

# Division to Department Status – Why is it So Hard if Independence Benefits the Health System?

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## History Lesson

- Mission: education, research, patient care
- For 2000 years after Hippocrates, physicians remained unorganized
- 16<sup>th</sup> century European Universities – “Faculties of Medicine”
  - professors of anatomy, materia medica (pharmacology), and clinical practice
- 1518: the birth of the Royal College of Physicians in London
  - Standards of medical practice, education, and professional behavior established
  - Physicians (Dr.) distinguished from Surgeons (Mr.)
- End of 19th century – “Faculties of Medicine” in Western Europe and the United States were organized around “Professorial Units”
  - a Professor and a few Assistants

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## History Lesson

- Turn of the century:
  - Medicine and Surgery began to divide
    - Pathology, pediatrics, radiology, psychiatry, neurology, and dermatology
    - obstetrics-gynecology, anesthesiology, orthopedics, ophthalmology, otorhinolaryngology, and neurosurgery
- Medical school growth: Professorial Units evolved into Departments
  - organizational framework for larger groups of faculty with similar training and goals to pursue the tripartite mission
  - sharing of intellectual and physical resources, such as space, equipment, and libraries
  - Control identification, recruitment, and promotion of the most promising faculty

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## History Lesson

- Departments catalyzed by the creation of Johns Hopkins Hospital in 1888 and Johns Hopkins University School of Medicine in 1892
  - first four departments: Medicine, Surgery, Pathology, and Gynecology
- American Boards of Otolaryngology, Orthopedic Surgery, Colon and Rectal Surgery, **Urology**, and Plastic Surgery *preceded* the formation of the American Board of Surgery in 1937

Landefeld, TACCA 2016

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## History Lesson

- 1930s: departments well established as the basic organizational units of American medical schools and universities
- Essentially autonomous units, decision-making centralized to Chairman
- Operational fiefdoms, little accountability:
  - upward (medical school, university, hospital authorities)
  - downward (faculty and trainees)
  - laterally (fellow department chairs)

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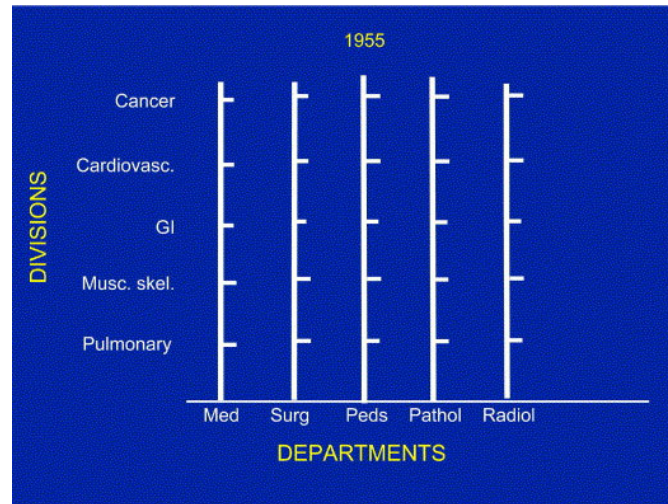
## History Lesson

- early post-World War II years:
  - unprecedented increase in basic science and clinical medical knowledge
  - rapid technological advances
  - research support from the National Institutes of Health (NIH)
  - introduction of Medicare and third-party reimbursement for clinical care
- New need for subspecialty expertise

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1950s: many clinical departments established divisions organized largely around organ or organ-system–based diseases



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## History Lesson

- “Divisionalization” stimulus:
  - subspecialization of medical knowledge
  - accompanying need for advanced specialized training
  - rapidly evolving laboratory and procedural technologies

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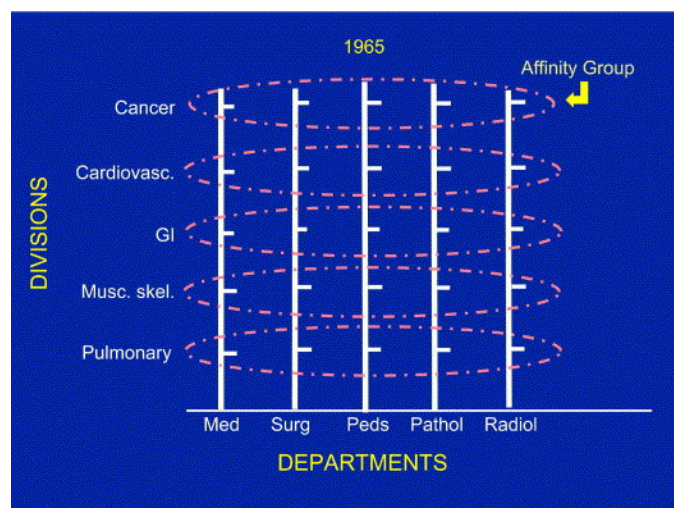
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## History Lesson

- 1960s: a multidepartmental, multidisciplinary approach to providing care to certain patients. Examples:
  - Cardiology
    - the birth of *cardiac surgery*
    - collaboration between cardiac surgeons and *adult and pediatric cardiologists*
    - Specialized skills of *cardiovascular radiologists, pathologists, and anesthesiologists*
  - Oncology
    - a new subspecialty, *medical oncology*
    - Cooperation with *surgeons, radiotherapists, and pathologists* to enhance patient care

