

The Evolution of the Medical School Deanship: From Patriarch to CEO to System Dean

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ABSTRACT

Medical school deanship in the US has evolved during the past 200 years as the complexity of the US health care system has evolved. With the introduction of Medicare and Medicaid and the growth of the National Institutes of Health, the 19th-century and first half of the 20th-century role of the medical school dean as guild master transformed into that of resource allocator as faculty practice plans grew in scope and grew as an important source of medical school and university revenue. By 2000, the role of the medical school dean had transformed into that of CEO, with the dean having control over school mission and strategy, faculty practice plans, education, research dollars, and philanthropy. An alternative path to the Dean/CEO model has developed—the System Dean, who functions as a team player within a broader health system that determines the mission for the medical school and the related clinical enterprise. In this paper, the authors discuss the evolution of the medical school dean with respect to scope of authority and role within the health care system.

intent to identify common developmental patterns in the evolution of medical school deanship that may be used as a model for future study and analysis of this pivotal role. The model we propose is a descriptive one, and all medical schools do not necessarily pass through any or all of these stages in their development.

It is our contention that the role of dean, which we trace from figurehead to autocrat to system CEO, is about to enter a new developmental phase. In this instance, we point to the announcement of a new medical school by Kaiser Permanente as evidence of an accelerating trend that has already been identified in earlier studies as that of the system dean.^{9,10} In this configuration, the role and mission of the school are determined elsewhere by the sponsoring organization and transmitted to the school. In the instance of Kaiser Permanente, the preordained mission is to concentrate on primary care education and public health concerns. To a casual observer, it can be argued that this is no different from actions many state legislatures take on behalf of their constituents in establishing so-called community schools of medicine with similar foci and mission emphasis.

Weiner and colleagues⁹ identified the subsidiary model as one combining “high clinical enterprise organization, high academic-clinical enterprise integration, and low academic authority over the clinical enterprise.”⁹ They further observe, “Yet the medical school faculty’s clinical activity may constitute only a small portion of the organized delivery system’s total clinical activity. As such, the financial interdependence between the academic and clinical enterprises is also asymmetrical.”⁹

INTRODUCTION

The role of the medical school dean has been an evolving one influenced by changing organizational culture, educational philosophy, and redirection of the health care system. Studies from various sources have confirmed the high expectations modern medical school deans face while performing a role that demands accountability to many stakeholders. This role occasionally features wide gaps between responsibility, authority, and resources available to complete assigned tasks.¹⁻³ This growing tension between responsibility and resources has arisen despite a century of progress in US medical education and unprecedented advances in innovative technology.⁴ It is impossible to appreciate fully the nature and seriousness of the resource gap without the benefit of historical perspective.² Indeed, effective recruitment of medical school deans requires not only an understanding of this gap but an appreciation for the various management styles that these environs have produced. Different types of medical school organizations

dictate which management style will best guide that environment. Although tempered by the unique culture of any given administrative structure, the role of new medical school deans should be viewed in the context of the evolution of medical school deanship in the past century.^{5,6} The purpose of this work is to broaden that understanding and to guide recruitment efforts based on both historical and future leadership trends.

A HISTORICAL PERSPECTIVE

Each medical school is a unique entity with its own history, traditions, and culture.⁷ Research-oriented schools have strategies different from those of community-based institutions, often with competing priorities even within governing boards.⁸ Schools founded to serve particular populations or demographic groups have had patterns of development different from those with more general charters.⁸ Therefore, it might seem presumptuous to posit a general pattern for medical school leadership and administration. It is our

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They conclude that “The subsidiary model is most likely to be found among medical schools that have grown out of health care systems.”⁹

In the case of the system school, we point to two prominent examples that presently exist. These are the Uniformed Services University of the Health Sciences and the Mayo Medical School. The Uniformed Services University is chartered by the federal government and is avowedly organized for the education of individuals who will practice in a uniformed service. As national rankings of US Service Academies demonstrate, there is no essential conflict between academic excellence and operation of the institution within the structure of the nation’s military organization. The commandant or superintendent is a senior officer drawn from the ranks of military leadership and performs his or her responsibilities between the requirements of the sponsoring military branch on the one hand and the traditional prerequisites of faculty governance on the other.

