the importance of several competencies regarding the success of an academic medical center chair. These

competencies will be the basis for part of our upcoming discussion. Please complete this before we speak.

Thanking you in advance for your participation, I am,

Sincerely,

Tony Etzel

Collecting data from Chairs

I will then schedule 30-minute interviews with each of the chairs identified by the deans

Script for Interview Meetings with Chairs:

I sincerely thank you for making time in what I know is a busy schedule for this interview. Before we get started, please allow me to introduce myself and tell you a little about my project.

My name is Tony Etzel, and my career has been in academic medical center administration, working in partnership with Department Chairs. My first Administrator role was with Charlie Cummings at Johns Hopkins, then also worked with Lloyd Minor (now Dean at Stanford), John Niparko, and for the past nine years I've worked with Fred Telischi at University of Miami. Having worked with these any many other Chairs during my career, I've seen a variety of approaches to professional development as Chairs transition to leadership roles. As a doctoral student at Vanderbilt, I am researching what makes an academic medical center chair successful, as well as how they approach professional development. I am partnering with Korn/Ferry and using their KF4D as a tool to describe the competencies needed to be a high-performing Chair. Thank you for completing the survey. Now, I'd like to ask you some questions about your experience.

With your permission, I would like to record our meeting. This is for the purpose of accuracy and only I will hear the recording. While the name of your medical school will appear in my report, all of your responses will be confidential. No quotes will be attributed to specific participants without expressed permission.

Guiding Questions:

1. What competencies most contribute to your success as a leader? (Open ended.) Based on your response to the survey, you indicated these were the most important competencies. _____ Why?

2. What motivates you to be a high performing leader? Please describe the situation.

3. Did you feel well-prepared and why? If not, why not?

4. How did you prepare for your leadership role? Gather descriptive details. And how did professional development/executive coaching effect your career?

5. How did your development as a leader differ from your training as a physician?

6. What were some pivotal moments in your leadership experience? What are your takeaways?

7. As you have developed identity as a leader, what caused the change?

8. Do you feel the support of your leader and/or institution in your development as a leader?

9. Do you feel a sense of community among your peer chairs?

a. Within your organization?

b. Within your specialty society?

c. Through formal or informal ways?

10. How do you see the role of department chair in an academic medical center changing? Positive ways? Challenges?

11. What are the leadership qualities needed in leading the change/in the future? (If needed, prompt them with the list of the competencies.) Why?

