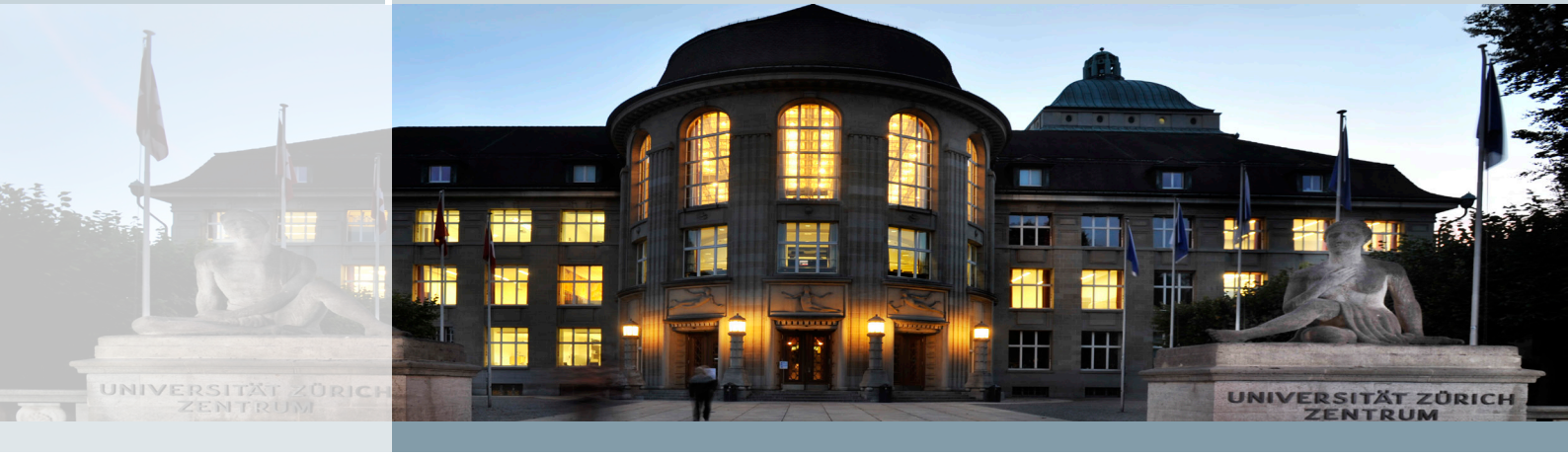
Panel 9



How should Post Recruitment Evaluation and Guidance be Defined?

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Abstract

Optimal evaluation should be non-judgmental, independent, holistic, based on solid metrics and values, and integrative. In academics, the extension of the Chair's activities including scientific production, clinical duties, coaching, teaching and management and interpersonal relationship render such evaluations difficult: They should be integrated in a general scheme with quantitative indicators (H-index, numerical ratings), qualitative measures (pedagogy, peer reviews) and subjective appraisals (management, social skills, self-evaluation).

We propose an initial, "relative" evaluation at appointment, where the goals, and performance outcomes are matched with the means available. This roadmap allows an integrated approach including recurrent coaching, and midterm evaluation.

"The achieved milestones should be appraised by conventional criteria (scientometry, capacity building), but also in the context of the recruitment intended mission (creation or fusion of departments) and the chair's personal approach (integrity, commitment).

Evaluations start at the Dean's office, and should include senior faculties, hospital CEOs, colleagues-experts from other medical schools. The documentation includes written annual reports, achievement evidence, a 360-degree evaluation by various collaborators and staff, and most importantly the chair's self-appraisal regarding his/her achievements, personal satisfaction and future milestones. Feedback is given by the Dean's office in written form, allowing a reply from the Chair.

Tutorial support (coaching by professionals, by peers and former chairs), is highly recommended, allowing to explore new areas of academic interest. In summary, an integrated approach, linking appointment criteria -coaching/guidance-midterm reciprocal appraisal-reelection in a continuous flow is highly desirable, as an element of a total quality procedure.

