Assoc. of Orthopaedic Chairmen 1990

DEPARTMENT VS. DIVISION STATUS FOR ORTHOPAEDICS

Wayne Akeson, M.D. - There is obviously an imperative about the administrative structure in schools of medicine and in associated fellowship where the structure should facilitate the development of research programs, excellence of teaching and clinical performance within a balance that's healthy for a school of medicine. There are some other things that have come up in recent years, especially accellerating, things about financial stability and ability to adapt to the 90's.

Showed slides. I'm using Shannon's slides from last year. They give a general background and perspective about the universe of departments and divisions. Total US & Canada academic units is something like 201. The US residencies total 165. Totals are from 1990. The department/division breakdown in orthopaedic sections, 59% departments, 70 those with only residencies it's 68% are departments. The non-university dependent residencies have a roughly similar split. In Canada there is only 1 department and 15 divisions. In 1987-89 there were 7 schools from division to department. In 1990 there are 3 new departments. We have a distribution that's about 2/3 department structures at present. Most hospitals that have executive committee representative, orthopaedics is a department through its ability to fill beds, its need for operating rooms, its influence on the bottom line, which hospital administrators recognize first and foremost. The impact of orthopaedic clinical activity is clearly evident in some of this.

We have a panel that will discuss this issue of Department vs. Division Status in Orthopaedics and then we will open the floor to questions. I would like to make a few preliminary points. Mostly general surgeons run chairmanships of departments. Among that are 2 groups. 1) Call them General Surgicus? Dispaticus?, kind of the general surgeon. He has the old time philosophy of general surgery. He has some conflict with what his goals are for his department and his goals for the general surgery division which he heads simultaneously. 2) General Surgicus? Deninicus? who are of a different character, easy to work under. They have fewer committees to be on and fewer school of medicine obligations. They don't have access to teaching time. Coloration that one comes away

with depends quite clearly on ones own individual experience. We will see a reflection of those diverse points of view today. The change from division to department is quite a torture process. It takes much hammering of collecting data, meeting with committees, getting rejections, trying to counter the rejections, trying to get out of the department; enough even if you have extensive support.

Herbert Kaufer, M.D., Chairman at Kentucky - My assignment is to speak in favor of divisional status. Showed slides. The background on this, this is Wayne's data, of 118 US medical schools in 1986, 57% of orthopaedic units were departments and January 1990 it was 63%. There has been a gradual trend in this. This is the basic issue, that orthopaedics is a unit in a complex administrative structure. The orthopaedic unit will either relate directly to a dean or relate directly to a department chair. Now the perception is that the seat of real power is here, the Dean's office, rather than the department chair. Its better to deal directly with the seat of power than to deal with an intermediary. What has happened in some institutes is that orthopaedics has been granted the department status but in name only. Instead of the orthopaedic division chief dealing the department head who deals with the Dean, the orthopaedic department now speaks to an Associate Dean for Surgical Affairs. There is still a buffer layer between the orthopaedist and seat of power. If, indeed, orthopaedic department chairman can deal directly with the seat of power then certainly departmental status is a distinct advantage. But if you have this other layer of administrative filter between you and the seat of power, then there is no difference between division and department status. That's one issue.

If you are going to deal with the dean, the dean is a character who frequently has considerable power. His background is usually this: pathology, internal medicine, biochemistry, the Dean is relatively infrequently a surgeon and less frequently an orthopaedist. So if you are dealing with a Dean he is like not to be a kindred soul and he may have difficulty understanding those things that are near and dear to your heart. Whereas if you are an orthopaedic chief dealing with a surgery department head, then you are dealing with a surgeon, he will be a more sympathetic ear. This information

isn't firm, but another difference is that it's obvious that the longevity of the office of the surgery department chairs is much greater than deans. That may be good or bad. If you are relating to a dean and can't get along and you hate him, then this short life expectancy is very good. If the administrative superior you are dealing with has got an extended life expectancy, if your relationship is good, that's very favorable, if it's poor that's a bummer. Whether or not this is good or bad depends on the relationship with the individual, but it is a clear and distinct difference between you and folks you are dealing with.