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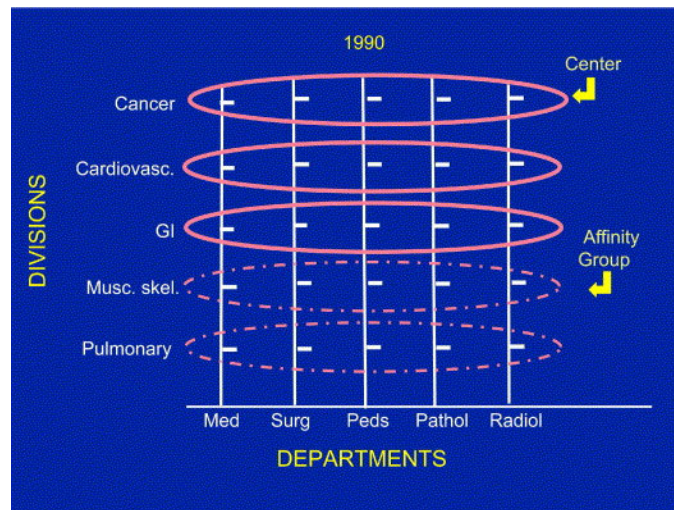
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1960s: “Affinity Groups” Emerge

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1980s: "Centers" (Programs, Institutes) emerge

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## Division, Department or Center in 2024

American Medical Schools, Universities and Academic Medical Centers are quite diverse in their:

- goals
- size
- financial resources
- research
- clinical strengths and weaknesses
- relation to their parent universities
- affiliated hospitals
- federal, state, and local governments
- communities

**It is not possible to prescribe an optimal organizational pattern for all**

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## Division, Department or Center in 2024

### Is it all about the money?

- university operational funds
- allocations of state funds by public universities
- clinical revenue from caring for patients directly
- contracts with the medical center
- contracts with outside entities for services
- extramural grants, including indirect cost recovery
- income from endowments, patents, and licenses
- external activities
- philanthropy
- affiliated VAMCs or County Health Systems

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## Smarter people than me ...

- **mostly financial**
- no matter what your role or leadership or structure *you will always have someone above you*
- Highly dependent on the structure of the organization you work within
- Hospital partner / annual agreement vs integrated partnerships - which still create funding tensions
- Department head creates a budget but may not be funded (to the tune of 1M shortfall..)
- Do you answer to the Dept Chair, Clinical Program Head, the Dean or the President? (or the Chancellor?)

Kevin Lally, Chair Peds Surgery, UT McGovern

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## Smarter people than me ...

- *Best scenario is Division under a great Chair*
- At UT Dr A leaves you alone completely until you need help. However may be different elsewhere.
- As Dept you do have more “autonomy” but still have to answer to higher ups.
- Far more administrative headaches to deal with as Dept.
- **Modern healthcare is all about the bottom line and revenue so the distinctions and benefits of Dept status are disappearing.**

Kevin Lally, Chair Peds Surgery, UT McGovern

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## Smarter people than me ...

- Being a Dept chair does give you a **better seat at the table**, invited to meetings with the president such as clinical service leadership and administrative council.
- Better understanding of what is going on at the university or organization.
- Better optics and recognition by other clinical services.
- Either way a clinical program will follow a path or vision as a division or a dept.
- **Budget neutral or in the black will likely keep their job**

Kevin Lally, Chair Peds Surgery, UT McGovern

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## Smarter people than me ...

- All depends on the # of faculty and your profit. If you are in the black then makes sense to be a department so you have a seat at the table and control of your destiny. ***Otherwise you get the scraps.***

- Steve Brandes

- Overhead costs are split and shared as division, you are responsible for that as department. This becomes **non-viable for a small group. Perhaps critical mass is at least 20-25 faculty.** Ultimately the financials are what drive it, but once you are big enough then being a dept comes with more negotiating power and a seat at the big table.

- Richard Andrassy, Chair Dept Surgery UT McGovern

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## Smarter people than me ...

- **Set up, goals and egos.** Money plays in of course.
- Autonomy is clear, independent decision making.
- Largely historical as institutions grow. Much more algorithmic now.
- **Leadership at top set guidelines for how money and support flows.** Depends on the institutional set up.
- Urology departments rarely big. So for example hiring a research physician scientist? Untenable – can't do it with small dept.
- extreme example of any type of non-clinical infrastructure. Clinical stuff somewhat easier, all the rest harder.

- Stephen Savage, Int Chair MUSC

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## Smarter people than me ...

- If med school / hospital has well delineated rules and roles for a division it could be better than dept status.
- if too few people no time for admin demands of dept.
- Maybe **things are changing** – when we trained people were very adamant about being a dept. History of poor treatment as division. Urologists were outsiders compared to vascular, cardiothoracic. But now are things changing? **Roles and finances are more prescribed, based on outcomes, data, algorithms.** So its changing.

- Stephen Savage, Int Chair MUSC

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## Smarter people than me ...

