Commentary: Getting to the Next Phase in Medical Education—A Role for the Vice-Chair for Education

Louis N. Pangaro, MD

Abstract

The author argues that a particular kind of departmental leadership is needed lest medical education become hostage both to distant management through regulatory metrics (which can displace local, institutional creativity) and to the financial pressures within the institution. Departmental chairs themselves have often been seen as barriers to successful integration and redesign of medical school curricula. The vice-chair for education is a critical figure in achieving this new kind of leadership.

The author describes three forms of curriculum planning and management: phase 1, where the department chair makes the decisions; phase 2, dominated by regulation from above (in part a reaction to problems with the phase 1 approach); and phase 3, the author's vision of an approach in which decisions occur within departments but with an awareness of the institution as a collaborative system, and grounded in educational theory and research. The vice-chair for education would have a key role, carrying out interdepartmental planning and assessment for the chairs, who would provide them the needed time, training (in leadership and in educational theory and practice), support (from professional educators, with advanced degrees in education), and routes to academic advancement.

Responding effectively to a complex and changing environment requires senior leaders at the middle-management level (such as vice-chairs for education) who are well trained in both the content of their specialties and also in interpersonal and collaborative skills, and who have the desire to reach a common future.

Editor's Note: This is a commentary on Brownfield E, Clyburn B, Santen S, Heudebert G, Hemmer PA. The activities and responsibilities of the vice chair for education in U.S. and Canadian departments of medicine. Acad Med. 2012;87:1041–1045.

It is exciting to read the article by Brownfield and colleagues1 on the activities and responsibilities of the vice-chair for education. The roles of vice-chair for education (hereafter, vice-chair) and of clerkship director for one’s clinical department are often the most satisfying in an educational career.

It is essential for chairs to develop, nurture, and protect the role of the vice-chair in a system of medical education, especially at this junction of our medical education culture, when service to the public2 is becoming a priority and is primarily sought through regulatory control by those outside.

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One’s own institution. My theme for this commentary is that a particular departmental leadership is needed lest medical education become solely hostage to both distant management through regulatory metrics (which can displace local, institutional creativity) and to the financial pressures within the institution.

Departmental chairs have themselves often been seen as barriers to successful integration and redesign of medical school curricula,3 and I believe that the vice-chair for education is a critical figure in moving this cultural nexus in the right direction.

Two Phases of Curriculum Planning and Management

In the past, departments and chairs had considerable prerogatives in deciding what and how students would be taught. In that phase of curriculum planning and management, content expertise was seen as the major, even exclusive, guide to instructional methods and assessment, and departmental priorities did not need to be coordinated, or even harmonized, across departments and disciplines. This approach4 yielded what are often called— with a clearly pejorative connotation— “silos” in the curriculum.

Faced with these silos and with years of curricular reform without change, we were in a situation where the opinions of the department chairs held sway in matters concerning the curriculum, whether in planning the basic science syllabus, the clinical curriculum, or other areas. Expertise in one’s specialty in a leadership position was felt sufficient to make decisions about curricular content and process. This “phase 1” approach (my term for curriculum as an extension of departmental authority) prompted responses from the Association of American Medical Colleges5 and from the Liaison Committee on Medical Education (LCME).6 The latter, in particular, makes explicit this distrust about potential departmental distortions of the curriculum. As seen in the annotation for ED-33 of LCME standards for curricular management,5(p13) oversight must be separated from parochial influence, and it requires “empowerment, through bylaws or decanal mandate, to work in the best interest of the institutions without regard for parochial or political influence or departmental pressures.”

Perhaps because the chairs’ need to generate income from patient care and grants had become so pressing, it was at times suggested that course and clerkship directors should have...
their accountability, and perhaps even reporting chains, moved to the dean’s office to protect those directors’ autonomy. (GME program directors were excepted, although in the last decade, the Accreditation Council for Graduate Medical Education [ACGME]* has also felt that regulation from above has been needed to achieve public accountability for educational outcomes.) This “phase 2” approach (again, my term) has had its own limitations and risks because the chairs themselves were not only content experts but also controlled many of the resources (access to patients and provision and supervision of faculty, including salary and academic promotion). However, the phase 2 reaction to the ancien régime was understandable, given how the academic culture had ingested the principles of the business environment in the last two decades, which prefers an “executive model” to the former, decentralized one. The executive model is characterized by a highly centralized control system, managed by outcomes, in which variation in process is undesirable. The desire to improve outcomes through management by metrics is understandable, as is the goal of measuring everything that is important. This quantified approach, a kind of “engineering model” to govern institutions, is certainly appealing to those of us who are academic researchers.

Envisioning a Third Phase

Despite its appeal, the engineering model is not the way medical education should go. I worry that the phase 2 approach hasn’t yet fostered, much less required, institutional support of educational research. When coupled with regulation from outside, it may have actually led to frustration and burnout of program leaders. Could we, or should we, work toward creating an educational culture that fosters local creativity and tolerates more interinstitutional variance and, therefore, generates more educational scholarship and leads to more evidence-driven educational practices? And how would we do this?

My answer is a strong “Yes!”; vice-chairs would be critical in this process, providing institutional leaders whom we (chairs) would expect to carry out interdepartmental planning and assessment and for whom we would provide the needed time, training (in leadership and in educational theory and practice), support (from professional educators, with advanced degrees in education), and routes to academic advancement.