In this big complex administrative structure called medical schools, if the organization is that of the traditional monolithic surgery department where the brotherhood of the blades, so to speak, all the surgeons are together, that makes a very powerful group. They are powerful in terms of personality, clinical revenues, clinical activities, numbers of beds they keep occupied and so on. If this is a picture of your institution, the monolithic surgical department is almost certain to make an influence on the medical administrative hierarchy more strongly than a monolithic medicine department, and so the tilt of that institution is more likely to be favorable to surgery than it is to medicine. On the other hand, if the surgery departments are fragmented and each of the surgical specialties is its own department, generally that does not happen in medicine departments. Medicine departments are more likely to remain monolithic. If this is the model of your medical school you will find that the medical school administrative hierarchy will be tilted in a direction favorable to medicine. I have noticed this in Kentucky where there is a traditional monolithic surgery department, ENT is part of the surgery department. The surgery department at my institution rules the roost. We want more anesthesia people, they materialize. More OR nurses, we get them. Quite different from the situation in Ann Arbor where the power of the medicine department overrules the power of the surgery department.

Even if surgery stays as a unified whole and it's just orthopaedics that comes out as a separate department, then once again I think that the likelihood that the orthopaedic department can have any

where near the influence on the medical school hierarchy that the large surgery department can is very unlikely.

Let's look at the differences. Division pays a dean's tax and department tax. The department pays a dean's tax. In this comparison the plus is on the side of the department.

If you are a division, it turns out that stronger divisions will support weaker divisions. If you are a department, it turns out that strong departments will wind up in a medical school supporting weaker departments. I think this is probably a wash, in terms of your dollars going to support someone else who is less affluent than you, whether you are called division or department it will happen to you any how.

As far as divisions: If the division chief has a problem with the dean or the dean's office or upper level of administration, a division chief finds that he rarely can turn to a formal appeals process to address a grievance. Not so for department chairmen. Department chairmen will almost always have an ingrained formal appeals process. It may be fruitless to go through that process, but at least it exists. In this comparison the plus goes on the side of departmental status.

If you are a division you clearly have less committee opportunity, so you may not have has much exposure to medical students as you would like because divisions don't get on curriculum committees and departments do. On the other hand, the department has greater committee obligations,which is not always positive. In the balance this winds up as a plus on the side of department status. Because the influence you have through committee participation probably more than compensates for the obligation, personnel and time.

If you add those up, it sounds like it is better to be a department. What are the advantages for divisional status? Well there is less committee obligation and that saves you manpower, hours and effort. Depending upon the department that you're in, you can in fact receive departmental benefits and services and I do. The surgery department of which I am a unit, for example,

employees 2 full-time educational Ph.D.s to help with the educational program. They organize curricula, coordinate examination procedures, and so on. If I were an independent orthopaedic department I doubt very much that I could afford 2 Ph.D.s in education to help with my program. We have a very vigorous editorial office with word processing capabilities, art department, photographic department, and so on, as well as research facilities, for instance, a departmental common tissue culture laboratory, which is 1st rate with ongoing studies. This is a resource I can draw on as part of the department. The fact that one can receive departmental services cannot be ignored. And the other point I mentioned earlier, is that as part of a very powerful department one has a potential for more institutional clout, than if you were an independent orthopaedic unit.

Finally, whether you call yourself a division or a department, the key ingredient, the foundation you need for success, as an orthopaedic unit is fiscal autonomy. You can have that with either title, or you cannot have that with either title. That's a degree of fiscal autonomy that let's you run your affairs, is really the key ingredient, and that's not quite that same as the title.

Victoria Masear, M.D., Chairman at the University of Alabama - I'm not here to defend either side, but I think it needs to be looked at individually in each program. At our institution we are a division. I don't think divisional status is always bad. Let me give a little background about our institution. Four years ago our director of the orthopaedic division resigned. This started a letter writing campaign, started by his residents, that stretched across the country, resulting in blackballing the chairman of the department of surgery, saying that he was inhibiting the progress of orthopaedics. It was felt that we ought to be a department. It seemed that everyone agreed with this without really asking why. It resulted in difficulty in hiring a divisional director. When people were contacted they said, "Make it a department and I'll come." No one would come and consider the position. I was offered the position, not really seeking it, but felt we needed a director and the program wasn't going anywhere without one. The primary reason for becoming a department in any institution is controlling

your own finances. We at UAB have complete control of our own finances. The reasons for not becoming a department at our institution are both political and economic.