12. Do you have suggestions for leadership development for future-oriented chairs?

Seq	Competency	Chair														Dean		Mean	Rank	Mid-Level Skill 360	Mid-Level Importance 360	Top-Level Skill 360	Top-Level Importance 360	Mid-Level Rank	Top-Level Rank	d Mid Level	d Top Level
Q3_28	Drives Results	5	4	3	4	5	4	5	4	4	4	4	5	4	5	5	4	4.31	20.5	3.88	4.27	3.94	4.31	1	1	-19.5	-19.5
Q3_36	Instills Trust	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5.00	1.0	3.95	4.21	3.97	4.27	3	2	2.0	1.0
Q3_7	Communicates Effectively	3	5	4	4	5	5	5	4	5	5	3	5	4	5	5	5	4.50	8.5	3.72	4.21	3.74	4.24	2	3	-6.5	-5.5
Q3_6	Collaboration	4	5	5	4	4	4	5	4	5	5	4	4	4	4	5	4	4.38	16.0	3.86	4.20	3.88	4.22	4	4	-12.0	-12.0
Q3_12	Decision Quality	3	5	5	5	4	5	5	4	5	5	4	4	4	4	4	4	4.38	16.0	3.77	4.17	3.83	4.22	7	5	-9.0	-11.0
Q3_34	Builds Effective Teams	5	5	4	4	5	5	5	4	5	5	4	5	5	4	4	5	4.63	4.0	3.63	4.17	3.66	4.20	6	6	2.0	2.0
Q3_1	Ensures Accountability	5	5	4	4	5	5	5	4	5	5	4	4	4	4	5	5	4.56	6.0	3.78	4.16	3.81	4.19	8	7	2.0	1.0
Q3_11	Customer Focus	3	4	4	4	4	4	5	4	4	3	4	3	4	4	3	5	3.88	33.5	3.87	4.19	3.88	4.18	5	8	-28.5	-25.5
Q3_8	Manages Complexity	5	5	4	5	4	5	5	4	5	4	3	3	4	5	4	4	4.31	20.5	3.81	4.11	3.86	4.15	10	9	-10.5	-11.5
Q3_2	Action Oriented	3	5	4	4	4	4	5	4	5	4	4	4	4	5	4	5	4.25	25.0	3.95	4.12	4.01	4.14	9	10	-16.0	-15.0
Q3_33	Strategic Mindset	3	4	4	4	5	5	5	5	5	4	3	4	5	4	5	4	4.31	20.5	3.56	3.97	3.69	4.13	22	11	1.5	-9.5
Q3_4	Attracts Top Talent	4	5	2	5	5	5	5	4	3	5	4	4	5	5	5	4	4.38	16.0	3.52	4.02	3.58	4.11	16	12	0.0	-4.0
Q3_37	Drives Vision and Purpose	5	5	4	4	5	5	5	5	5	4	4	4	5	5	5	4	4.63	4.0	3.57	3.97	3.69	4.10	21	13	17.0	9.0
Q3_25	Plans and Aligns	4	4	4	5	5	4	5	5	5	4	4	4	5	4	5	4	4.44	12.5	3.70	4.07	3.75	4.10	12	14	-0.5	1.5
Q3_26	Being Resilient	4	5	3	5	5	5	4	4	5	4	4	3	4	4	5	5	4.31	20.5	3.87	4.05	3.95	4.09	13	15	-7.5	-5.5
Q3_5	Business Insight	3	4	3	4	4	4	4	4	4	4	4	3	4	4	4	4	3.81	35.0	3.72	3.91	3.89	4.08	28	16	-7.0	-19.0
Q3_15	Directs Work	5	3	3	3	4	5	5	5	5	4	5	4	4	4	5	5	4.31	20.5	3.67	4.10	3.67	4.07	11	17	-9.5	-3.5
Q3_16	Drives En gagement	4	5	4	4	5	4	5	5	5	4	4	4	5	5	4	5	4.50	8.5	3.63	4.04	3.67	4.07	15	18	6.5	9.5