INTRODUCTION

Evaluation is an indispensable and integral part of any multiple variables optimization process. It allows regular assessment and goal setting, and provides useful guidance to its agents of change. Evaluation, in order to be effective, has to fulfill several requirements: it has to be neutral and non-judgmental, leaving personal biases aside; it must be independent, avoiding conflicts of interest both of the assessor and the subject/theme under examination; it has to be based on a solid architecture of recognized metrics and/or values; it should be holistic and all-encompassing in order to be credible; and finally, it has to fulfill the criteria of integrity to be recognized. Each domain of human activity has its own evaluation procedures, depending on its contents, its intrinsic values, its goals, and most importantly, its methodology. For instance, evaluations of domains/agents in public policy, finance, human resources or life sciences each have their specific indicators. Conceptually, however, they all aim for the same goals, i.e. providing support and guidance for the active optimization process.

In life sciences and medicine, evaluation has become a necessity, due to the development of a competitive landscape, but its methodology and metrics are hampered by many difficulties,whereas scientific production can be assessed by accepted, albeit recently disputed indicators, such as bibliometrics (see panel IV) and peer reviews, other functions such as clinical activity, coaching, teaching, supervising, leadership aspects and societal impact have either not received the necessary attention or not found appropriate evaluation tools (see panel see panels VI & VII). In these fields, the relevant literature essentially gives recommendations regarding personal and interpersonal activities without providing the necessary objective documentation. The problem is even more complex, when it involves the evaluation of medical chairs: taking into consideration basic requirements such as neutrality, independence, holistic approach and integrity, what would be the adequate metrics for the multidimensional activity of a Chair encompassing scientific production, clinical duties, coaching, teaching/supervising, leadership/management, governance and interpersonal skills? Here more than anywhere else, the recognized quantitative and qualitative indicators cannot be integrated into a general, universally accepted evaluation scheme of the "ideal chair" [1-5]. Consequently, this translates in the medical/educational literature in opinions and recommendations by almost each medical school without any robust data to support them.

A general appraisal of the many performance indicators published in the medical literature allows distinguishing three separate categories: quantitative indicators, as used for the scientific performance (citation index, etc.); qualitative indicators, as used in the pedagogic and coaching activity (reputation, awards, assessment by students); and vague, often subjective appraisals for managerial, interpersonal and social skills: In medicine, this group of personal skills has no clear assessment scheme, in contrast for instance, to the private economy sector, where the performance of a leader is measured in fine by the annual financial statements and by the shareholders' asset evaluation – also questionable indicators.

In order to overcome these difficulties, we believe that a Chair of medicine should be evaluated in a "relative evaluation" procedure. By this, we mean that at the moment of selection and appointment, the new Chairperson should work out with the search committee, as well as with the persons they will report to directly in the future, a clear and comprehensive contractual program or job description with precise, defined goals and objectives, annual performance outcomes completed by assessment criteria (as defined in panel 1). This would provide the nominee with a well-defined roadmap, containing the expected milestones, the institutional assessment system, the support and the needed or requested guidance. With such a scheme, the evaluation procedure becomes an integral part of the nomination process. Thus, being Chair - a middle management position between the Department colleagues and the Dean or the Rector – can count on clearly defined goals with adequate, negotiated resources for a defined, and space and time for personal achievement, collaboration and innovation.

METHODS

We searched the Medline database using PUBMED using various search strategies. Specific strategies using “AND” and “OR” were remarkably unsuccessful. Therefore, we used very broad keywords and limited our search to the presence of the keywords in the “title” or “title/abstract” to reduce noise.

