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Dane H. Salazar  
*Loyola University Health System*

James H. Herndon  
*Harvard University*

Thomas P. Vail  
*University of California, San Francisco*

Joseph D. Zuckerman  
*NYU Hospital for Joint Diseases*

Richard H. Gelberman  
*Washington University School of Medicine in St. Louis*

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## AOA Critical Issues

# Academic Orthopaedic Leadership: Current Challenges and Lessons Learned

### AOA Critical Issues

Dane H. Salazar, MD, MBA, James H. Herndon, MD, MBA, Thomas P. Vail, MD, Joseph D. Zuckerman, MD, and Richard H. Gelberman, MD

**Abstract:** Health-care reform, market competition, cost containment, and pressure for productivity have dramatically impacted the practice of orthopaedic surgery and academic surgical training. Orthopaedic leaders and training programs are striving to identify and solve these contemporary challenges. Herein, we focus on 4 areas that currently pose important challenges to modern orthopaedic surgical departments and academic hospital systems, including the demanding and evolving skill sets that are required of physician leaders, the effects of the changing medical-legal environment on academic medicine, the impact of increased clinical productivity emphasis on surgical education, and departmental leadership transitions.

Traditionally, the missions of orthopaedic departments and health-care systems have focused on providing excellent patient care, conducting critical scientific research, and educating future orthopaedic surgeons. However, the changing landscape of health care has introduced new and sometimes challenging hurdles for orthopaedic surgeons, orthopaedic residents, and, especially, academic orthopaedic leaders<sup>1-4</sup>. The complexities of health law, federal regulation, price capitation, bundled payments, health-care insurance structure, cost containment, market competition, and ever-changing technology demand sophisticated managerial, leadership, business, communication, and interpersonal skills. These changes have required orthopaedic chairs, residency program directors, attending surgeons, and trainees to evolve the manner in which surgical education is conducted, and have forced an emphasis on the business requirements of successful contemporary

surgical departments. Herein, we focus on 4 areas that currently pose critical challenges to academic leaders who are tasked with training future orthopaedic surgeons and leading modern orthopaedic surgical departments. These include exploring the demanding and evolving skill sets that are required of successful academic leaders, the effects of a changing medical-legal environment on academic departments, the impact of increased clinical productivity emphasis on surgical education, and the critical need for departmental leadership succession planning.

### New and Demanding Leadership and Managerial Skill Sets Required of Successful Academic Leaders

Recent data from a survey of current academic leaders demonstrate that only 40% to 45% of a chair's time is dedicated to clinical activities<sup>5</sup>. The remaining 55% to 60% is spent on departmental

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operations (budgeting, staffing, and financial management), personnel recruiting, mentoring, and contributing to institutional programs<sup>5</sup>. These tasks include optimizing clinical operations, winning contracts, enhancing revenue, reducing costs, recruiting and managing a diverse workforce of physicians and staff, and addressing issues such as consumer satisfaction and marketing. Academic surgeons' formal professional education, research experiences, and clinical practices often are inadequate to develop sufficient expertise in these necessary abilities, and frequently leave our leaders ill-prepared for the challenges that they face in leadership roles. Unlike our corporate and military counterparts, academic physicians receive little or no formal training in valuable skills such as executive leadership, change management, negotiation skills, business administration, and strategy. The need for these skills, combined with mature business acumen, has become paramount to successful leadership in contemporary health-care organizations<sup>2-4,6-10</sup>. At the 2017 Annual Meeting of the American Orthopaedic Association (AOA), registrants were asked if they "feel that business and administrative experience are important aspects of becoming a successful chair in an orthopaedic department"; 94% of those surveyed responded that they either "agreed" or "strongly agreed" with the statement.

Recent efforts have been made to identify the essential "soft" skills that are necessary for the successful leadership of academic departments. Lobas investigated the capabilities and conditions for organizational success among leaders in academic medicine<sup>5</sup>. The study involved collecting and analyzing curriculum vitae, administering 2 survey instruments that explored self-efficacy and job content, and conducting 3 structured interviews with randomly selected academic chairs<sup>5</sup>. The author identified 12 factors that correlated with departmental success: leadership congruency, leadership skills, emotional intelligence, communication skills, development of a departmental vision, a strong executive leadership team, professional development, renewable resources, business acumen, personnel management, managing change, and defining success. Grigsby et al. identified similar qualities and attributes in their study, "The Future-Oriented Department Chair," grouping these characteristics into 6 areas: emotional competency, resiliency, leadership, communication, results orientation, and personnel development<sup>11</sup>.

