

Chairs and Chiefs of Plastic Surgery: Is It an Insider Job?

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Purpose: There is no more important decision an academic Plastic Surgery Department or Division can make than naming a chair or chief. Externally recruited leadership brings fresh perspectives and connections. Critics, however, argue that they lack the in-depth knowledge of the institution's culture and history that may be needed to succeed. The ability and skill of an internal candidate is already known and can increase the odds of that person's success in the leadership position. Finally, external recruitment can be a more costly process. Ultimately, the decision is really a litmus test for a Plastic Surgery program. The authors aim to evaluate factors influencing ascent in Plastic Surgery leadership, including training history, internal promotion, and external recruiting.

Methods: All Plastic Surgery residency programs accredited by the Accreditation Council for Graduate Medical Education were noted ($n = 71$). Academic departmental chairs or divisional chiefs of these residency programs were identified at the time of study design (October 1, 2011). For each chair or chief, gender, training history, and faculty appointment immediately prior to the current leadership position was recorded.

Results: There were 71 academic chairs or chiefs of Plastic Surgery residency programs at the time of data collection. The majority (62%) had done fellowship training following Plastic Surgery residency. Fellowships included hand (43%), craniofacial (29%), microsurgery (18%), and other types (10%). The majority (73%) of leaders were internal hires ($P < 0.01$), having faculty appointments at their institutions prior to promotion. However, only a fraction (22%) of these internal hires had done Plastic Surgery residency or fellowship training at that institution ($P < 0.01$). External recruits consisted of 27% of all 71 academic hires ($P < 0.01$).

Conclusions: Many factors influence the decision to recruit leadership from internally or to hire an external candidate. These include the time to fill the position, program culture, candidate experience, and cost. These results support that the insider/outsider hire decision is ultimately one of duality. That dichotomy is achieved with an emphasis on internal promotion, but always with an eye towards the advantages of bringing in external talent as a valuable contribution to increase organizational success.

Key Words: Chair, chief, academic, plastic surgery

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Leadership of academic Plastic Surgery programs has grown increasingly complex as budgetary demands, clinical competition, institutional pressures, and regulatory compliance have become increasingly challenging.^{1–3} The practice of medicine is now more than the simple act of delivering healthcare to patients. In part, the quality and cost efficiency of services rendered have become increasingly scrutinized parameters. Third-party payment systems, managed care, and decreasing reimbursements have added greater difficulty to the practicing physician. This changing landscape has made the role of leaders indispensable and integral to the success of Plastic Surgery Divisions and Departments.

Chairs and chiefs of academic Plastic Surgery units face many management challenges, similar to their executive counterparts in other industries.⁴ In many aspects, a Plastic Surgery leader must act in ways similar to those executed by a chief executive officer, chief financial officer, or a chief operating officer. These leaders must consider the cost of doing business, managing surgical quality and cost efficiency.

Academic leadership extends far beyond financial management and fiscal solvency.⁵ Chairs and chiefs must ensure academic and organizational productivity. Effective operations management requires overseeing other faculty surgeons, support personnel, and trainees. Finally, Plastic Surgery leaders must themselves be able to work with institutional leadership.

There is no more important decision an academic Plastic Surgery Department or Division can make than naming a chair or chief.⁶ Leader turnover can create significant departmental or divisional strain. While recruiting new leadership, the institution can look at existing faculty surgeons. Alternatively, externally recruited leadership can be sought. Both approaches have advantages and limitations. Ultimately, the decision is really a litmus test for a Plastic Surgery program. In this study, the authors aim to evaluate factors influencing ascent in Plastic Surgery leadership, including training history, internal promotion, and external recruiting.

METHODS

All Plastic Surgery residency programs accredited by the Accreditation Council for Graduate Medical Education were identified at the time of study design (October 1, 2011). Concomitantly, academic departmental chairs or divisional chiefs of these residency



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programs were noted. For any residency program(s) based equally out of several institutions, the residency program director was arbitrarily assigned as the Plastic Surgery leader.

For each chair or chief, several parameters were examined. The gender of the leader was noted. His or her training history was examined, with all residencies and fellowships noted. The type and location of these training programs was also noted. The faculty appointment immediately prior to the current leadership position was recorded. Finally, programs were queried if chair/chief selection was through a search committee. Where appropriate, these data were then converted into variables with “yes/no” values (eg, prior faculty appointment at same institution as current leadership position—“yes” or “no”).

For statistical analysis, all variables were evaluated using a 2-tailed binomial test. The proportion of all current chairs with a “yes” value for each variable was tested against the null hypothesis that the proportion of “yes”/“no” values would be 0.5 (50%). For example, in testing if a chair is more likely to be an external or internal hire, the null hypothesis assumes that if there was no tendency for prior faculty appointment to influence hiring as a chair, that there would be a 50:50 mix of internal and external hires. For all tests, a *P* value less than 0.05 was considered significant. Data analysis was performed using R (OSX v. 2.9.2, 2009).