Q3_13	Develops Talent	4	5	4	5	5	5	4	5	5	5	5	5	5	5	5	5	4.81	2.0	3.53	4.04	3.56	4.06	14	19	12.0	17.0
Q3_20	Interpersonal Savvy	3	4	4	4	5	5	5	4	5	5	5	5	4	4	5	5	4.50	8.5	3.78	3.99	3.83	4.05	18	20	9.5	11.5
Q3_27	Resourcefulness	5	5	3	4	5	5	5	4	5	4	5	4	4	5	4	4	4.44	12.5	3.79	4.02	3.83	4.04	17	21	4.5	8.5
Q3_3	Manages Ambiguity	3	5	3	5	4	5	5	4	5	4	5	3	4	4	4	4	4.19	28.0	3.65	3.98	3.71	4.03	19	22	-9.0	-6.0
Q3_10	Courage	5	5	4	4	5	5	4	4	5	4	5	4	4	4	5	5	4.50	8.5	3.84	3.95	3.91	4.02	23	23	14.5	14.5
Q3_17	Finacial Acumen	4	5	2	4	4	4	4	3	5	4	3	3	4	4	4	5	3.88	33.5	3.66	3.87	3.80	4.02	30	24	-3.5	-9.5
Q3_32	Balances Stakeholders	3	4	3	4	4	4	5	4	5	4	5	4	5	4	5	5	4.25	25.0	3.68	3.95	3.74	4.02	24	25	-1.0	0.0
Q3_24	Persuades	3	4	3	4	5	5	5	3	5	5	4	3	5	4	5	4	4.19	28.0	3.56	3.95	3.65	4.01	25	26	-3.0	-2.0
Q3_9	Manages Conflict	3	5	4	4	5	5	3	4	5	4	5	4	4	4	5	5	4.31	20.5	3.49	3.98	3.52	4.01	20	27	-0.5	6.5
Q3_23	Organizational Savvy	4	3	5	4	5	5	5	4	5	4	4	4	5	4	5	5	4.44	12.5	3.67	3.91	3.76	4.01	27	28	14.5	15.5
Q3_21	Navigates Networks	3	3	4	4	5	5	4	5	4	4	3	3	4	5	4	5	4.19	28.0	3.75	3.93	3.84	4.01	26	29	-2.0	1.0
Q3_31	Situational Adaptability	3	5	4	5	4	5	5	4	5	4	4	3	4	4	4	5	4.25	25.0	3.57	3.86	3.61	3.89	31	30	6.0	5.0
Q3_22	Nimble Learning	3	3	2	5	4	4	5	4	3	3	3	4	4	3	4	4	3.63	36.5	3.79	3.84	3.81	3.86	32	31	-4.5	-5.5
Q3_19	Cultivates Innovation	4	4	2	4	4	5	5	5	3	4	5	4	4	4	5	4	4.13	30.0	3.56	3.79	3.60	3.84	35	32	5.0	2.0
Q3_38	Optimizes Work Processes	3	3	3	4	4	4	5	5	4	3	4	4	4	4	5	4	3.94	32.0	3.62	3.90	3.59	3.84	29	33	-3.0	1.0
Q3_29	Demonstrates Self-Awareness	3	4	4	5	5	5	5	5	5	5	4	5	5	4	5	5	4.63	4.0	3.55	3.80	3.55	3.83	34	34	30.0	30.0
Q3_30	Self-Development	3	3	4	4	4	4	3	4	4	3	5	4	5	4	5	5	4.00	31.0	3.83	3.82	3.84	3.81	33	35	2.0	4.0
Q3_14	Values Differences	5	5	5	4	5	5	3	4	4	4	4	4	5	4	5	5	4.44	12.5	3.65	3.77	3.69	3.81	36	36	23.5	23.5
Q3_18	Global Perspective	3	5	3	4	4	4	1	4	5	3	3	3	4	3	5	4	3.63	36.5	3.55	3.66	3.68	3.78	37	37	0.5	0.5
Q3_35	Tech Savvy	2	3	2	4	4	4	4	5	3	3	3	3	3	3	5	4	3.44	38.0	3.54	3.51	3.50	3.50	38	38	0.0	0.0
																				0.11	0.58	0.08	0.57				