There is a growing consensus that special skills are not only desirable, but required for effective leadership in a contemporary academic department<sup>8-10,12</sup>. However, traditional surgical training involves little or no formal education in these aspects of professional development. Thus, there is considerable debate on how and when surgeon leaders should obtain these skills. Some have advocated acquiring additional skills by obtaining a Master of Business Administration (MBA) degree. These programs range from 12-month full-time programs to 18 to 24-month executive programs that are attended in the evenings and on weekends. Approximately 20 hours of additional work per week are required to fulfill the educational requirements (total of >1,500 hours of commitment). The MBA programs give in-depth training on both the "soft" leadership skills (executive

leadership, change management, strategy, ethics, etc.) and the "hard" business skills (accounting, finance, economics, marketing, etc.). However, these degree programs are expensive, time-intensive, and often difficult to complete while maintaining a busy clinical practice.

Traditionally, executive orthopaedic leaders have relied heavily on self-education through readings, seminars, and on-the-job training. Multiple excellent books, webinars, and videos on executive leadership currently are available<sup>13-21</sup>. Books and seminars can be valuable sources for personal and professional growth, but their quality and applicability often are difficult to ascertain prior to making substantial time and monetary commitments. Alternative options include shorter non-degree executive leadership immersion courses, such as the "Fundamentals of Financial Planning and Control of Health-Care Organizations" at the Wharton School of the University of Pennsylvania. These are intensive programs in leadership and organizational management that are designed for busy executives and professionals. Similar programs are offered at various institutions, but the most well-known and widely attended by orthopaedic surgeons have been at Stanford University, Harvard Business School, the University of Chicago Booth School of Business, the Northwestern University Kellogg School of Business, the Notre Dame Mendoza College of Business, and the Wharton School of the University of Pennsylvania.

Additional leadership training opportunities exist within the American Academy of Orthopaedic Surgeons (AAOS) and its subspecialty societies. The AAOS offers a Leadership Fellows Program (LFP) for individuals who are interested in future leadership in orthopaedics. Additionally, the AOA offers both the Emerging Leaders Program (ELP) and the C. McCollister Evarts Resident Leadership Program (RLP) for resident trainees and young practicing orthopaedic surgeons with a desire and the motivation for career paths that involve potential leadership positions. In past years, the AOA has offered multiple leadership training modules in affiliation with the Kellogg and Booth business schools in Illinois (Evanston and Chicago, respectively). Less-formal leadership opportunities consist of involvement with committees and boards of medical societies, institutional faculty development programs, and personal coaching<sup>7,12,22</sup>. While these programs all offer the opportunity to obtain or refine the business, managerial, and leadership skills that are lacking in current professional surgical training and education, they lack the depth of exposure that is necessary to become proficient in the complex modern health-care environment. Both the depth and breadth of the knowledge and skills obtained during degree-earning programs are unparalleled. For those individuals who are able to make the substantial commitment of time and resources, the professional growth and return on investment are unequaled.

### Effects of the Changing Medical-Legal Environment on Academic Medicine

The changing medical-legal environment has had substantial impacts on medical practices and surgical training in the United States. The effect of malpractice litigation on physicians

and hospitals is both obvious and well-documented. This phenomenon has been coined in the literature as “defensive medicine.” This concept suggests that physicians and surgeons alter their practice decisions, either consciously or unconsciously, because of a fear of malpractice litigation. This fear and scrutiny has unintentionally eroded resident autonomy in the emergency room, the operating room, and in the clinic.

Outside of malpractice cases, most physicians have little experience or understanding of the complexity of jurisprudence. Non-malpractice cases and less obvious legal threats have become more commonplace, often creating difficult and resource-consuming hurdles for physician leaders. Multiple jurisdictions of the legal system, including contract law, intellectual property rights, employment law, product liability, and torts, have huge influences on surgical practices.

An example of situations that often dramatically affect health-care professionals are human resource disputes that involve employment law. Performance and behavior problems among medical students, resident trainees, staff, and attending surgeons create complex and delicate human resource issues. These situations require careful documentation and the early involvement of multiple parties (e.g., the Accreditation Council for Graduate Medical Education [ACGME], human resources, risk management, general counsel, office of graduate medical education, and various disciplinary boards). These cases quickly can become contentious, and both individuals and institutions become vulnerable to potential lawsuits for such things as wrongful termination, discrimination, harassment, and tortious interference.