The first search was “(academic[Title/Abstract] and chairs[Title/Abstract]) or (academic[Title/Abstract] and heads[Title/Abstract])”. It retrieved 438 references, of which 79 were relevant to various aspects of being an academic chair, but none directly relevant to evaluation or guidance. The second search was “faculty[Title] and evaluation[Title]”. It retrieved 271 articles, among which none were relevant to Chair evaluation. Our final search was “academic[Title] and leadership[Title]”, which enable to retrieve 134 articles, of which four were relevant to the topic of leadership development for academic chairs [6-9], one of which was a systematic review [9].

In summary, there is no empirical data on successful processes or strategies for Chair evaluation and only very little data on the effectiveness of leadership development programs, that could be considered as part of the guidance process. Therefore, the thoughts presented in this text are mainly the result of our group’s reflections. Hence, no level of evidence can be attributed from our panel’s perspective. We would consider, however, that these opinions could nevertheless be rated as “strong” or “weak” based on the degree of consensus reached during the consensus conference.

QUESTIONS

1. What are the criteria/indicators for an optimal evaluation?
2. Who should conduct the evaluation? Are there alternatives?
3. What documentation and information should be available for the evaluation?
   How is the feedback of the evaluation to be given to the Chair?
4. How should guidance be given to the Chair? What help could be provided?
5. Is an integrated approach linking nomination/election to midterm evaluation, monitoring and re-election into a continuous flow desirable?

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RESULTS

1. What are the criteria/indicators for an optimal evaluation?

As mentioned above, today ´s criteria of choice for a Chair of a clinical department are conventionally of academic nature: scientific performance, clinical skills, teaching aptitude [10]. However, other less well-defined competences have to be included, because of their growing importance in today's world, such as management and governance abilities, social and interpersonal skills, coaching of young faculty, delivery of well-trained physicians to the community [11, 12]. Today these competences can only be assessed by self-evaluation and by semi-structured interviews, gauging, whether such preset goals have been achieved. Besides these criteria, evaluation should also include context dependent items:

a) Recently many departments have integrated highly sophisticated basic research with clinical services: oncology, genetics, neurosciences are such examples, and this trend will grow in the future. In such cases, fundraising, international recognition and scientific performance of the institution will be specific aspects to consider for an adequate evaluation. On the other hand, more primary-care oriented departments may need other sets of criteria, such as the successful building of community networks, the training of highly-qualified primary care physicians, capacity-building for successful community-based clinical and epidemiological research and impact on health care policy and delivery.
b) Under certain contextual conditions, specific goals pertaining to the situation, evolution or creation of a department have to be included: implementation of the creation of a new department, of a fusion with other academic structures, or targeting specific goals for an ailing or failing department.

Context dependence requires therefore, in addition to the general criteria defined under 1a), a catalogue of specific objectives and goals, (as described under 1b) at the time of the nomination (see 5).

In a document published in its online journal [13], the Academy of American Medical Colleges (AAMC) has established a set of personal characteristics for leadership in academic medicine: besides the usual criteria (research, clinical expertise, teaching), they have added the following personal competences:

- Integrity
- Authenticity
- Institutional commitment
- Communication skills
- Administrative and financial acumen

Such personal qualities should also be included in the self-evaluation document (see 3)

From our panel's perspective, we would suggest that:

a) Evaluation criteria should be broad and encompass academic, management and leadership performances, which would include teaching skills, leadership and management competencies and interpersonal and social skills.
b) Evaluation criteria should match the criteria, that were defined for selecting the department chair, as discussed in panel I.
c) Evaluation criteria should be specific, adapted to the context and to the job description, and explicit.