As one moves up the pyramid of educational responsibility (see Figure 1) to the highest level of leadership (department chairs, deans, and CEOs), one is in the terrain of the “academic executives” in our system of medical education. These are the top leaders who provide both “upward” communication of needs to the chair, and “downward” communication to the “academic directors,” that is, the course, clerkship, and program directors (CCPDs) responsible for implementing institutional goals and priorities. Vice-chairs are the necessary change agents who can socialize an institution to the needs for and possibility of change. They are especially able—perhaps, even, the only ones able—to fill this role. The vice-chair oversees the CCPDs, the academic directors who manage the curriculum, day by day. They are not down in the weeds of running things, and they are close enough to the executives (the chairs) without becoming more remote (the dean’s office).

The vice-chair would be at the interface between the top of the pyramid—the executives, who provide resources (chairs, deans, and CEOs)—and the next level down, the academic directors. The vice-chair would negotiate with those above for resources and would help allocate these; the vice-chair would also often be best able to provide support, mentoring, and training for the CCPDs in their own roles of working with students and faculty.

Brownfield and colleagues provide a thorough and detailed description of what the roles and responsibilities of vice-chairs are, and ought to be, in a system of medical education. The essential roles that they discovered by surveying colleagues—overseeing programs, providing expertise, generating scholarship, providing institutional leadership—make it possible for medical schools to coordinate the complex mesh of interests, requirements, and resources that allow students to flourish and, hopefully, develop toward a “2025 curriculum” that meets the needs of their students, their institutions, and the public. This requires not only managerial talent but also the ability to develop and share a vision for the future.

However, it is very difficult to predict the future. Responding effectively to a complex and changing environment requires leaders at the middle-management level (academic directors) who are well trained in both the content of their specialties and also in interpersonal and collaborative skills, and who have the desire to reach a common future. Such a “phase 3” in medical education is approachable through a stable group of more senior leaders, like the vice-chairs.

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As one moves up the pyramid of educational responsibility (see Figure 1) to the highest level of leadership (department chairs, deans, and CEOs), one is in the terrain of the “academic executives” in our system of medical education. These are the top leaders who provide the direction and, especially, resources for institutional missions, and they are necessarily preoccupied with dollar outcomes, legal concerns, and issues of quality. They often struggle to make the balance sheets come out even, by managing through metrics such as relative value units. In those departments that have them, the vice-chair works for the chair, one of these academic executives, and in the process I am proposing, could provide both “upward” communication of needs to the chair, and “downward” communication to the “academic directors,” that is, the course, clerkship, and program directors (CCPDs) responsible for implementing institutional goals and priorities. Vice-chairs are the necessary change agents who can socialize an institution to the needs for and possibility of change. They are especially able—perhaps, even, the only ones able—to fill this role. The vice-chair oversees the CCPDs, the academic directors who manage the curriculum, day by day. They are not down in the weeds of running things, and they are close enough to the executives (the chairs) without becoming more remote (the dean’s office).

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support they need. Whereas residency review committees specify the amount of protected time expected for program directors and key faculty, at this point there is no equivalent “strong force” mandating the equivalent protected time for medical school course and clerkship directors. We do have the recommendation of the Alliance for Clinical Education, the coordinating council of the eight national clerkship organizations in the United States. That recommendation—that clerkship directors should have a minimum of 25% of their time protected for administration, and an additional 25% for teaching and scholarship—has been endorsed by the specialty educational organizations, but it is only advisory, not compulsory. It’s striking that almost all vice-chairs in internal medicine are senior faculty (two-thirds are professors, and one-third are associate professors). Therefore, they probably do have protected time to carry out their roles and, perhaps, to support the CCPDs under them. Is this true in other specialties? Brownfield and colleagues’ findings indicate that most vice-chairs in internal medicine are “senior” in other ways—that is, a little over 50 years old. As with most others currently in this age group in academic medicine, they are predominantly male and white. The majority have been either residency program directors or clerkship directors, and 20% have had positions in the dean’s office. As expected, they would have had considerable experience in managing a major educational program before taking on oversight of multiple programs as a vice-chair.

It is actually encouraging that around two-thirds of departments of medicine in North America actually do have a position of vice-chair for education. It would be wonderful to know something about those departments that do not. What is different about those institutions? It would also be good to know about the position of vice-chair in other specialties. A quick search of the literature and e-mails to my colleagues in the Alliance for Clinical Education made it clear that many departments do have vice-chairs for education, though we do not know the percentage or the seniority of those. It’s probably a safe assumption that the position would only be given to a senior person. But what is the training or mentoring for this kind of position?

Brownfield and colleagues refer to a “degree of uncertainty that is not desirable” in the role of vice-chairs for education. Could we learn more details about this uncertainty? Clarity in what is expected “of” and “for” academic directors has been the focus of attention in internal medicine and other clerkships for the last few years. This has become more and more necessary as the prescriptive influence of regulatory bodies such as the LCME, the residency review committees, and the ACGME has moved us—appropriately!—beyond simply allowing students to join an existing patient care team. We now expect that both processes and outcomes of the educational process will be tracked, even measured, more rigorously. Further, the unintended side effects of Medicare reimbursement rules and payment for teaching faculty have made it more difficult to negotiate the role of students. Regulation and reimbursement are the “strong forces” whose influence in education may overwhelm the weaker forces of educational practice, theory, and research.

In summary, there are many challenges to redesigning the curricula of medical schools and residencies, and I argue that the most effective solutions will have to be based within departments, and from educational research that starts in departments—not from above departments. The vice-chair will be the key figure in making this happen.

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References

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