Politically, we have an executive board; we work for what's called a Health Services Foundation, rather than working directly for the University. On the Executive Committee is 5 members; one of which is the Chairman of the Department of Surgery; one is the Chairman of the Department of Medicine; and then there are 3 members-at-large who rotate every 3 years from 18 other departments. If orthopaedics was a department they would be represented 1 out of 6 years. It would also be a much smaller department than surgery or medicine, and basically no one listens to small departments as we all know. Also, do you want to deal with your Department of Surgery Chairman or with your Dean. I'd much rather deal with the Chairman of the Department of Surgery, who has a vested interest in us becoming more important and larger, and he gives us support. The Dean basically has no time. He doesn't want orthopaedics to be a department because he doesn't want to have another person he has to talk to. What advantage is it to be a department if the Dean doesn't want to talk to you?

The second reason is financial. Financially, we are much better off. I've heard some Departments of Orthopaedics say they pay as much as 18% on billing and administration, we pay only 3.5%. We pay 1% to the Department of Surgery Chairman's fund, we pay nothing to the Dean, so our total financial obligation is 4.5%. I don't know any department that can beat that.

The only reason I can see for becoming a department is that we are having difficulty recruiting because of national attitude. Even though we now have a permanent director, it's still difficult to recruit, because one of their 1st questions is are you a division or a department. If you are a division they don't want to hear anything.

Currently we are having a conflict between medicine and surgery. We are in the process of building a new clinic. Both medicine and surgery are paying the same amount. Medicine thinks that surgery

should pay more because they make more. But the Department of Surgery won and the percentage being paid remains equal as to who pays what. Medicine didn't like this and are now trying to hurt the Surgery Department. They fired the surgical administrator because he was making more money than the University President. Now they are trying to split up the various divisions from the Department of Surgery. They are pushing to make orthopaedics a department. They want surgery divided.

In our institution we are better off being a division, because we have complete control of our finances. I think that each situation has to be looked at individually.

Vert Mooney, M.D. - I will approach this from the standpoint that department is better, and I think that's justified by the figures. The question is, do you want more power or less, or do you want more resources or less? I think departmental status has that. I am not aware of any division which became a department who lost power and resources, but gained power and resources in that regard. Reflected in the trend of today, there are 85 departments, and 46 divisions from my count.

Div. to - Department

When I applied to the Job at Univ. of TX, Southwestern in Dallas, in 1977, I had not had any previous full-time academic experience. I came in with a strong hand, with negotiating room, but didn't feel comfortable enough to fight the political wars and accepted the division. Things went along alright until it came down to the right time to make a change. Strategy is important in this game. At the time, the University was building a new hospital and they needed to fill that hospital. It was time for some good negotiating. Also having help along the way is important. Many of the candidates turned them down when they heard it was going to be division instead of a department. Many of the people in this conflict have since left. My predecessor, Dr. Bucholz, came in with a politically weak hand in that he was the home boy. Most organizations want to bring in new blood. Nonetheless, with those pressures to fill a new hospital and to achieve a greater level of fiscal and economic autonomy, it was a good time for pressure to change things. That's the advantage of the first switch from a

division to a department. You do have the opportunity to get things right, at least from your perspective, maybe not from the institution or university's perspective. You need to be sure your own machine is working smoothly before you worry about the machine of the institution as a whole. You would be better ~~about~~ able to help the institution when you're a strong department and have more control fiscally. Even if you feel that you have fiscal autonomy, which I did as a division, still there were a lot of things that happened that I didn't know about. For example, the State of Texas was giving the Division of Orthopaedics, $25,000 a year which I never saw because it was drifting out to departmental status.

In my mind, no doubt, department status is better. I'm certainly pleased to be at the new department at UCSD. My most recent past location UCI is about to bounce into departmental status. I think things are going to work out very well for orthopaedics academically.

Robert Bucholz, M.D. - I don't think I was asked to speak because of my background. I don't have the global perspective the previous speakers had on the relative merits of division vs department status. Rather I have a very personal, local perspective. The Section of Orthopaedic Surgery at the University of Texas, Southwestern, ~~where~~ which Vert left about 3 years ago, remained a division for 1-1/2 years. During this rather lengthy search, we went through 2 different search committees until finally I was appointed about 2 years ago. Since that time having departmental status has made a world of difference. Rather than going over theoretical advantages and disadvantages, with all due respect to Dr. Kaufer and Masear, let me just briefly itemize for you what were the real benefits for becoming a department.