2. Who should conduct the evaluation? Are there alternatives?

They are many models available as to whom should conduct the midterm evaluation: Indeed, almost every medical school has its own system. Central to all models is the concept that the evaluation should start from the Dean's or Rector´s office, that it should include the department chair in an open, transparent dialogue, and that the necessary documentation should be provided to all those involved in the process [14]. The evaluation committee should be nominated by the Dean's/Rector´s office, and include among others senior faculty of the medical school, as well as 1 to 2 chairpersons of the same domain from other medical schools. As the evaluation is destined to academic chairs in clinical medicine, and considering the intricate interplay between academic and hospital departments, the university hospital CEO should also be involved in the evaluation process, especially, if he already played a role in the Chair's selection [14, 15]. The evaluation committee uses a standard, semi structured self-evaluation document with

a) general points,
b) department specific points,
c) personal and context-dependent objectives based on the performance agreement establishes at the time of nomination. This document will be the starting point of the evaluation process.

The Medical College of Virginia offers an interesting team model for a chairperson's nomination, that could serve for evaluations as well: it consists in a stable core team which concentrates for a limited number of years on search, nomination and evaluation methodologies, i.e. three members, who are professionally dedicated to academic evaluation procedures, while the other part of the Core Team is complemented by faculty members chosen ad hoc.

From our panel's perspective, we would suggest that:

a) Chair evaluation should be conducted by the Dean or Rector and a committee, including senior faculty of the medical school, the hospital CEO and 1 or 2 chairpersons of the same domain from other medical schools.
b) The evaluation process should be based on a semi-structured self-evaluation document by the department Chair.
c) Chair evaluation should be conducted at regular intervals, starting at midterm.

3. What documentation and information should be available for the evaluation? How is the feedback of the evaluation to be given to the chair?

There is little indication in the literature regarding the pre-evaluation portfolio, probably because it is highly context- and university policy-dependent. Schematically, the documentation can be organized into two fields of interests:

a) "**conventional departmental documentation**" reviewing the academic and clinical achievements of the department and its Chair, and
b) "**personal documentation**" taking into account the Chair's specific activities.

The personal documentation, however, is key to the evaluation process: it contains a semi-structured self-evaluation of the Chair regarding the goals set at the nomination and her/his achievements, but it also offers open space for comments such as personal satisfaction, self-efficacy, major problems encountered and foreseen, proposals to optimize the Chair's performance, proposals for special niches of the department giving it more specificity.

Also, some medical schools include a 360-degree evaluation [16], i.e., a structured feedback from students, assistants and colleagues focusing on leadership aspects and other skills such as mentoring, communication, cooperation. This system is well-established in the Vienna University of Veterinary Medicine (Prof. S. Hammerschmid, personal communication).

Since it is our conviction (see question 5), that evaluations are embedded into a total quality procedure starting with the nomination of the Chair, the major documents pertaining to the selection phase should be part of the package, and provide the terms of reference for the questions asked subsequently by the evaluation committee.

Since the evaluation process is orchestrated by the evaluation committee, it is responsible for delivering its conclusions and proposals to the Chair in an open, nonjudgmental style, accompanied by a written document. It is indeed paramount for the evaluation process to be clearly identified as a component of a supportive institutional culture rather than an intrusive process. This document can be commented and completed by the evaluated person, after which it is signed and kept confidentially at the Dean's/Rector´s office.

From our panel's perspective, we would suggest that:

a) The evaluation should be based on a portfolio including the department Chair's self-evaluation and an analysis of evaluation criteria and goals set at the time of nomination or previous evaluation. A 360-degree evaluation may also be part of the portfolio.
b) Feedback on the evaluation and proposals for improvement should be delivered in an open, nonjudgmental style, accompanied by a written document. The evaluation should include updated goals and recommendations, that will form the basis of the next evaluation.

c) The evaluated Chair should be given the opportunity to comment and complete this document, which will be kept confidentially at the Deans's/Rectors´s Office.

4. How should guidance be given to the Chair? What help could be provided?

Academic chairs nowadays are overstretched: besides research, clinical duties, teaching, a clinical Chair has to fulfill managerial and leadership functions, activate fundraising, possess interpersonal and social skills, and prepare the department's future. But innovative thinking needs time, an independent mind, and contacts with "out of the box thinkers".

