The Current State and Future Possibilities of Recruiting Leaders of Academic Health Centers

William T. Mallon, EdD, and Peter F. Buckley, MD

Abstract

For more than 30 years, commentators have been questioning the processes that medical schools and teaching hospitals use to search and recruit their leaders. Recent studies suggest that these problems persist, not only within academic medicine but across industries and countries.

The authors’ thesis in this article is that the search process, although always important, will be of even greater consequence than before, given the current environment for academic medicine. They (1) demonstrate why the academic medicine sector faces an impending talent crisis, (2) review the evidence on how a systematic approach to talent development has important organizational outcomes, (3) review the current state of the search and recruitment process for leaders in academic medicine centers, and (4) underscore the use of a continuous improvement approach as a way to improve the search process.

The authors describe one such approach, which included retaining a core set of search committee members from one search to the next, appointing an associate dean for leadership development who instilled consistency in search and recruitment processes, and evaluating and making improvements to the search process via participant and stakeholder feedback.

For more than 30 years, commentators have been questioning the processes that medical schools and teaching hospitals use to search and recruit their leaders.1–4 They identified several serious flaws with the way that academic health centers (AHCs) hire leadership talent, including passive approaches to developing candidate pools (e.g., assuming candidates will respond to job announcements) and protracted amounts of time to complete the process. Recent studies suggest that these problems persist, not only within academic medicine in the United States but also across industries and countries.5–7

Since the time when these commentators raised concerns in the peer-reviewed literature, the environment in which medical schools and teaching hospitals operate has changed considerably. Medical education has expanded in the United States amid projections of workforce shortages; inflation-adjusted federal funding for biomedical and health sciences research has declined,8 as has state funding for higher education;9 the outlook for health care spending has become more volatile;10 and major shifts are expected in the delivery and payment mechanisms for patient care services,11 in the science of health care delivery,12 and in the education of health care professionals.13

These changes in the environment, taken together, suggest that the leaders, faculty, staff, and learners within AHCs must think and act differently for these organizations to meet the multiple missions of health professions education, scientific discovery, patient care, and community service. These changes necessitate that leaders at all levels be change enablers, skillful in continuous quality improvement methods, and able to develop, lead, and participate in teams, develop high-performing organizational cultures, and measure and be accountable for performance.14,15

The process by which medical schools and teaching hospitals search for and recruit their organizational leaders has always been important. Our thesis in this article is that the search process will be of even greater consequence than before, given the current environment for academic medicine. We present evidence to demonstrate why the academic medicine sector faces an impending talent crisis. We review the evidence on how a systematic approach to talent development has important organizational outcomes. We review the current state of the search and recruitment process for leaders in AHCs. Finally, we underscore the use of a continuous improvement approach as a way to improve the search process.

The Changing Realities of Workforce Talent in Academic Medicine

A number of demographic trends affect the ability of medical schools and teaching hospitals to attract and develop top workforce talent (see Table 1). Although these data have been published elsewhere, to our knowledge they have not previously been synthesized to illustrate the complexity of the workforce challenges faced by academic medicine.

Workforce challenges for physicians and physician leaders. Much attention has been devoted on the projected physician workforce shortages in the United States in meeting the health needs of the public, especially in the context of health care reform legislation.16,17 The literature has appropriately focused on the implications of these shortages on health care access and quality. Yet unaddressed in these discussions are the implications of physician shortages for AHCs as employers of physicians,
physician leaders, and other health care professionals. If there are greater workforce shortages in the future, ipso facto, there will be increased competition of both physicians and physician leaders in the employment marketplace, including medical schools and teaching hospitals. Such competition, in turn, will put greater emphasis on the quality of workplace environments and on recruitment and retention effectiveness. In an era of physician shortages, AHCs will find themselves competing for top talent—not only among other academic settings but with private practice, industry, and other sectors.

Trends in career promotion and advancement. Recent analyses suggest that AHCs have struggled in creating sustainable career pathways. Liu and Alexander’s 2010 analysis revealed that promotion rates for first-time professors have declined over the last 40 years. For the cohorts of faculty hired from 1967 to 1976, 44% of first-time assistant professors were promoted within 10 years. For the most recent cohorts of faculty available for analysis, from 1987 to 1996, only 33% have achieved that success—meaning that a greater percentage of faculty within AHCs are not achieving the milestones of career progress within expected time frames. This trend also has implications for leadership recruitment in AHCs, as many executives emerge from the senior faculty ranks.