I view a department chairman as a middle manager, and as a middle manager there are 3 important things. They are money, space and people. When I took over the department, the division at the time had only several hundred thousand dollars in hard state money a year. Some of these funds never got into our hands, which Vert alluded to. In addition, we were subsidizing our community

hospital, Parkland Hospital, about $100,000 to $150,000 a year, to pay the premiums for our resident malpractice insurance.

Now the changes that occurred were rather dramatic. We doubled immediately our hard state money. Parkland Hospital assumed the responsibility for the resident malpractice. Now we have $600,000 a year in faculty salary support. That represents an annual aggregate of more than $1,000,000 million dollars a year in non-dean taxed income. Which as you all know is a very important source of funding. In addition, we have established in the last year, a $1,000,000 dollar distinguished chair for orthopaedics. We're working on our second million dollar distinguished chair. We've doubled our practice income because we've had the opportunity of taking over the billing and collections from the Department of Surgery so that we have those individuals directly responsible to the Orthopaedic Department rather than to the General Surgery Department. In addition, because we are now a department, we are the source of benefactor funds that are directed toward the university, indeed, largely due to some of the work that Vert had done before he left. We were just given a $6,000,000 dollar grant for the creation of a musculoskeletal rehab unit at our school. So, in terms of money, it's like night and day.

In terms of space, we were able to take over immediately, all of the office space for cardia thoracic surgery; we were just awarded 15-20,000 sq. ft. new clinic space for the bone and joint institute. We increased our OR time 50%, and the new University Hospital, neurosurgery, which is another strong independent surgical department and orthopaedics were each allotted 1/2 of one floor. The two small surgical groups had the same amount of space as all the other surgical specialties.

In terms of people, when I took over the department in 1988, we had 7 individuals in the division. It's been very easy to recruit because of the increased salaries that I have been able to arrange through the university, ~~to recruit~~. We have 6 new faculty in two years. I have 4 more positions posted. We have state funding now for Ph.D. positioning which we didn't have as a division.

More importantly, as soon as I became a department chairman, I was placed on the search committee for the new Dean, who would be my boss. I found that once we identified that individual, we were able to get an internist from Philadelphia to come and fill that position, who very much looks favorably upon orthopaedics, because of his good experience at Thomas Jefferson. He has been very cooperative and helpful in developing the orthopaedic department. We now have a direct line of communication with the powers to be, what we call the tower at our institution, and I'm on the phone talking directly to the Dean or President every week.

I really attribute these changes not to myself but to the fact that we were able to get that departmental status. There 2 other divisions of the surgery department, who in that interim period obtained new chairmen, pediatric & plastic surgery and I can tell you that none of them that stayed in the division had a significant increase in their resources. In my opinion, there is no down side to becoming a department, and I think the numbers are more convincing than any argument that would be presented. I think the real issue in this whole topic is not whether one is more desirable than the other, I think clearly departmental status is more desirable, but if you don't have it, how do you get it? I hope that will be the focus of the discussion period.

C. McCollister Evarts, M.D., Senior Vice President & Dean of Medical Affairs, College of Medicine at Hershey - There are not a lot of orthopaedic deans as you well know. This isn't necessarily appropriate, I think there should be more. I began my academic career at the Cleveland Clinic where the arrangement there was a large division of surgery with departmental status for all the surgical specialties. When I went to Rochester, I was one of those people who said I would not be interested in the position unless it became a department. That was in 1974; now I've assumed a different role. I am not only responsible for the hospital, but the college of medicine. It is a busy role, but on the other hand it gives a perspective, and I would say that I've exceeded the half life of 3-1/2 years.

Dr. Evart showed some slides. It concerns me a bit listening here that I didn't hear much said about education or research. Somehow we have gotten to a point where there is a tremendous focus on finances. You've heard how some deans view the origin of new departments. You may find that from the dean's viewpoint that there is a disadvantage in having a large number of departments. I would submit that's not the issue at all. The issue is not the number of departments but rather the quality.