Define Success	Metrics	Competencies	Preparation of Chairs	Changing Job of Chairs	Future Leadership Development
"Success is a kind of legacy you leave and the people you develop, impact you make in the culture and the society broader."	In progress, need for some numerical metrics that can be measured objectively, education metrics, satisfaction of students, residents, research metrics	Servant leader, developing people, developing relationships across departments; be a national advocate	ELAM @ Drexel University; Harvard course for new chairs; re-vamp internal offerings; pilot program Executive Coaching	Refer to 2005 Article 'Future Oriented Chair' - just as relevant today; Being inclusive; increased need to collaborate outside of the medical school	Change management
	Annual evaluations and bonus system - choosing metrics to achieve bonus, so dedicating effort to changing metrics to be meaningful. Financial performance; Press Ganey patient satisfaction surveys;	MBA not necessary, but business acumen important; Develop a team.	Require new chairs to attend Harvard course or AAMC course.	"The days of the triple threat are weaning rapidly if not already gone." Emotional Intelligence; Relationship Building. Article "Rock stars in Academic Medicine" You don't need the rock star, you need someone who can lead, orchestrate the team...	Desire to have stronger internal leadership development program, but it is difficult to commit the time and resources
Commitment to excellence; Integrity, Leaders vs. power seekers, Emotional Intelligence. Wants everyone on his team to be a "gardener" - Plant seeds and reap fruit.	Should be measured by your team	Hire the best people (Team): Scrutinize applicant pool, be self-less, don't micromanage, demonstrate curiosity, be a disruptor, tenacity/determination; motivation, humility	Working on re-vamped Leadership Development Program with Business School; MBA is not a magic ticket is you don't have Emotional Intelligence	Emphasis on leadership is going to be greater; ability to function within a health system; can't just be a great clinician or scientist	Team Approach - also part of the new MD curriculum.
Knowledge domains: Education, care mission, community partnership	360 degree success - not only immediate boss -- health system board, parent university	Business acumen; people management; Emotional Intelligence Quotient - 360 degrees. Ability to communicate with people; have confidence of the faculty (instills trust)	customizable to the chair; AAMC workshop; assign a peer mentor. LIAM - Leadership and Innovation in Academic Medicine - geared toward emerging leaders ; (Associate Professors); on-going professional development offered by central university; stuff from specialty societies (decentralized)	Understanding the health system; service lines, programs, that sometimes you can't just wear your department chair hat, you have to wear an institutional hat	Emotional intelligence to understand the relationships, to the board
	All departments in the black. Consider the amount of cash reserves.	1. Someone who is excellent in their field (top notch surgeon - scientist). 2. A person who is expert in their field today but has an absolute passion and commitment to move the field forward. (Isn't satisfied, wants to do more). 3. Embraces and supports the notion that the whole is greater than the sum of its parts. (team player)	Developed 18-month leadership development program. Extensive use of executive coaching, paid for by the Dean's office; Course run by the Business School (accounting, balance sheet, P&L) more important Difficult Conversations	Future Thinker; be a citizen of a broader universe	
	Financial targets, satisfaction, quality and safety, research productivity - aligned across the enterprise - use the same for 2-3 years until no further improvement is possible.	EQ - this is where we have chairs struggle the most - unable to embrace suggestions, criticisms, etc. EQ as ability to change course depending on circumstances is very important; Integrity; Business Acumen, ability to build programs (Team)	Six month series of courses after chair on-boarding regarding every aspect of their job; Leadership assessment performed by external firm for chair finalists; Assigned executive coaches for a one-year engagement (use small number of coaches that know the organization well)	Still need excellence in one of the academic areas; ability to adapt in the ever-changing landscape; changes in culture; teamwork among chairs	recently changed, so no plans; additional point - How long is optimal to serve in the role?