Trends in faculty and leadership retention. Perhaps related to the downward trends in career promotion, significant proportions of faculty leave AHCs within a decade.16 As of 2008, 4 in 10 medical school faculty—and 5 in 10 clinical faculty—were leaving their medical school employers within 10 years. Of those who left their medical school, 40% left within 3 years, 55% left within 6 years.22 This finding suggests that many AHCs face quick “throughput” of their top executives.

Trends in the aging of the faculty and leadership workforce. Data indicate that the average age of medical school faculty is increasing.21 Less than 1 in 10 faculty members were over the age of 55 years in 1967. In 1987, the proportion was 1 in 5. In 2007, it was nearly 1 in 3. Although we are unaware of comparable data for physician and nonphysician leaders in AHCs, the trends in faculty cohorts imply a similar phenomenon. The graying of the workforce has at least two implications for AHCs. First, some organizations will need to recruit and integrate unusually large numbers of faculty and leaders in the near- to midterm future as they experience waves of retirements that outpace historical norms. At the same time, organizations will need to manage the financial implications of

### Table 1

**Recent Research Findings on Physician and Leadership Workforce and Implications on Recruitment for Medical Schools and Teaching Hospitals**

<table>
<thead>
<tr>
<th>Topic</th>
<th>Data source</th>
<th>Finding(s)</th>
<th>Implication for recruiting leaders of academic medicine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workforce shortages</td>
<td>AAMC, 201017</td>
<td>Overall shortage of 130,600 active patient care physicians in 2025 and a primary care shortage of 65,800 physicians in 2025.</td>
<td>Increased competition among employers of physicians and physician leaders, including academic health centers. Greater demand for recruitment and retention effectiveness.</td>
</tr>
<tr>
<td>Career pathways</td>
<td>Liu and Alexander, 201018</td>
<td>Eleven percent decrease in percentage of first-time assistant professors promoted within 10 years.</td>
<td>Greater percentage of medical faculty not achieving expected career milestones; negative impact on pool of future leaders emerging from the faculty.</td>
</tr>
<tr>
<td>Employee retention</td>
<td>Alexander and Lang, 200819</td>
<td>Four in 10 full-time medical school faculty members leave their employers within 10 years.</td>
<td>High demand to recruit and develop replacement faculty and leaders.</td>
</tr>
<tr>
<td>Aging of workforce</td>
<td>Alexander and Liu, 200920</td>
<td>Nine percent of faculty over the age of 55 in 1987; 29% over the age of 55 in 2007.</td>
<td>High demand to recruit and develop replacement faculty and leaders.</td>
</tr>
<tr>
<td>Generational differences in workforce</td>
<td>Salberg, 200721</td>
<td>Seventy-one percent of physicians under 50 rated “time for family/personal” as most desirable aspect of career.</td>
<td>Career disenchantment among younger physicians, scientists, and emerging leaders of academic health centers; increased difficulty to recruit younger, emerging leaders.</td>
</tr>
<tr>
<td>Cost of workforce recruitment and development</td>
<td>Joner et al, 200722</td>
<td>Faculty members had to be retained in excess of 10 years for the academic health center to recoup the initial central investment (i.e., “start-up package”) required for recruitment.</td>
<td>“Hidden” financial costs of recruitment are considerable; place a premium on long-term (in excess of 10 years) retention.</td>
</tr>
<tr>
<td></td>
<td>Schloss et al, 200923</td>
<td>Cost of physician turnover in one academic health center estimated to be $115,000 for a generalist and $587,000 for a surgical subspecialist.</td>
<td>Increased competition among employers of physicians and physician leaders, including academic health centers. Greater demand for recruitment and retention effectiveness.</td>
</tr>
<tr>
<td></td>
<td>Waldman et al, 200424</td>
<td>Cost of physician turnover at one academic health center estimated to be equivalent of 5% of annual budget.</td>
<td>Increased competition among employers of physicians and physician leaders, including academic health centers. Greater demand for recruitment and retention effectiveness.</td>
</tr>
</tbody>
</table>

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**Note:**

1. Salsberg, 200723 Seventy-one percent of physicians under 50 rated “time for family/personal” as most desirable aspect of career.
2. Joiner et al, 200726 Faculty members had to be retained in excess of 10 years for the academic health center to recoup the initial central investment (i.e., “start-up package”) required for recruitment.
3. Schloss et al, 200927 Cost of physician turnover in one academic health center estimated to be $115,000 for a generalist and $587,000 for a surgical subspecialist.
4. Waldman et al, 200428 Cost of physician turnover at one academic health center estimated to be equivalent of 5% of annual budget.
an increasingly older (and higher-paid) workforce.