A somewhat more nuanced case is that of the Mayo Medical School, which is now also well established and nearing its 40th anniversary. Similar to the case of the Uniformed Services University of the Health Sciences, the Mayo Medical School derives its founding purpose and mission from the Mayo Clinic. In distinction from graduates of the Uniformed Services University of the Health Sciences, however, Mayo Medical School graduates are not expected to be employed at Mayo Clinic for their professional practice (although this is certainly not discouraged). Mayo Medical School has announced the opening of a new MD-granting campus in Scottsdale, AZ, in 2017, and the awarding of a cooperative degree in health systems in conjunction with Arizona State University (personal communication; Steven Rose, MD; 2016 Feb 29).^a

The Mayo Medical School dean functions as part of a team of three leaders who collaborate in efforts to integrate education, research, and the practice of the clinic. These three leaders are members of the Mayo Medical School governing board chaired by the president of the Mayo Foundation. The annual budget of the school is set “within the system,” although it is proposed and managed by the dean.

A new hybrid organization is emerging in which the clinical enterprise of the medical school (hospital and faculty practice plan) is consolidated with a community-based partner. A prominent recent example is that of Southwestern Health Resources, recently approved by the University of Texas Board of Regents. This system includes 27 hospitals and 3000 physicians drawn from the University of Texas Southwestern health sciences organization and the community faith-based nonprofit health system operator Texas Health Resources. The recently announced officers of the new delivery system do not include the dean of the medical school at University of Texas Southwestern, who is described as the chief academic officer of the school.¹¹ It is likely that affiliations of this sort will increase as organizational consolidation in the health care delivery system continues to intensify.

Examples of such integration of professional schools into delivery systems can be identified in other professions. A particular example is engineering and the establishment of the General Motors (GM) Institute. GM acquired the institute in 1926 to meet its needs for professionals specifically trained in engineering disciplines. A “co-op” model of education was introduced that required the trainee to align with a GM division for 6 to 12 weeks of practical instruction, an approach comparable with third- and fourth-year clerkships in medical school. In 1982, GM and the institute separated as GM reduced operations in Flint, MI, and the institute gradually evolved into Kettering University, as it is known today.

The evolution of the deanship of the medical school will be examined to assess how the emerging model of system dean contrasts with the other prominent contemporary model in health systems that has evolved from teaching hospitals and medical schools. This is the dean (chief academic officer) as CEO of an educational/health delivery system in which the faculty are at once both educators and direct care practitioners, and the institutional resources of the system exist to support the educational mission rather than the opposite. This model is in turn giving way to an emerging model of the system dean in which the dean functions within

the mission and vision of a larger health care delivery organization.

The Medical Guild Master (and Figurehead)

Early medical school deans coming into the 19th and 20th centuries followed a leadership tradition that stretched back at least to the Middle Ages.¹² Organized medicine in the New World arose from the European guild system, primarily concentrated among surgical practices, that provided a method of apprenticeship that formed the basis of the medical residency system used today.¹³ The apprenticeship model emphasized personal relationships between student and solo practitioner as the substrate for teaching and learning, with little consideration for the complexity that would evolve as the industry of medicine progressed.

In America, the apprenticeship remained the most common mode of medical learning well into the 19th century in both university-based and proprietary medical schools.¹⁴ In 1910, Flexner questioned the quality of medical education in the US. He suggested that medical schools include basic science departments, laboratories, and wards for student training. As the Flexnerian model of medical education rose to the level of a standard early in the 20th century, medical school deans had to foster relationships between teachers, scientists, and students.¹⁵ It should be noted that Flexner’s work described current trends in medical education but paid little attention to the management styles present at US medical schools at the time.

In the early 1900s, at the time of Flexner, the dean served as the medical master of apprentices and functioned largely as a patriarch. This dean-figurehead style assured a remarkable degree of stability and served as a source of power for the dean as the ultimate overseer of the “guild.” This leadership model seemed common in an environment in which medical schools were small with few faculty, small budgets, and few students, allowing the dean ultimate control as in the case of a guild master.^{9,15} The dean did not have to function as an organization manager on a daily basis but was able to balance simple administrative duties with an active teaching and clinical practice. The dean’s visibility and assertiveness, and ability to teach,

were crucial in gaining respect and trust from the faculty.¹⁶ Such dean-figureheads were by definition quite authoritative.¹⁷⁻²⁰ In this model there was relatively little gap between responsibility and authority because such deans enjoyed all the power that guild masters had traditionally exercised. Application of the dean-figurehead model in a modern setting, where resources are limited and the dean's role in acquiring resources plays such an important role in decanal management success, would likely not work.²¹ The model may be applicable only for the very rare institution in which resources are already plentiful.