Recently, in extreme cases of workplace disputes, medical professionals and medical trainee plaintiffs in wrongful termination cases have utilized the more obscure legal claim of tortious interference<sup>23</sup>. The term is derived from the common law of torts, and refers to a situation where one person intentionally damages someone else’s contractual or business relationships (job) or potential job offer with a third party, causing economic harm<sup>23</sup>. In layman’s terms, it is the assertion that a third party sabotaged an impending or future contract. Conceptually, plaintiffs assert that their termination or disciplinary action has wrongfully either interfered with their future ability to make a living or has cost them a future training position (such as a fellowship) in the workplace. Because of this type of litigation, it has become very challenging to discipline or terminate the employment of both resident trainees and attending surgeons, even in the face of valid and well-documented performance and/or behavioral deficiencies.

Even if allegations of wrongdoing have absolutely no merit and the situations are carefully navigated with proper documentation and graduated disciplinary action, they may take years to adjudicate, impact organizational morale, create harmful distractions, and consume substantial resources. As surgeons, it is imperative to understand that legal issues that are germane to the practice of orthopaedics go far beyond malpractice. Physicians should have at least a cursory understanding of these issues and should be well versed in the available resources to address these matters as they inevitably arise, such

as the details of coverage in their Directors and Officers (D&O) insurance. The key to success is to be knowledgeable, flexible, and prepared while seeking appropriate early guidance.

### **Impact of Hospital Systems and the Emphasis of Clinical Productivity on Surgical Education**

Over the past 2 decades, the turmoil ensuing from the economics of health care and health-care reform has led to a transformation of academic medical centers. Medical schools and hospitals are experiencing the impact of powerful market forces and a shift in influence on patient referral away from providers and toward health-care systems and payers. This circumstance has created less individual physician practice influence in the marketplace and less autonomy in clinical practices and research endeavors<sup>9,11,24,25</sup>. Grigsby et al. recognized that modern “medicine has become an industry governed by free market competition, where, to a large extent, the bottom line has increasing importance.”<sup>11</sup>

The traditional model of a single large academic hospital with a cadre of dedicated teaching faculty is becoming obsolete, and is being replaced by large academic hospital systems with multiple facilities, large catchment areas, and attending staff with varying degrees of educational involvement. It is now commonplace for resident physicians to be far outnumbered by attending faculty. The faculty member’s clinical practice is no longer located at 1 large teaching hospital, and often takes him or her to geographically separated outpatient clinics and surgical centers. This phenomenon has made coverage of all surgical cases and outpatient clinics by resident physicians impossible. This new model of care delivery has created a natural tension between the educational mission of the medical school and the business of the hospital system (patient volume, payer mix, burden of documentation, clinic access/wait times, physician compensation, resident education/autonomy, and physician satisfaction). An increasing emphasis on cost containment, high clinical volume, and increased surgical productivity has had a substantial impact on resident education and surgical autonomy. Academic surgeons’ time and resources for research and teaching have gradually eroded because there is a greater focus on clinical productivity. With these new and changing infrastructure models and market forces, academic departments and surgeon leaders are required to address these issues to minimize the impact to trainee education and to maximize surgical learning.

The pressures from the business of medicine will likely continue to grow with time, and it is the duty of academic orthopaedic leadership to safeguard the quality of surgical training and the learning opportunities experienced by resident surgeons. The creation and institution of policies and procedures that are intended to ensure that we maintain the quality of surgical education over time are paramount. These include the use of physician extenders, duty-hour management, graded and appropriate resident autonomy, protected didactic learning, trainee case-log management, dedicated research time, and the use of technology to augment traditional training.

### Organizational Leadership Transitions and Succession Planning

Leadership transitions in all organizations can cause uncertainty and strife, and sometimes lead to upheaval. Academic departments are not immune to these stresses, which frequently lead to a loss of departmental collegiality, uncertainty, and substantial personnel departures. Sonnenfeld of the Harvard Business School has studied executive leadership transitions and organizational succession planning. With a project that was conducted over 5 years and involved 500 executive leaders at 101 Fortune 500 companies<sup>26</sup>, he concluded that executive leaders tend to cast themselves in heroic molds and to judge their contributions by standards unlikely to be applied by subordinates<sup>26</sup>. Sonnenfeld identified 4 principal types of departure scenarios, grouping them into categories based on the departing leader's personality. The 4 categories were termed "monarchs," "generals," "ambassadors," and "governors," based on broad, well-known, and easy-to-understand leadership positions<sup>26</sup>. Leaders in all 4 of the categories were susceptible to common barriers to exit, with the ease of succession linked most closely to how well these barriers were addressed. The 2 most common barriers to exit were "heroic stature" and "heroic mission." Heroic stature describes a scenario where the leader is reluctant to leave because his or her personal sense of status and self-worth is intimately tied to his or her professional title or organizational role. This individual is reluctant to leave the leadership position because of the fear that his or her personal status or sense of self-worth will be diminished. The second hurdle to relinquishing power, heroic mission, occurs when the leader feels that he or she has unrealized career goals and that his or her professional legacy remains incomplete. A leader may be hesitant to leave the organization because of unfinished business.