How do you distinguish quality? And how does a dean, school or institution approach the creation of a department from a division? Let me show you how we how approached this in all 3 of the centers I've had the opportunity of serving. There has been an evolutionary process in orthopaedics. Orthopaedics has evolved from a subspecialty within general surgery to a status as a discipline in the field of medicine. When you look at the definition of orthopaedics as discipline it comes out something like this. It is indeed the medical specialty that includes the preservation, investigation and so forth. It should say to all of you that you are more than just a surgeon. You are indeed someone who approaches the musculoskeletal system with a fairly broad perspective. You're interested in not only getting into the operating room and doing those things, but rather you're interested in the patient with a musculoskeletal disorder, including things like restoration, deform and function of the spine by surgical and physical methods; and as you know, in many centers the Department of Physical Therapy and Rehabilitation is part of this musculoskeletal unit.

As orthopaedics has emerged as a discipline, then I think there has been a cry for more departmental status or more status within the institution. In Some institutions, I suspect, status depends on the financial power behind that particular unit. On the other hand, if some of you would stop to think, there are many, many departments that are less leaders within the college of medicine. Finances aren't the driving force for at least the administration for the creation of a department. If you see this cartoon also, you'll understand, that's where orthopaedics has come.

What are some of the criteria? I've mentioned about the fact that there has to be encompassable body of knowledge that involves that particular area. There must be knowledge that extends and crosses departmental lines. Think about the amount of knowledge we have in orthopaedics about rehabilitation, about endocrinology in certain areas, about rheumatology, about pediatrics. It's a broad encompassing thing, this musculoskeletal system. And of course, there is a well-established specialty board, and I think we can be rightfully proud of the role we played early on in education in this country.

What are some of the other criteria? I submit that you not only need to deliver patient care, but there must be a balance in academic department of orthopaedics between patient care, research and education. I would also submit that you cannot forget the fact that the reason you are in an academic center is to provide education not only for the medical student but also for the resident or whoever else may come in contact with you. And I would also encourage you to think about your role in the education of the family and community physician individual who will be the front line of defense and needs the expertise of how to at least analyze the musculoskeletal system to go out into practice in some of the areas they are called to do. So there requires a body of ability, and either patient care so you can occupy that 1/2 of the floor, or whatever it is.

But where have we been as far as research has been in the field of orthopaedics? I've said this from a national format 2 or 3 times and I would say it again. If you want to hold your own in an academic medical center, having a lot of money and being a busy patient care service is not going to hold your own with some of the classic individuals doing cell molecular biology and coming close to winning nobel prizes, in a large department of medicine with a huge basis of research.

You must remember who you are there. You are there to do patient care, research and education. The education of a surgeon is a very important thing, but I would submit that the education of the surgeon has to be fed by all of the specialists involved in surgery

from the orthopaedic standpoint. There has to be some way of providing a core of education to the medical student which not only involves orthopaedics but the other specialty parts of surgery and gives that person a sense of surgery as a broad discipline.

Finally, what does a dean look at as far as becoming a department? You're going to look at innovative programs that are going to contribute to the growth of the institution. I don't necessarily mean financial growth. But, of course, it is the job of dean to worry about the financial growth. You are looking for programs both in research and in education and in patient care that will contribute to the growth of that institution. I really think that's a very important point. Also, you don't want to focus on this personality business too much, because if you say well you're going to relate better to a departmental chair who knows surgery, I have 18 or so departments and I am not a molecular biologist or genetist? or anything else, but I have to relate to all of those equally well. I don't think that's a particularly good argument.

You've heard all the advantages, and there are true advantages for departmental status. They have to do with patient care, education including a development of a curriculum, working their discipline with other departments, looking at graduate and post-graduate education. It also has to do with research and the funding of research and fund raising and certainly space. Although, remember, most deans are in the business of succeeding not in failing. And to succeed you create strong units and strong departments and provide space and as much money as you can for the success of whatever unit you are dealing with.

And the administration, as far as institutional impact, you will be put on more committees, most likely, and you will have direct access to the dean. On the other hand, depending upon the personality you might have less direct access to the dean. I see the disadvantages of a department mostly in the fact that departments such as ear, nose & throat and orthopaedics and neurosurgery become fiercely independent; have forgotten there surgical heritage; don't want anything to do with the basic roots from which they came; and so they get fragmented and they're out

there doing everything alone. I'm not sure, looking out in this audience, that there are not many who are really very skilled in fluid electrolyte balance. And I'm not sure there are too many out there qualified to educate the young student or house officer in some of the basics of surgery. We are certainly very good at what we do, but I think that you need more than that in this education core of experience that I would speak too.