Generational differences in faculty expectations. As large cadres of senior members of the AHC workforce transition into retirement over the next 10 years, new faculty, staff, and leaders from younger generations bring expectations for the workplace that are very different from those of their senior colleagues. For example, in a 2007 survey of practicing physicians under the age of 50 carried out by the Association of American Medical Colleges (AAMC) and the American Medical Association, 71% of both male and female physicians under 50 years old rated “time for family/personal” as the most desirable aspect of a career, some 30 percentage points over the next most desirable item. In 2009, Mason and colleagues found that younger members of the academic workforce were disenchanted with work/life balance: Among federal grant-supported PhDs with children, only 35% of men and 16% of women indicated that tenure-track faculty careers at research-intensive universities were family-friendly.

Some AHCs are planning for and responding to a generation of talent whose members have different motivations, different expectations, and different demands, but we are unaware of data or information that elucidates how extensive this planning is across academic medicine as a whole. Our impression is that it is not as widespread as it ought to be.

The “hidden” costs of workforce recruitment and development. A range of studies have examined the cost of hiring, developing, and sustaining careers in AHCs. Joiner and colleagues found that faculty members at one AHC had to be retained in excess of 10 years to recoup the initial central investment required for their recruitment. Studies have estimated the “hidden” costs of physician turnover to vary from $115,000 for a generalist to $587,000 for a surgical subspecialist, and that these costs can consume as much as 5% of an AHC’s annual budget. Although we are unaware of studies examining turnover costs for AHC executives, we assert that such hidden costs, especially for those who stay in office only a short duration, are also significant.

The Case for a Strategic Approach to Attracting, Developing, and Retaining Leaders and Faculty

Each of the above-mentioned indicators or trends—the current and emerging shortages of available talent; falling success rates in career advancement; high long-term attrition; an aging academic medical workforce; sharp generational differences and expectations among younger cohorts of faculty, staff, and leaders; and staggering costs of recruitment and turnover—is worrisome when examined in isolation. Taken together, the data paint a significantly troubling picture of the realities that AHCs face in managing and developing their current and future leadership and academic workforce.

Yet a strong evidence base exists on the benefits of a strategic, enterprise-wide approach to systematically managing recruitment, career development, promotional pathways, and succession planning. In a 2011 review of the literature, Fox et al found evidence that a “strategic talent management” approach leads to higher levels of employee satisfaction and retention; improved organizational productivity and financial measures; positive individual-level performance of faculty and staff, including job performance and organizational citizenship behaviors; and positive organizational-level performance, including quality of patient care, hospital mortality rates, and customer service quality. In a study conducted in the United Kingdom, researchers found that hospitals with high-performing human resources systems—that is, those that had strong training, performance management, employee participation, decentralization, use of teams, and talent management systems—had lower patient mortality rates than those hospitals without strong people management. Other studies have demonstrated linkages between intentions of turnover and workplace culture and leadership culture and organizational performance.

How AHCs Currently Search for and Recruit Their Leaders

Despite calls for reform and the evidence that supports a strategic approach, AHCs, like organizations in most sectors, do not have high-performing search and recruitment processes. One of us (W.T.M.) was the lead author on studies that indicated the following characteristics of those processes.

AHCs have high recruitment loads at any given time. A 2009 study found that U.S. medical school deans who recruited new leaders had, on average, appointed 4.1 new chairs or center directors during a two-year period. A 2011 study found that teaching hospital CEOs who recruited new leaders had, on average, appointed 2.5 new executive-level positions (e.g., chief medical officer, chief financial officer, chief nursing officer) during a two-year period. Taken together, these studies indicate that AHCs are juggling many high-profile, high-impact, and high-cost recruitment processes year in and year out.

The average search process for leadership of AHCs is national in scope and takes a long time. Data confirm the anecdotal reports that the leadership search process in academic medicine is slow. The average search process for clinical department chairs in U.S. medical schools is 11.9 months; the average length of the search process for executives in teaching hospitals is 7.3 months. One contributing factor in time-to-completion is that most AHCs launch national searches for their leadership positions (as opposed to simply anointing an internal candidate without conducting a search). Research indicates that three of every four executive appointments in teaching hospitals, for example, are made after a national search.

Search committees are large. Medical schools and teaching hospitals commonly use search committees composed of faculty, staff, administrators, learners, and others. Studies in 2009 and 2011 indicate that 85% of searches for clinical department chairs and 74% of searches for teaching hospital executives used search committees. The use of peer committees is far less common in business and industry—One study published a little over a decade ago found that only 31% of companies included peers of the position in the search process.