The relatively small scale of medical school operations in the first half of the 20th century allowed the dean to function effectively with minimal support staff and without associate deans. Because the institution could not readily sustain any failure of the figurehead, the dean-figurehead had job security based in part on fear of institutional collapse in the event of a departure.¹ However, figurehead deans could not completely withdraw behind the bounds of their own institutions. These deans did have to occasionally negotiate with university presidents, state legislatures, and state medical societies. They were also sometimes called upon to mediate faculty disputes and help resolve interpersonal conflicts.^{19,20} The dean-figurehead model often exposed many leadership deficiencies because the dean was the only recognized institutional leader. However, the figurehead model survived for several centuries in Europe and migrated to the New World, even outlasting the guild master trend seen in other trades.²²

Model Transition

The management style of figurehead dean could not survive the great shifts that occurred in the American educational system following World War II. As knowledge exploded and public interest in scientific research burgeoned, outside forces began to expand the dean's foothold in medical education. The new environment called for integration of medical schools with their home universities to a degree never before anticipated. This was further complicated as better integration was sought between universities, medical schools, and their major clinical enterprise.⁹ As federal money

entered the American medical industry in the form of research dollars as well as clinical dollars through Medicare and Medicaid, the demands of federal and state authorities also began to stiffen. Along with these influences came the various local, state, and federal guidelines and compliance mandates governing medical education and faculty relationships within both the medical school and the larger university.

This naturally changed the nature of the leader required.⁹ Dean-figureheads with their narrow skill set and scope of responsibilities could not hope to maintain their personal, independent styles and attitudes in an era when accountability to outside stakeholders became an integral part of the job description.⁹ The dean-spokesperson, typical of that transitional era following World War II, had to be willing to exercise leadership and management on a level beyond that of the medical school itself. Development of a leadership team was typical of medical schools in the US when the dean-spokesperson model was most common. Associate deans emerged for fiscal management, academic affairs, student services, and the like around this time to scrutinize resource allocation and distribute workflow. The introduction of this managerial layer deflected some actual responsibility from the dean and allowed a buffer from possible negative consequence.²¹ Regardless, the administrative workload had expanded beyond the capacity of any one person irrespective of how skilled they were as a manager. One result of this change was that the dean-spokesperson could not exercise autocratic, sometimes impulsive or overly instinctive, and very personalized decision-making processes characteristic of the figurehead. The associate dean model, in many ways, facilitated a more scrutinized management of the dean's role itself. Medical schools were simply becoming too large, too complicated, and accountable to too many other entities, such as university presidents and governing boards. Obviously, institutions of this type, with multiple layers of current associate deans, would have to consider the varied management styles of the associate deans before the selection of a new dean.

Historically, the age of faculty committees, university senates, and layered hierarchies had dawned with expanding

medical school faculty numbers. At this time, in addition to managing the faculty and academic missions, medical school deans faced pressures to embrace corporate capitalism by responding aggressively to the revenue opportunities that became available, not the least being the growth in the budget of the National Institutes of Health. The incredible impact of substantial and readily obtained National Institutes of Health grants arrived, and the development of faculty practice plans to manage revenue soon followed.²³ Clinical revenue was augmented by a variety of factors, including medical school-hospital relationships, particularly after the enactment of Medicare and Medicaid in 1965.²⁴ This more complex organization could lead to internal conflict among groups that had not been a consideration for earlier deans because internal power blocks might change at a pace different from that proposed by the dean. Thus, the dean-spokesperson had a new job description as fiscal manager and clearly needed a new skill set to function effectively in this emerging management role.

