

# The Leadership Forum

## Words of Wisdom

### From Chief to Chair: Tapping a Pool of Highly Qualified Leaders

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As I start my second year as a chair of medicine, a striking “lesson learned” is that leading a division of general internal medicine (DGIM) is unparalleled preparation for this position. Having come directly from the

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division chief’s spot, I know that successful chiefs of DGIM master many of the same skills and build the same experience that are essential for an effective academic chair of medicine, across diverse settings and with a remarkable variety of staff and colleagues. They live and breathe on a daily basis the most pressing concerns of academic health center administrative leadership—increasing case mix index, reducing LOS, cutting readmissions, and expanding the primary care base, among many others.

I’m grateful—and relieved—that serving as division chief gave me a unique perspective on so many of the moving parts that create a successful department of medicine. Like chairs, many chiefs of GIM manage large, complex organizations composed of disparate sections with multiple functions and diverging goals: hospital medicine, ambulatory care practices, major educational programs, and clinical research units. We juggle budgets, productivity and incentive plans, mentoring, professional development, team-building, quality monitoring and

improvement, and many other demanding leadership and management tasks, all with a careful eye on politics and community relations. Chiefs of GIM often oversee more providers and staff than those of other DOM divisions—sometimes more than entire departments, such as urology or orthopedics.

General internal medicine also has a strong culture of professional development for us as well as our future leaders—a discipline that serves chairs well. GIM chiefs pride ourselves on developing junior faculty as educators and researchers, and we constantly renew and improve our skills—to give just one example, our national meetings strongly focus on developing management, scholarship, and leadership.

Another example: Collaboration and teamwork are critical to successful management of a large, complex department of medicine. Chiefs of general medicine who build successful, sustainable programs are natural

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collaborators. Every project I undertook as a chief of GIM started with the understanding that success would come only if our division collaborated closely and consistently with specialists, nursing, and administration.

At the same time, however, a GIM chief does face several unique chal-

lenges when moving to chair of medicine. Most successful chiefs of GIM are experts at developing and monitoring productivity and incentives, using strategies such as national benchmarks that facilitate comparisons of faculty to colleagues in similar positions, both locally and nationally. DGIM faculty are often rather homogenous and provide naturally occurring samples, with faculty functions relatively well standardized across the field. This facilitates the creation and implementation of effective incentive and productivity plans. However, many of our subspecialty colleagues in medicine are not so fortunate. For example, in pulmonary and critical care each faculty member may have to be viewed as a unique entity with unique incentive and productivity plans with no local comparison and no national or regional comparison. An invasive bronchoscopist has such a unique job in our system that we need to create an individual plan for her benchmarking against her own prior performance and other mutually-agreed-upon outcomes. The elements of an effective and meaningful plan remain the same, but creating the plan requires different skills, insight, and experience.

So if chiefs of DGIM are uniquely qualified to run academic departments of medicine, why are so few of them in those positions? It’s a complex phenomenon, with multiple factors at play. At research-intensive institutions, many chairs focus primarily (and understandably) on building their NIH-

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funded basic-science portfolios and thus seek out faculty with track records in basic-science funding. Some departments of medicine are attempting to build particular specialties that have a procedural bent, to complement their surgical programs.

At first glance, these considerations seem to answer the question and resolve the issue. From my new vantage point, however, it's clear that in the long run it doesn't make sense to bypass highly qualified leaders in GIM for chairs of medicine solely because they devote so much time to managing a complex organization rather than performing basic science research.

A more likely explanation is a somewhat puzzling traditional bias. Most chairs at AHCs have been specialists with a basic research focus. If these chairs are successful, leadership tends to assume that their successors should have the same background. To the contrary: building an academic DOM and building a powerful sustainable research enterprise, in both specialty and basic research, requires leadership and management skills more than it requires direct experience with specific areas of research or clinical work. Indeed, the capacity to respond rapidly and effectively to shifts in institutional dynamics is a critical

skill that successful chiefs of GIM have cultivated. We are likely to have direct experience of how to manage the multiple dimensions of change across the organization.

It's time to question assumptions and "think different" when it comes to building and rebuilding leadership and management in academic medicine. At this critical juncture in the transformation of our nation's healthcare system, we can't afford to bypass highly qualified leaders. So as new schools open and general medicine gains national attention, we are highly likely to see a shift in those who sit at the helm of our nation's 130 AHCs.