Search committees in academic medicine tend to be large: In 2011, the average size of search committees for leadership
positions in teaching hospitals was 10 members; almost 1 in 5 exceeded 15 members. In medical schools, the average committee size was 12 members. Expert published literature argues that the “ideal” size of a search committee is 5 to 7 members.  

The use of professional search consultants varies among medical schools and teaching hospitals. Only 26% of clinical department chair searches used external professional search firms in 2009. In contrast, 74% of teaching hospitals employed search firms for their executive-level searches. As reported elsewhere, the reasons for such differences may be, in part, cultural. Department chair searches typically adhere to a faculty-driven process, and faculty may be skeptical of using “head hunters.” Hospitals may have more corporate cultures that are more accepting of the use of such firms as part of “doing business.”

AHC executives are dissatisfied with key outcomes of the search process. Although medical school deans and teaching hospital CEOs indicate strong satisfaction with certain aspects of the search process (e.g., the performance of the search committee, quality of finalists), they are not similarly satisfied with the outcomes in achieving diversity in the applicant pools and ultimately in their executive teams. In a study published in 2009, only 21% of medical school deans were satisfied with the number of women finalists in clinical chair searches, and only 20% were satisfied with the number of finalists who were racial or ethnic minorities. A 2011 study reported that among hospital CEOs, 47% were satisfied with the number of women finalists and 36% were satisfied with the number of finalists who were racial/ethnic minorities.

Leadership search and recruitment in academic medicine does not appear to be linked to an overall system of talent management. Two findings in the literature suggest that the search process in academic medicine is not aligned with systems to develop and sustain leaders over time. A 2009 study found that a notable percentage of CEOs at integrated teaching hospitals—43%—played no role in the evaluation of the new chair’s performance within the first 12 months of employment. This finding indicates a serious flaw in how executives link recruitment with ongoing performance evaluation and development of their teams.

For executive positions within teaching hospitals, 62% of the individuals hired for these roles were external hires, an inverse percentage to the common benchmark in the business sector, where 70% of leadership positions are targeted to be internal hires. This finding may indicate a failure to identify, develop, and promote emerging leaders already employed in these organizations.

Continuous Improvement in the Leadership Search Process

Given the workforce trends bearing down on academic medicine, the evidence base for a strategic approach to talent management, and the current state of the search process within medical schools and teaching hospitals, we assert that these organizations should intentionally create a continuous quality improvement approach to the search process.

With increased frequency, academic medicine has responded to calls for performance improvement in quality and patient safety, continuing medical education, and evidence-based medicine and management. A continuous quality approach within the leadership search process would enable organizations to conduct after-action assessments, learn from recruitment successes and missteps, and make improvements over time, all of which would address the limitations in the typical process mentioned in the literature.

One of us (P.F.B.) led a continuous improvement approach to search and recruitment at the Medical College of Georgia (MCG) at Georgia Health Sciences University. The impact of such an approach was immediate and long-lasting. This approach had the following elements.

“Carry-over” representation in the search committee. In an effort to build consistency and institutional memory, three members of the search committee from one search (for the chair of the Department of Medicine [DOM]) were retained to serve on the next search committee (for a chair of the Department of Pediatrics [DOP]). In subsequent searches, this model was excessively demanding on selected faculty. We are aware of other AHCs, however, that have adopted similar approaches—for example, faculty affairs dean’s staff who co-chair search committees to instill ongoing consistency and learning.

Institutional leadership for leadership search. In the effort to establish a coordinated approach to searches, an associate dean for leadership development oversaw the search process with both central administrative support and departmental administrative support. This decanal position provided a consistent approach from one search to the next and acted as a conduit for integrating lessons learned from the DOM search into the DOP search. A detailed description of this position can be found in the literature. In subsequent efforts, this role has been shared by a basic science department chair and clinical department chair.

Anecdotally, we are aware of other decanal positions or administrative positions at other AHCs that have a similar set of responsibilities in coordinating leadership-level searches across the organization. Additionally, some AHCs have created professionally staffed recruitment offices to ensure that consistent processes and best practices are employed from one search to the next; Georgia Health Sciences University has taken this approach with senior executive searches.