Yet, in all of this, certain requirements of the figurehead model did not vanish. There was still the expectation of a significant level of personal and visible leadership from the dean—it took on a paternalistic style because most deans of that era were men. Layers of associate deans created during this transitional period served to assist the dean and augment his ability to reach out to faculty, students, and alumni but could not substitute for him, especially in symbolic roles.⁹ In an age of institutional expansion and bureaucratization, interpersonal skills became even more important because there was no substitute for building effective relationships through communication and trust. This applied both to internal constituencies (faculty, chairs, students, etc) and to the external partners, such as hospital directors, who were necessary if the medical school were to be effective. In dealing with internal leaders, particularly department chairs, the spokesman had to be perceived as the leader among leaders.^{9,25} He also had to deal with the proliferation of cultures and “fiefdoms” that evolved their own governance mechanisms as departments and chairs became

powerful through their own extramural funding.^{14,23}

Throughout the 1970s and 1980s, the dean acquired other roles, including those of negotiator and resource allocator, especially as institutions became more complex and budgets became larger.⁹ Lessons learned at many medical schools in the 1960s and 1970s made it clear that deans with high accountability but a widening responsibility/authority gap often exposed their lack of authority or alternatively became expendable when departments became stronger and garnered their own financial resources. Thus, schools that had alliance or coalition-type organizational models were more apt to benefit from the type of management style in which the dean facilitated but did not command resource acquisition and allocation.^{9,21} It

should not be surprising in retrospect that increased dean turnover accompanied this paradigm shift and resulted in a decline in decanal tenure from 6.7 years (1940-1959) to 3.5 years (1980-1992), a pattern that persisted through the 2000s.^{1,18,26,27}

Dean-CEOs and Dean-Presidents

The demands of the market in terms of research funding, resource dependency, and clinical competition began to dramatically affect the workload of the medical school dean in the mid-1980s.²⁷ A new skill set was needed for the modern era as the workload and accountability became more and more demanding and extraordinary. Deans of this era needed to combine skills in fiscal and human resource management with communication skills to be effective executives. Because of rapid changes in the health care market, being a change agent became a core element in the medical dean’s job description. The 21st-century dean as CEO needed to be concerned with leading change while still being held accountable for accomplishing a variety of functions beyond traditional academic leadership, including leadership of the clinical enterprise of hospitals, managing professional practices, and in some instances negotiating with insurers.

The additional skill sets required by modern deans can be best seen in the current trend found in many institutions in which the roles and titles of the dean are combined with those of health sciences chancellor, vice president, or vice chancellor (Table 1). With this change in structure, the dean’s style of leadership

becomes more nuanced depending on whether the clinical enterprise related to the school is more or less financially dominant. Obviously, those schools with higher integration of clinical practice and school authority structure require deans to have better overall control and actual decision-making power over financial allocations. Despite a single individual holding several roles, the positions often exist apart from or even in competition with each other.^{1,27} This trend developed in the 1970s and has intensified during the succeeding decades (Table 2). In assessing current medical school environments, the dean usually remains the senior leader for students and educational affairs. Super-executive titles imply greater responsibility and create an overall empowering effect.

The recent emergence of the dean-president role (Table 2) empowers deans as agents of change. The dean-president role has accompanied the organizational transformations of some academic medical centers in the US, such as that observed at the University of Pennsylvania,²⁴ where the “single ownership” of a fully integrated academic-clinical enterprise model including hospital, practice, and school lends itself well to a dean with a corporate leadership and management style with great authority and scope.^{8,9} According to that model, the “chief executive’s role, directly or indirectly, contains that of the traditional dean or vice president, including responsibility for the academic mission and the business operations of the integrated delivery system.”²⁸ Although the leader of such mega-organizations could be referred

Table 1. Ancillary titles of US medical school deans as listed by the Association of American Medical Colleges Council of Deans, 2000 and 2012^a

Title	2000	2012
Vice president ^b	48 (40%)	46 (33%)
Vice chancellor ^c	10 (8%)	15 (11%)
Provost	7 (6%)	8 (6%)
President	2 (2%)	5 (4%)
Chancellor	3 (3%)	2 (1%)
CEO ^d	2 (2%)	14 (10%)

^a Some deans have multiple titles.

^b Vice president includes senior vice president or executive vice president.

^c Vice chancellor includes senior vice chancellor or executive vice chancellor.

^d CEO includes chief medical officer or chief academic officer.