Competencies that contribute to success	Motivation	Well-prepared?	Preparation	Development different than MD	Pivotal Moments	Identity Change	Support of Inst.	Community	Role Change	Competencies / future state	Development Changes
hire strong business partner but having strong business acumen; "People-Person"; carefully consider decisions; Drive engagement; cultivates innovation; builds teams, instills trust; optimizes work processes	to do good; to serve people	learned from family business; listening; gut feeling; Jesuit education	family business; Academy of Opthalmology; put together resource team of chairs and deans - monthly calls	yes and no - medical school didn't have exams, MPH allowed you to move toward areas of expertise	Realized there is always more than one agenda. Every problem is manageable.	Only when people tell me I'm a leader, people look to me for assurance. But always drawn toward it: high school president, medical school president - trust that my persona carries with it...persona of servant leader	very supported by Dean, Institution, University President	Sense that people will listen when needed	Clinician scientist role - don't need an MBA - re-defining the chair into what they feel comfortable	Must protect the "academic" and not become another large clinical system.	Institution-based programs, with input from Business School
Open mind; leveraging resources; having talented people around you (building team); Collaboration - look the lead instead of the me; behind decisive; instills trust	just how I was raised; maximize talents and use them to the best of your ability	learned some skills along the way; learned from good and bad decisions;	executive MBA experience - no degree, but robust experience; Leadership Fellows Program from professional society; J3 Personica (Alan Freidman)	being a surgeon is highly objective; leadership is more relationship based		Enjoy being a chair, part ego; very fulfilled when others meet their goals and become successful; pushing others	chair was highly supportive; mentors along the way, opportunities were afforded	mostly strong group among 17 chairs; peer ortho network - informal and formal ways	Business of Medicine is big business; Need skills of others on the team; balancing patient decisions with business decisions	perseverance; longitudinal roles to understand context	
Team work; open and honest communication	passionate about what you are doing; not about title; belief in the mission	yes in communication skills (considered law school); no in leadership development as it relates to business acumen	"school of hard knocks"; leadership literature	autonomy of the surgeon was more prevalent; now more team-based which is more aligned with leadership	Conflict - disruptive faculty member, hospital contracting. Wherever you pivot and shift you learn.	distinction of being the leader comes in; but otherwise lead from within, lead beside people than above people; frame the challenge to push the team	excellent support from Dean; formal leadership development; engagement, professional, kind;	evolving among peer chairs; SUO/AADO professional networks very strong	not a monarchy; not top-down - people much more informed; want to be heard; move toward team models	Ability to sacrifice for benefit of other departments	economic modeling; negotiations; read beyond your discipline; Harvard business review; MBA/MHA, chair development programs, stay engaged, listen to multiple perspectives; EDI
Communication, emotional IQ	nothing external, don't mind financial reward, but its more the ability to lift others and them be successful; internal motivation, wanting to do a good job	In some ways; need more experience dealing with professionalism issues	Masters health services administration; still gathering experience by having a seat at the table; leadership course at Harvard	clinician role is one on one or small groups; some overlap with educator role,	flight back from Harvard course thinking how much I enjoyed this and I want more of this	Professionally, more measured in what I say and how I react; work ethic still very high		sense of community with peer chairs, large department so perspective is respected		chair role marginalized as hospitals are more administratively centric	need ability to make decisions, not struggle with financial questions; need to work with others
Effective Communicator, Emotional Intelligence, Trust with coworkers; Develops talent	small wins; seeing individuals achieve success, promotion	no, thrust upon me, had trust of peers	servant leader mindset, no leadership development activities before the role	no leadership education in medical curriculum, but it is being added	difficult decisions, HR matters, successful recruitments	shift from feeling like everyone's friend, but it is a little different; identify more as leader once I became a bit more nimble as making decisions	Dean took a chance on me, support gave me confidence	little more difficult to develop network among peer chairs, as young member you feel imposter syndrome, a bit intimidating, but improving	Financial challenge to balance the missions; clinical productivity can take over life, need to include the research, scholarship, academic endeavors. Have fun.	Business acumen, but you can rely heavily on an administrative partner; emotional intelligence, self awareness; ability to "read the room"	Develop people skills, mentor/mentee relationships, advanced degree - Harvard course, but also training of skill development along the way
Developing people - investing in them, develop their capabilities, how to uncover their hidden talents; listening to people; strategic thinking	love being a clinician scientist, training the next generation, nothing makes me happier than seeing people achieve their goals	yes, not for pandemic or systemic racism	Health services/health system researcher, so developed understanding of healthcare business concepts; policy evaluation; organization; worked with payers; Business School programs; long walks with Bob Quinn	Absolutely. The things learned to become doctors become muscle memory. Now you need to invest time in leadership education.				need to work on sense of community among chairs; member of two groups within medical society	Very punctuated growth, small leadership roles, 360 evaluation every time	Understanding context; more collaborative; value accountability	
Authenticity; transparency, empathy; build trust; "know your lane"; self assessment; emotional intelligence - having the sense of responding in a way that will resound with the recipient of the information	really care about the mission, care about the individuals (faculty and staff), commitment to triparte mission; internally motivated	thought I was prepared, six months later not so much; everyone used to my predecessor's style	workshops, Harvard Leadership course, Wharton class; change management piece lacking	as a physician the steps are fairly defined, mandated to do medical school, residency, more structured; leadership development didn't have the same rigor; it takes different skills to be a good leader			support of dean/institution; very much sense of community with peer chairs; served as president of medical society - network of chairs nationally		World is changing, still have generational issues in terms of expectations; autocratic styles won't fly today; advocate for shared decision making	Making people feel involved (team); shared decision making; effective communication, EDI; ability to accept feedback; including junior people on leadership team	executive coaching; business acumen as well as trust in administrative partners
Passion, vision; make people carry on tasks to work on top of their capabilities; strategy; listen to people; self-development	don't want to fail; give it all due effort; being passionate about the work	not trained on finance side	observed characteristics of good chairs; read books on leadership, one or two courses,	goals are different, the very core of being a physician is the relationship 1:1 to the patient; leadership is about team;	times of crisis; try to be a stabilizing force, learn to alter preconceived notions	Important to shift your identity; rely on your own accomplishments to be the way you are judged ; important to revel in others' success	Dean wants us to be better leaders; but the metrics don't align	sense of community with peer chairs but everyone is really busy; limited connection with other derm chairs as only 25-30 are similar	More integration; clinical enterprise is going to run centrally; much less autonomy	have to worry about funding initiatives; business acumen of increasing importance	balance a variety of things
transparency; engagement - solution energizing; communication skills, organizational skills, listening; Drives results; managing complexity	always been someone driven by hard work; want to leave a legacy; try to mentor - see others achieve - that's gratifying	reasonably	Had been a division director, never did the Harvard course, don't have an MBA, have masters Epidemiology; considered a coach, too expensive; some courses though ; business school; started Academy Neurology leadership training program	different - medical school gives you training through residency - some element of difficult conversations.	difficult decisions, getting rid of a division chief; financial crisis; changes in leadership - have to establish yourself with new leaders	Never had a super ego thing; I guess so; people look up to me as a leader, but sometimes I don't think of myself as the leader	Support of dean that hired me; amazing cheerleader in the beginning; get excited about progress; other leaders supportive but haven't had to go to them for help	somewhat. Introvert personality; should have built stronger camaraderie; strong relationships with medical society peers	Academic and Education missions under siege	Fiscal ones; emotional intelligence	
Surround yourself with the smartest people; how you treat people; resource them, clear the path for them to succeed; understand money	"work family"	thought I was, but there is a big difference between being vice chair and being chair	running with "Uncle Alex" - executive with Ford; didn't engage in any professional development of coaching, but should have	Crisis management; EQ required for leadership level;			Administrative Partner has become very good friend; Dean stays out of my way; successfully negotiated resources when asked to renew role as Chair	Strong community among chairs despite variety of ages; strong network of chairs (9 worked under the same chair)		have to understand finances "tragically well"; need to understand humans	understand finances and how to hire the right people.