RESULTS

There were 71 Plastic Surgery residency programs identified at the time of data collection (October 1, 2011). The 71 (*n* = 71) academic chairs or chiefs of these programs were noted. When considering gender, the majority (92%) of academic Plastic Surgery leaders were male.

Examining training history and prior faculty appointments demonstrated several interesting findings. The majority of leaders (62%) had done fellowship training following Plastic Surgery residency (*P* = 0.05) (Fig. 1). Of those that completed fellowship training, the most common was hand surgery (43%). This was followed by craniofacial surgery (29%), microsurgery (18%), and the remaining completing other types (10%).

TABLE 1. Gender, Training History, and Faculty Location Prior to Leadership Are Noted

Plastic Surgery Leaders (n = 71)		% (n)
Gender	Male	92% (65/71)
	Female	8% (6/71)
Fellowship training	Hand	43% (19/44)
	CF	29% (13/44)
	Micro	18% (8/44)
	Other	10% (4/44)
Training institution	Same fellow or res program	35% (25/71)
	Same fellow or res region	65% (46/71)
Hire	Internal	73% (52/71)
	External	27% (19/71)

Fellow indicates fellowship; res, residency.

A fraction (35%) of academic Plastic Surgery leaders had done residency (29%) or fellowship (21%) training at the institution at which they currently lead (*P* = 0.017). Programs were separated into regions, as determined by the US census bureau criteria. These included Northeast, South, Midwest, and West. The majority (65%) of Plastic Surgery leaders did residency or fellowship training in the same region as they serve as Division Chief or Departmental Chair (*P* = 0.017).

The majority (73%) of leaders were internal hires (*P* = 0.0001), having faculty appointments at their institutions prior to promotion. Almost half (42%) of these internal hires had done Plastic Surgery residency or fellowship training at the same institution (*P* = 0.33).

External recruits consisted of 27% of all 71 academic hires (*P* = 0.0001). Of these, only a fraction (16%) had done Plastic

Fellowship Type

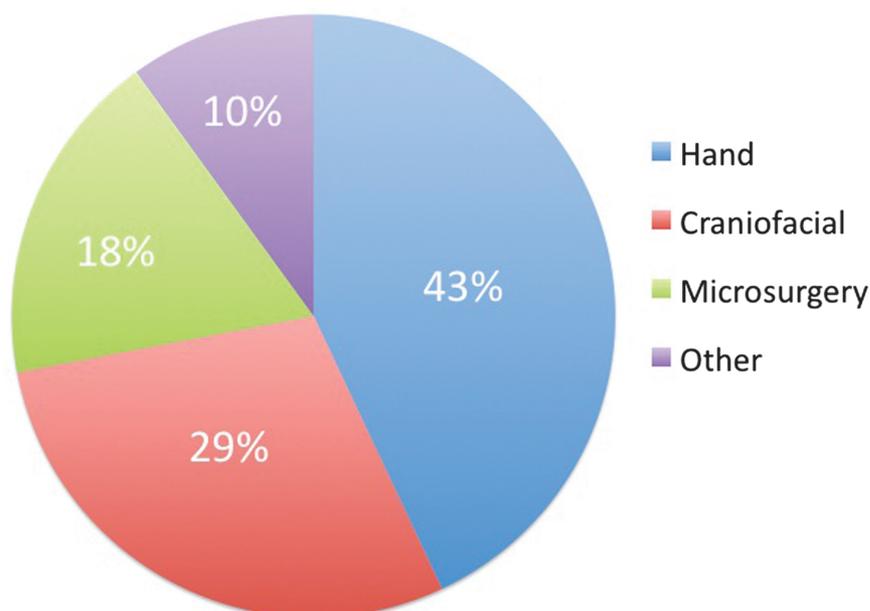


FIGURE 1. The chart depicts the program types of those Plastic Surgery leaders who completed fellowship training.

Surgery residency or fellowship training at the departments/divisions they were hired to lead ($P = 0.004$). Analysis of the role of search committees in the appointment of chairs or chiefs was incomplete. Programs were queried if chair/chief selection was through a search committee. The response rate to this query was too low (<40%) to provide significant analysis. Table 1 summarizes the data.

DISCUSSION

Academic Plastic Surgery is a continuously changing landscape. The environment has evolved such that surgeons, today, have pressures that extend far beyond the clinical outcomes of their patients. There is a push for them to examine the cost efficiency of their interventions, while ensuring the same high-quality results. Furthermore, the importance of teaching, innovation, and research continues to exist.

Plastic Surgery leaders are held to the same standards, but have the added responsibility of running successful Divisions and Departments. The mission of contemporary academic Plastic Surgery units can no longer be simply viewed as goals that fall within 3 traditional categories (tertiary clinical care, education, and research). Declining reimbursements, changes in managed care, introduction of cost-containment strategies by payers, and malpractice reform have all contributed to the increasing difficulty of viewing the mission in the traditional sense. With the changing landscape of academic healthcare, the choice of leader and his or her actions is critical and indispensable to the success of the Plastic Surgery unit.⁵

Leadership turnover can be a significant turning point for an academic Plastic Surgery Division or Department.⁴ A once successful Division could lose solvency, while a stagnant Department could gain much needed momentum. Institutions recognize this and should spend considerable resources (time and financial) in recruiting a new leader. There is no more important decision an academic Plastic Surgery unit can make than naming a chair or chief.