Orthopaedic academic leaders often fall into categories combining the characteristics of both the general and the monarch. Traditionally, monarchs leave office only when forced out, or when personal health issues no longer allow for continuing service to the organization. Their departure commonly is prompted by internal departmental unrest, resignations/departures of individuals within the organization, or ultimatums from hospital or medical school leadership. Generals are typically reluctant to leave on their own terms and also often are forced out by external forces. They tend to attempt to stay connected to the organization and strategically plan to return to their previous position in order to "rescue the department from the inadequacy of their successor." This phenomenon has been called the "White Knight Syndrome." The departing leader often creates internal departmental strife as he or she promotes faculty and staff who favor his or her return.

In contrast, ambassadors withdraw gracefully, serve as postretirement mentors, and oversee a smooth succession. They offer great public support to their successor and avoid behaviors or actions that sabotage or undermine the new leader. Upon their departure, they attempt to provide continuity and counsel to the new leadership. Ambassadors are

untroubled by their loss of professional status and are willing to put the greater good of the department ahead of their self-interests. They no longer feel compelled to prove their worth to the organization and are comfortable with the legacy that they have earned. Governors either hold their leadership positions with an interim title or serve for a specific time limit. For this reason, some academic departments have mandatory retirement ages or 10-year term limits for their executive leadership positions. Governors typically are the least affected by the loss of their job title, and they typically retain only loose ties to their organizations, quickly pursuing new interests, such as hospital administration or medical school leadership positions (chief medical officer, dean, provost, chief of staff, etc.).

As noted by author Dr. Herndon, Joseph Martin, MD, former dean at Harvard Medical School, believes that in medical and surgical positions of leadership, "hanging on too long becomes a disservice not only to the community but to the incumbent as well." Strategic and thoughtful succession planning often can ease the inevitable stress that accompanies organizational leadership transitions. As mentioned above, some programs have instituted mandatory retirement ages and term limits in order to alleviate the aforementioned barriers to exit. However, the debate on the most effective way to manage leadership change in academic orthopaedic surgery remains ongoing and unsettled. The key for both individuals and organizations is to identify and acknowledge that these barriers exist and to develop strategies on how to best address them.

### Conclusion

Health-care reforms, market competition, focus on cost containment, and pressure for clinical productivity have dramatically impacted the practice of orthopaedic surgery and surgical training. Current orthopaedic leaders have increased their attention and time directed toward administrative management at academic health centers. Multiple and often competing constituencies and agendas exist, requiring careful navigation and thoughtful strategies to achieve departmental goals. Formal courses and training in executive leadership and business management are helpful in enhancing knowledge and skills in these disciplines.

Academic health centers are beginning to understand the impact that both the changing medical-legal environment and the national health-care system are having on training programs and resident education. Current and former orthopaedic leaders represent an invaluable source of knowledge and provide our community with valuable "lessons learned" from careers dedicated to academic orthopaedic surgery. Despite the increasing challenges associated with modern health care, the ultimate objective of academic programs is unchanged because it continues to be the provision of world-class patient care, surgical education, and impactful research. In a modern health-care system, true departmental excellence requires capable leaders who identify current challenges, have mature managerial skill sets, and form strategic



visions based on the wisdom imparted by their predecessors and mentors. ■

Dane H. Salazar, MD, MBA<sup>1</sup>  
James H. Herndon, MD, MBA<sup>2</sup>  
Thomas P. Vail, MD<sup>3</sup>  
Joseph D. Zuckerman, MD<sup>4</sup>  
Richard H. Gelberman, MD<sup>5</sup>

<sup>1</sup>Department of Orthopaedic Surgery and Rehabilitation, Loyola University Health System, Hines, Illinois

<sup>2</sup>Partners Department of Orthopaedic Surgery, Harvard Medical School, Boston, Massachusetts

<sup>3</sup>Department of Orthopaedic Surgery, University of California San Francisco Medical Center, San Francisco, California

<sup>4</sup>Department of Orthopedic Surgery, NYU Hospital for Joint Diseases, New York, NY

<sup>5</sup>Department of Orthopaedic Surgery, Washington University School of Medicine, St. Louis, Missouri

E-mail address for D.H. Salazar: [dsalazar@lumc.edu](mailto:dsalazar@lumc.edu)

ORCID iD for D.H. Salazar: [0000-0003-0269-5224](https://orcid.org/0000-0003-0269-5224)

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