In addition, new developments are or will deeply modify both our academic and health systems: the present leaders in medicine have to be more cognizant of these major changes in order to integrate them into their planning, as suggested by the following examples: legal, financial and ethical issues underpinning the rapid rise in public/private partnerships of all kinds; collaboration and association with big data collectors/analysts in the healthcare industry; IT-based learning and testing, MOOCS, patient simulation, virtual reality; mobile applications, and their inherent questions of intellectual ownership, pricing, data protection, patient confidentiality; organization of large international consortia for clinical research, phase 3 trials in personalized medicine, and so on.

The evaluation procedure should therefore be intimately connected and integrated with a general guidance system organized by the Dean's office at the Chair's nomination and giving – among other things- the background knowledge to the questions listed above. This help can be provided in a combined form for several department Chairs, and necessarily requires intellectual support from outside the department and the University, collaboration with the private sector being mandatory.

Besides the knowledge support described above, the concept of a generalized tutorial help at all levels within the universities is gaining progressive support and momentum. At Stanford and at University of Southern California, for instance, it has become a standard requirement for the whole academic community. This is also a requirement at the Vienna University of Veterinary Medicine ("Leading Vet" program, http://www.vetmeduni.ac.at/en).

Indeed, the literature insists on the fact that being an outstanding academic is not a guarantee of being a successful leader administrator. Many schools have, therefore, introduced mandatory leadership workshops for Chairpersons, where the biggest learning comes from exchanges between persons with the same functions, and often face the same challenges [9]. In our case, this personal mentorship in personal skills can be provided by past Chairs, Chairs in other medical schools in the same field, leaders from the private sector, and/or executive coaches [14]. The composition of this guidance group will result from the open discussion between the Dean/Rector, the evaluation committee and the department chair. Additionally, mentoring on a more personal level should also be proposed to encourage the informal sharing of difficulties and adaptation strategies. Indeed, several surveys report the same proportion of burn-out among academic chairs as among other physicians [17]. However, since the concept of coaching and assisting academic chairpersons is not universally acquired and accepted, as a needed and standard professional development (i.e.

continuing professional education) in all academic institutions, it is highly recommended that the process should be introduced carefully and effectively.

From our panel's perspective, we would suggest that:

a) A guidance system should be organized by the dean's/rector´s office at the Chair's nomination. Guidance should be mandatory for all clinical department chairs.
b) Guidance should be provided on topics requiring continuing Chair education (new areas of knowledge) and evolutions, trends relevant to the department's activities and leadership. Formal leadership programs may be an interesting option.
c) Guidance may be provided by persons from inside the medical school including a member or members of the evaluation committee. Guidance from persons outside the faculty off medicine or the university may also be provided.
d) Mentoring should be proposed, preferably by a peer (for example by a present or former Chair).

5. Is an integrated approach linking nomination/election to midterm evaluation, monitoring and reelection into a continuous flow desirable?

Academic Chairs are overburdened by administrative tasks and by a too wide requirement of personal competences, for which on-the-job training is too slow and overly time-consuming in the present academic and economic competitive environment. Offering guidance in their tasks, right from the moment of their election, would provide the medical leaders with the necessary tools to save their time, and most importantly to set ambitious goals for the future in a fast-moving society and scientific/technical world.

Providing continuous guidance at these two levels - capturing the essentials of future developments and expanding practical knowledge for a modern management - does not mean subduing nor castrating the Chair. Rather, it is giving the means for optimization of the clinical, academic and managerial activities, while providing an outlook into the future.

The evaluation process must therefore be integrated into a more general academic optimization process: it has to become part of a continuum starting with the selection and election process, [11, 12, 18, 19] where goals, means, timeline are clearly defined and accepted by the candidate; this is followed by the guidance mechanisms described under 4, evolving naturally into a later evaluation, where in a one-to-one relationship, the terms of agreement are analyzed and reformulated/complemented. Adapted guidance is provided again until the next evaluation. Ideally, the initial documentation should be used, enriched and complemented by the midterm evaluations. Half of the evaluation team should remain stable, recruited from the dean's/rector´s office, committed to academic assessment methods. Thus, it can provide institutional memory and academic consistency to a process, which is still faulty, incomplete and in full development.