Benchmarking and evaluation. To improve its search process, MCG employed a number of strategies. First, one of us (P.F.B.) participated in a national work group on leadership recruitment convened by the AAMC that facilitated benchmarking of MCG’s methods against established practices from 6 other AHCs. This benchmarking led to improvements in the search process such as use of a secure search Web site, identification of core interview questions, use of standardized evaluation forms, and solicitation of candidates’ vision statements. Although the national work group was a convenient opportunity to compare and contrast search approaches, any AHC could do benchmarking via informal networking among peer colleagues.
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Table 2

Opportunities Suggested by the Authors for Performance Improvement in the Recruitment Process at Academic Health Centers

<table>
<thead>
<tr>
<th>Aspect of search or recruitment</th>
<th>Suggested area for improvement</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Search committee size</td>
<td>Smaller number of members on the search committee.</td>
<td>Increased efficiency, higher levels of engagement among committee members.</td>
</tr>
<tr>
<td>Search committee composition</td>
<td>“Carry-over” representation from one search committee to another (one or more members of one search committee serve on a subsequent search committee).</td>
<td>Lessons learned in previous searches (what worked, what did not work) can be repeated and improved on in future searches.</td>
</tr>
<tr>
<td>Search process</td>
<td>“Active” process in which search committee members make inquiries to formal and informal networks via phone calls, personalized e-mails, and interactions with professional networks that focus on targeted groups (e.g., women’s subgroup of specialty society; minority interest group in profession).</td>
<td>Larger number of candidates in pool; greater percentage of diverse candidates.</td>
</tr>
<tr>
<td>Committee conduct in performing search</td>
<td>“Code of conduct” for shared expectations and behaviors among committee members.</td>
<td>Sets explicit expectations for confidentiality, respect, privacy, and conflicts of interest.</td>
</tr>
<tr>
<td>Recruitment leadership</td>
<td>Associate dean or other high-level leader to oversee and coordinate all leadership-level recruitment within academic health center.</td>
<td>Facilitates a consistent approach from one search to another; best practices can be integrated into all searches; opportunity to enhance institutional brand and image through polished, well-executed search operations.</td>
</tr>
<tr>
<td>Recruitment evaluation</td>
<td>Postsearch surveys and interviews of search committee members and candidates.</td>
<td>Evidence-based improvements can be made in subsequent searches; practices that are effective can be retained.</td>
</tr>
</tbody>
</table>

Second, a thorough search of the literature was conducted. The various articles, handbooks, and guidebooks that were found1–2,3,3,3,4 review how to conduct effective searches in the corporate sector, higher education, and academic medicine; they contain many good ideas about how to improve leadership recruitment processes. MCG makes this literature available to colleagues serving on these search committees.

Third, MCG sought direct feedback from stakeholders (external candidates and internal committee members) in both the DOM and DOP searches via a survey administered to all participants—administrators, faculty, and trainees—who had been involved in each search process. In addition, each candidate who had visited the campus was interviewed by phone to obtain direct feedback on his or her experiences with the search process.

As presented and reported elsewhere,48 these two methodologies (survey and qualitative interviews) revealed shortcomings in the DOM search that were then improved on in the DOP search. For example, candidates in the DOM search indicated that they wanted to be better informed about the status of the search, suggested more breaks in the candidate-visit schedule, and recommended a tour of the city. Faculty interviewers requested improved contact with administrative support and periodic updates on the search status. Each of these areas was improved in the DOP search, and subsequent evaluations provided evidence that improvements were effective.49 For example, 36% of interviewers agreed that they were informed about the progress of the search in the DOM search; in the DOP search, 67% of interviewers agreed. Whereas only 22% of all participants agreed that the DOM search was conducted in a timely manner, 94% agreed that the DOP search was.49

Overall, this evidence-based continuous improvement approach realized increased satisfaction and improved efficiency in completing the search as well as improved experiences among candidates. MCG has continued to build its search process on these efforts, incorporating additional refinements over time. We suggest that any AHC can take specific actions, such as those listed in Table 2, that would have a demonstrable positive impact on the search process.

Future Possibilities in Finding Top Talent

The search process for a new organizational leader in a medical school or teaching hospital is an opportunity for organizational improvement. A well-executed search can also be an opportunity for faculty and staff development and for enhancing institutional reputation, brand, and image by putting the organization’s “best foot forward” in a national process.

Many institutions create search committees to find new leaders and then disband the committees without review of the search process, a cycle that is perpetuated when the next search committee is formed. This approach limits the opportunity to build institutional capacity and to standardize procedures across searches. We believe medical schools and teaching hospitals can learn from the literature on the current state of searches and from the compelling body of evidence that portends major shifts in how academic medicine will need to recruit, develop, and retain its academic and administrative leaders. Recruiting individuals who can enable change, lead teams, drive system improvements, and facilitate high-performing cultures is and will continue to be critical for AHCs to fulfill their missions of improved health.

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References