Recruitment for new leadership can come within, by choosing an existing faculty member. Alternatively, the institution may choose to recruit externally. Both internal and external recruitment have advantages and disadvantages.

Externally recruited leadership brings fresh perspectives and connections. Especially if the hiring institution is recruiting an individual from a successful Division or Department, they are acquiring competitive intelligence from another Plastic Surgery unit. Critics, however, argue that external hires lack the in-depth knowledge of the institution's culture and history that may be needed to succeed. Additionally, external recruitment can be a more costly process. Finally, how the outside hire will establish his/her clinical practice in the setting of the hiring market place cannot be ignored.

The ability and skill of an internal candidate is already known and can increase the odds of that person's success in the leadership position. Most likely, promotion of an existing faculty member will have a lower time to fill the position and will come a lower cost to the institution. Additionally, the adjustment period of the new hire will be shorter as there is familiarity with the organization. Finally, hiring from within rewards academically minded junior faculty, as the institution has elected to embrace the culture of loyalty and internal promotion. The major drawback to an internal candidate is the possible lack of new ideas based on external experience.

The decision of who to name as chair or chief of an academic Plastic Surgery unit is crucial in the contemporary healthcare climate. Many factors influence this decision, including the time to fill the position, program culture, candidate experience, and cost. The results in this study support that the insider/outsider hire decision is ultimately one of duality. With the majority of leadership appointments arising from internal promotion (73%), there seems to be an emphasis on internal promotion. However, there are a fraction of

institutions (24%) that have brought in external talent. This may occur because they recognize the advantages of bringing in external talent as a valuable contribution to increase organizational success. However, it could have also happened out of necessity if no suitable candidates existed within existing faculty members. It would have been interesting to what fraction of the chairs or chiefs were appointed by a search committee. While the authors attempted to query programs of this information, the response rate was too low to draw any significant conclusions. This is an important consideration and should be central to future studies examining this topic.

The majority of academic Plastic Surgery leaders at the time of study design were male (92%) and completed fellowship training (62%). The higher incidence of subspecialty training was higher than expected, but not surprising for academic Plastic Surgery leaders. These results reflect the recognition that there are some specific populations of patients who would benefit from highly focused knowledge and skills obtained by additional training and certification beyond that of a Plastic Surgeon with no subspecialty training. In fact, these tertiary problems and patients may be more likely to be found at referral centers, such as academic medical centers. These institutions recognize this, and while this study could not determine this, a fellowship-trained Plastic Surgeon may be more desirable for an institution hiring a Plastic Surgery leader.

Male predominance among academic leaders is not a surprising finding. Only 28% of all active physicians practicing in 2007 in the United States were female.⁷ More specifically, when looking only at active Plastic Surgeons practicing in 2007, only 11.9% were female.⁷

This study characterized the background and appointment of contemporary academic Plastic Surgery leaders. An unfortunate limitation to this study is the inability to prospectively evaluate how the choice of leader influences the hiring Division or Department. At present, the authors found no obvious way to examine this.

The concept of indicators and benchmarks have been introduced and increasingly utilized in healthcare. As they become more pervasive, it would be interesting to follow the success of academic Plastic Surgery units. Establishing and examining indicators of clinical, academic, and financial productivity could allow for the comparison of Divisions and Departments. At a single institution, Plastic Surgery would be compared to other specialties. Alternatively, a particular Plastic Surgery unit could be compared to its peers across the countries. As these indicators become formalized, it will be interesting to extrapolate on this study and prospectively examine the success of Plastic Surgery organizations following external and internal hires.

REFERENCES

1. Noone RB, Goldwyn RM, McGrath MS, et al. 50th Anniversary Plastic Surgery Research Council Panel on the Future of Academic Plastic Surgery. *Plast Reconstr Surg* 2007;120:1709–1721
2. Rohrich RJ, McGrath MH, Lawrence WT, et al. American Society of Plastic Surgeons Plastic Surgery Workforce Task Force. Assessing the plastic surgery workforce: a template for the future of plastic surgery. *Plast Reconstr Surg* 2010;125:736–746
3. Beauchamp RD. The changing roles of a surgical department chair: adapting to a changing environment. *Arch Surg* 2005;140:258–263
4. Stapleton FB, Jones D, Fiser DH. Leadership trends in academic pediatric departments. *Pediatrics* 2005;116:342–344
5. Verheyden CN, Levin LS. Plastic surgery leadership in an institution: a primer. *Plast Reconstr Surg* 2010;125:1819–1825
6. Chung KC, Song JW, Kim HM, et al. Predictors of job satisfaction among academic faculty members: do instructional and clinical staff differ? *Med Educ* 2010;44:985–995
7. 2008 Physician Specialty Data. Available at: <https://www.aamc.org/download/47352/data/specialtydata.pdf>