From our panel's perspective, we would suggest that:

a) The evaluation process should be an integrated approach linking nomination/election to evaluation, monitoring and reelection.

b) The evaluation team should have stability and should simultaneously provide various forms of guidance to the chair.

References

1. Fisher M. Being chair: a 12-step program for medical school chairs. International Journal of Medical Education. 2011;2:147-51.
2. Heitz C, Hamilton GC. The academic chair in emergency medicine: current demographics and survey results identifying the skills and characteristics desired for the role. Acad Emerg Med. 2011;18:981-7.
3. Kastor JA. Chair of a department of medicine: now a different job. Acad Med. 2013;88:912-3.
4. Lieff S, Banack JG, Baker L, Martimianakis MA, Verma S, Whiteside C, Reeves S. Understanding the needs of department chairs in academic medicine. Acad Med. 2013;88:960-6.
5. Sheldon GF. Embrace the challenge: advice for current and prospective department chairs. Acad Med. 2013;88:914-5.
6. Symposium: Leadership development for academic medical centers. Res Med Educ. 1987;26:291-6.
7. Craighead PS, Anderson R, Sargent R. Developing leadership within an academic medical department in Canada: a road map for increasing leadership span. Healthc Q. 2011;14:80-4.
8. Fairchild DG, Benjamin EM, Gifford DR, Huot SJ. Physician leadership: enhancing the career development of academic physician administrators and leaders. Acad Med. 2004;79:214-8.
9. Straus SE, Soobiah C, Levinson W. The impact of leadership training programs on physicians in academic medical centers: a systematic review. Acad Med. 2013;88:710-23.
10. Buckley PF, Dauphinais D, Miller DD, Rawson JV, Curd ND. Academic leadership searches: evolving best practices. Journal of Healthcare Leadership. 2010;2: 61–7.
11. Mallon WT, Corrice A. Leadership Recruiting Practices in Academic Medicine. How Medical Schools and Teaching Hospitals Search for New Department Chairs and Center Directors. Association of American Medical Colleges, 2009.
12. Mallon WT, Hefner DS, Corrice A. C-Suite Recruiting Practices in Academic Medical Centers. How Teaching Hospitals Find Top Talent. Association of American Medical Colleges, 2011.
13. Harris S. Leadership in Academic Medicine: Department Chairs Require a Blend of Characteristics. AAMC Reporter [Internet]. 2013 September 30, 2014; (April). Available from: https://www.aamc.org/newsroom/reporter/april2013/334338/leadership.html.
14. Ross WE, Huang KH, Jones GH. Executive onboarding: ensuring the success of the newly hired department chair. Acad Med. 2014;89:728-33.
15. Souba W, Notestine M, Way D, Lucey C, Yu L, Sedmak D. Do deans and teaching hospital CEOs agree on what it takes to be a successful clinical department chair? Acad Med. 2011;86:974-81.
16. Donnon T, Al Ansari A, Al Alawi S, Violato C. The reliability, validity, and feasibility of multisource feedback physician assessment: a systematic review. Acad Med. 2014;89:511-6.

17. Cruz OA, Pole CJ, Thomas SM. Burnout in chairs of academic departments of ophthalmology. Ophthalmology. 2007;114:2350-5.
18. Fernández-Aráoz C, Groysberg B, Nohria N. The Definitive Guide to Recruiting in Good Times and Bad. Harvard Business review. 2009.
19. Kubiak NT, Guidot DM, Trimm RF, Kamen DL, Roman J. Recruitment and retention in academic medicine--what junior faculty and trainees want department chairs to know. Am J Med Sci. 2012;344:24-7.