Table 2. Evolution of the American medical school deanship, pre-1945 to present

Role	Era ^a	Characteristics
Dean-figurehead	Until 1945	Personal leadership with restricted demands
Dean-spokesman	1945-1965	Institutional leadership with a broader scope and with increasing demands and resources
Dean CEO negotiator	1965-1985	Leadership of decentralized institutions with increasing demands, variable resources, and decreasing authority focusing on processes and procedures
Dean resource-allocator	1985-2005	Leadership of institutions in transition with increasing internal management demands, decreasing resources, and decreasing authority focusing on aligning teams for creativity through constructive change
Dean-president CEO ^b	2005-present	Leadership with recentralized authority in heavily centralized institutions and with greatly increasing demands and decreasing resources focusing on efficient use of human resources and rationalized authority structures.
System dean	2015-present	Liaison role dominates in managing relationships within the medical school as well as with the broader health system; dean is chief academic officer but reliant on system leadership for budgetary and mission final decisions

^a Dates of categorization based on authors’ interpretation of historical trends.

^b Dean-president refers to a role that emerged prominently near the end of the 20th century in which leaders serve as CEO of the entire academic medical center that includes the medical school, principal teaching hospital, and faculty practice plan. The designation “president” is derived from the enterprisewide, highly authoritarian nature of the role.

to as simply CEO, the term “president” is often used, conveying the strong empowerment and comprehensive scope of power more precisely. The dean-president resembles the dean guild master with regard to responsibility and power but requires the additional accountability of a super-executive. Although the resource base of the new model is strikingly different from that of the 1800s, it could be argued that during a century of evolution of US medical schools, deanship has to date essentially produced an empowerment structure very much like its original design.

THE DEAN OF THE FUTURE: THE SYSTEM DEAN

The model of the dean as CEO is presently in fashion while academic health systems centralize operations of a wide array of clinical facilities and providers under a single governance structure united by the academic mission of the organization. This parallels the increasing consolidation of community and faculty providers into hierarchical organizations assisted by employed and network physician groups, such as that seen at the Memorial Hermann Health System, headquartered in Houston, TX. In this instance, the Memorial Hermann Health System network includes 2000 physicians in the network organization and 200 employed physicians.²⁸ By contrast, Aurora Health Care, headquartered in Milwaukee, WI, has 1730 physicians in its employed group and 1335 physicians in its network of independent physicians.²⁹

In the example of the Banner Health system in Arizona, this trend has led to Banner Health acquiring the University of Arizona Health Network (UAHN). Kutscher describes this acquisition when she writes that “Banner executives describe the takeover as part of its mission to be a good steward of medical education in the state. UAHN was struggling, and Banner had the resources to help. But Banner can now impose its particular stamp on UAHN, which operates the state’s only two medical schools, and transform physician education.”³⁰

As these clinical juggernauts continue to form, the model of practice has moved from solo and small group practice to large groups or institutional practice employed

models. Fully one-third of graduates of specific medical schools now start their postresidency careers within a specific dominant health system. The needs of these systems for practitioners, versed in primary care and population health, will inevitably affect the educational offerings of the medical school irrespective of the organizational location of the school.

In the system model, the dean is a member of a broader leadership team rather than a quasi-autonomous CEO. The dean is no longer the final arbiter of the mission and vision of the medical school enterprise, including its clinical relationships (hospital and practice plan). Rather, the dean is a negotiator with a broader health system that will heavily influence or make the final determination of priorities for the school. Consequently, this would necessarily broaden the skill set of the effective dean to include graduate degrees in business, health care administration, public health, or other related fields dependent on the direction in which the school’s mission is trending at the time of hire. Budgetary control may also be lodged outside the school in the health system, with the dean preparing a budget and receiving approval and authorization for expenditures and recruitment decisions from the sponsoring health delivery system. In this sense, this model is quite in contrast to the dean as CEO. In the Banner-University Medicine model, the academic relationship is managed by a newly created academic management council with equal representation from Banner Health and the UAHN.³⁰

Modern medical education has moved toward team-based care with the physician as a central, but no longer always dominant, actor in the team. The system dean faces new challenges in preserving Flexnerian versions of medical education because of the potential dominance of the clinical practice mission and its importance in funding the entire enterprise. Thus, this new kind of leader must be a respected member of the team, a passionate advocate, and an excellent negotiator. As Ofri³¹ has suggested in reviewing the Institute of Medicine’s 2015 report *Improving Diagnosis in Health Care*, “Bravo to the Institute of Medicine for recognizing that diagnosis is often a team sport, and that time spent analyzing a

case is as critically important as tests and procedures.”³¹ Mitchell, et al³² have identified core principles and values of effective team-based health care in their 2012 report for the National Academy of Sciences.³² In becoming a part of a larger team effort, the dean is being called upon to model the behavior expected of a future generation of physicians now in training.