- Never take a job where you are a division (!)
- *Urology is in general a profitable service.* Can be stifled by no access to revenue.
- Clayman at UCI was a division, he came and insisted conversion.
- At other institutions I saw how being a division did not benefit.
- **If you want to grow something beautiful you can't have your resources being siphoned away.**
- If your goal is to build the greatest Urology center in the world you are not going to do that as a division.

- Jaime Landman, Chair UCI

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## Smarter people than me ...

What does the role look like today?

- Previously the Chair job was straightforward: “Chair” generates revenue, president, dean etc take a cut. If your folks work efficiently you generate a profit and can grow.
- Now an “integrated model” / RVU based. *More like a “hostile takeover”* where admin came up with a fake currency. The local admin decides what your \$ is worth.
- A chair still has access to development (philanthropy) dollars.
- 20M contract budget only 150K profit. *Without the development / philanthropy would just be a division chair in practice.*
- But 10M (100M) development dollars – philanthropy – allows vision and growth

- Jaime Landman, Chair UCI

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## Smarter people than me ...

- Psychological shift in medical admin / management with RVU model.
- Now **division or dept is middle management**. “Leadership meetings” are now informational, waste of time.
- All my life I wanted to be a chair. Now you need to be in leadership. Associate Dean of Development for the system. This is where I believe I can bring value. Keep money in departments.

- Jaime Landman, Chair UCI

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## Smarter people than me ...

- 1) **Local pressures for recognition by peer institutions**, which were all Departments already. Such as next door UNC rival which had also recently attained Dept status.
- 2) **National recognition for the program and University / prestige**. This goal is likely more hypothetical than realistic because there are Divisions with very strong reputations nationally.
- 3) **Voice at the table**. On a local / University level. Voice at the table which is *different* than Dept of surgery. Urology has different goals that are not always aligned with surgery.

**Urology is unlike any other surgical discipline I know**

- Gary Faerber, Int Chair Duke

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## Smarter people than me ...

- Unlike gen surg where they fix something and say goodbye.
- Urology is procedure heavy and is a chronic health provider, therefore needs are different to support our patients.
- *the business model for urology practice is very different from gen surg. The wrong structure will sink it.*
- Having a “voice at the table” allows input into growing your clinical footprint.
- **If you are not at the table with leadership you can easily be overlooked.** Can't always count on the chair of surgery.

- Gary Faerber, Int Chair Duke

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## Smarter people than me ...

- However to transition you need to make the case that you will be financially viable
- **There is a critical mass of resources and revenue** to offset Dept costs. This is going to be individualized for each institution.
- At Duke, it turned out to be more expensive to remain a Division! (research support costs 1.4M vs 1.1M via SOM)
- *Philanthropic standpoint:* much more advantageous to be a Dept for *courting potential donors*
- *If you don't have a strong philanthropic base it is going to be a challenge to be a Dept.*
- **Middle managers** – *the only difference now is how many people you need to “manage up”*

- Gary Faerber, Int Chair Duke

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## Smarter people than me ...

- It comes up during resident interview once or twice per season
- Depends on circumstances and environments
- **Primarily the relationship between the Division head and the surgery Chair**
- Chairs are not untouchable - either they were not doing a good job or they were in conflict with the Dean
- Current era: *increased competition for resources* with the medical school and hospital system - APPs, faculty, research. Who do you lobby?
- Colorado Dept surgery has 280-300 faculty (generates ½ of all revenue at the hospital) – a **louder voice to argue for resources**
- We have *substantially more leverage as a department* with the school or system

- Andy Meachum, Chief UC

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## Smarter people than me ...

- Next question: how are those moneys / resources then distributed within the department?
- I'm often asked, **Don't you want to be a Department Chair? I can't think of a good reason based on where I am now.**
- Has grown the division from 5 faculty to more than 30 now.
- Becoming a department makes sense if you can't see eye to eye with the Chair, or are poorly treated.
- It all depends on the relationship you have with the person you report to. I've seen plenty of dept. chairs taken down by the Dean.
- *When I look at what my chair has to do, bureaucratic meetings, some important, some not, but I can learn what happened later, that's a day I could be doing something else productive.*

- Andy Meachum, Chief UC

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## Smarter people than me ...

- **How a division or department fairs in no small measure has to do with how they are doing financially**
- Also works in reverse – a division that is bleeding its department may find itself suddenly independent ..
- I don't really see the benefit
- **It depends on the institution and on the individuals**
- If the residents are getting a good education, the faculty getting opportunities and promotions, things are going well
- **Keep your eye on your goal**
- If what you want is to be a department chair, then interview for a department chair job!

- Andy Meachum, Chief UC

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## Division, Department or Center in 2024

Final thoughts:

- It depends, *each institution is unique*
- No one size fits all, but there is a critical mass *for each place*
- All about the finances but *the finances have changed*
- Do you have a seat at the table?
- A structure that allows vision and growth?
- Education, research and patient care
- Faculty satisfaction, development and advancement

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Recruiting:

- 1) Residency Program Director
- 2) Sexual Medicine and Men's Health Director



Thank You

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