Senge and colleagues³³ have written that the “deep changes necessary to accelerate progress against society’s most intractable problems require a unique type of leader—the system leader, a person who catalyzes collective leadership.” In the traditional medical education structures reviewed in this paper, the dean has been the dominant figure in the organization—initially academically, and subsequently in delivery system leadership. As such, it is essential that the dean be a change agent to meet the needs of a changing health care landscape. Furthermore, in the evolving role of the system dean, a more collaborative outlook and corresponding set of skills are required because the dean is a member of an ensemble cast and not necessarily the lead actor. This individual must have the ego strength, patience with tenacity, negotiating ability, and ability to achieve satisfaction if not gratification from influencing the team rather than “directing” them to change. We suggest that, although early in the next stage of the evolution of the deanship, the system dean will become the dominant model of the future as organizations such as Kaiser Permanente adopt more prominent positions and investments in direct medical education.

FUTURE TRENDS AND PREDICTIONS

Taking the lessons of history into account, certain predictions can be made for the future of academic medicine dependent on the nature of the school itself. It is important for governing boards and search committees to understand that the culture of the individual school will determine the candidate type in palpable ways. Schools must first identify what kind of dean types they have had in the past and whether that is what they want in the future. Timing will also play a role in this process because schools naturally go through periods in which a figurehead dean is more attractive to the governing board than a CEO

or any other combination. Should there be a major shift either at the board or at the university president level, that type of affinity could easily and suddenly change, as it often does. Given those obvious influences, there are certain trends for the future that can be based on the past.

First, the expectation that the dean must be “all things to all people” is likely to continue regardless of institutional organization. This will be especially true as the health care system continues to change with more government involvement. In addition, a new kind of decanal role will need to evolve as what may be called the health system dean assumes a broader role and ensures that medical education is integrated into large and often geographically distributed health care delivery systems. Education will have to be integrated across such systems, large groups of faculty will have to be placated, and the growing number of external forces will need to be aligned. The need for direction in times of limited resources, for instance, will require the dean to serve as an effective, almost “spiritual” leader with students, faculty, and upper administration to maintain optimism in whichever historical role best suits that environment.³⁴ This is a nuance somewhat changed from historical precedence and is further complicated by the potential that internal leadership may have not developed or may not be synchronized with that of the dean type. For instance, a school with figurehead chairs may not cooperate with a CEO dean or other dean type.

Mission-based management will complicate the dean's role in fiscal affairs in the context of the responsibility/authority gap.^{35,36} Few individuals are likely to have the time, talent, and endurance to function successfully in the dean-president role for a prolonged period. It would not, therefore, be surprising if earlier models were to reemerge as schools reorganize in the future and address national mandates such as producing more primary care physicians. This underscores the importance of a fit between decanal management style and skill and the needs of the individual medical school in the future.

Not surprisingly, the lack of a cohesive, effective leadership team has been the downfall of many deans.^{1,18,23,37,38}

The ability and willingness to delegate effectively and empower fully the entire leadership team, both above and below, have become essential while balancing the needs of stakeholders, such as parent university presidents and hospital board members. Increasing sex and racial diversity, as well as diversity in medical school dean academic specialty, will characterize future deanships. Approximately half of medical school deans in the past century were internal medicine specialists.²⁷ A recent analysis shows a much more diverse medical specialty portfolio for deans over time.³⁹ It will be of great interest to determine whether the inevitable increasing diversity of deans is accompanied by improved effectiveness and longevity, given the growing complexity of current resource demands of medical education.

CONCLUSION

The medical school dean is evolving from the medieval guild master to a system executive. In this contemporary version of the dean's role, the dean is a major player in setting organizational direction for the medical school within the mission and vision of a larger system of care. Taken in a historical context, one can only assume increasing complexities in the role of medical school dean as we move forward that may require a melding of these traditions. The failure or success of the dean in the future depends on the ability of the designated person to garner resources to best further the mission of the academic health center while maintaining the support of all stakeholders. ❖

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