What are some of the solutions? I'm not certain there are any easy solutions and I think Victoria mentioned that this is an individual situation. It certainly is, but certainly looking at the list of divisions, some of those divisions could meet the criteria for becoming a department, some of them cannot meet the criteria as I've outlined or any dean might outline or a panel of your peers within the institution might outline. Because those are the people who will end up making the decision. You're going to have to get the support of some of your peers to have this accomplished.

You really want to prevent this fragmentation of surgery and of orthopaedics. You don't really want surgery to fragment any more than it already has, despite the people that lead general surgery departments. You really need to maintain an educational experience that's common to surgery as a broad discipline. There needs to be a coordination of patient care programs. You can't run a very good orthopaedic department if you are not coordinated with endocrinology, rheumatology, pediatrics and so on. The same thing involves research. Most institutions can't let you develop a major institute of research as a department of orthopaedics. There are a few that have been successful. But the future doesn't bring that in research. The future of research is your interdisciplinary reactivity or the ability to attract people, and you'll be attracted to other people doing research in areas that are not purely musculoskeletal. Or if they are, you'll bring in expertise that you do not have.

There is something to be said about centralization of administrative services. If you can centralize the administrative services and have them truly deliver, then I think that's probably an advantage.

If you look at Atilla the Hun, there are many good sayings for the leader. One of them is: this is what we look for, from the administration for someone who is going to assume departmental status. You're really looking for someone who has moved through successive layers of responsibility, for the most part. Also, my word of caution to all of you, for another "Atillism" is that most dean's offices cannot be taken by storm but rather by sugar coating and sweetness and all those things I see from my faculty day in and day out.

So can you have something called a section of division of surgical sciences? Well, maybe you can, depending upon the guidelines. And the guidelines are: a direct reporting relationship to the dean and financial responsibility with a direct relationship between the dean and the person who is the Chair of the Department of Orthopaedics. So the director of this overall unit has to be someone who will be chosen not on the basis of the fact that they were a general surgeon, but on the basis of their leadership skills and their knowledge of surgery, that could be anyone of the surgical specialists to sit in this position. The position could provide a review and coordination of patient care, education and research and provide administrative services. At any rate that's a possible solution.

Showed a slide and made comparison with a picture of a Greek god who was to push a rock uphill for all eternity. I think orthopaedics is capable of doing this sort of thing, it has been proven and it has occurred in many centers. I would end on an encouraging note that this god outwitted death and in that process lived happily ever after.

Dr. Akeson introduced Dr. Petersdorf with a distinguished introduction, listing his accomplishments and positions he's held and thanked him for agreeing to take time from his hectic schedule to come and speak to us.

Robert Petersdorf, M.D., AAMC - I think the half-life of a dean is five years. I was a chairman of a monolithic medicine department,

mine still had dermatology and urology in them. It's still a monolithic department because the dean thinks it's going to cost him too much money to make them separate departments. This issue of department vs. division and whether or not you're going to take a job, whether you're going to be a department chair or a division head, is not unique to orthopaedics. On the surgical side departmental status is coveted by your colleagues in neurosurgery, urology, ENT, and sometimes in plastic and cardiac surgery.

Let me give you a little history. This movement really began with ophthamology which used to be part of surgery. When I came to UCSD as dean we were in the process of searching for our first chairman of Ophthalmology. Before this, anesthesiology was also part of the department of surgery. In medicine the arguments were around urology and dermatology both of which have achieved departmental status. In many schools there are a few departments of oncology which I don't think have been very heavy creations, cardiologists in a few institutions are flexing their muscles talking about departmental status. In some institutions they make even more money than you do.

According to the 1991 Directory of American Medical Education, there are 126 accredited American medical schools. 72 have departments of orthopaedics and 40 have divisions and 14 don't mention orthopaedics at all. I assume that these 14 don't have departments. That makes the score 72 to 54. Also the trend has been in the direction of departmental status. Five years ago, in 1986-87, using the same denominator, there were 67 departments and 60 divisions, and 10 years ago there were 56 departments and 59 division. I predict that by the 2030 there will be only departments, but for your sake, I hope you won't have this as an item on the agenda every year.

Why does one want to have a Department of Orthopaedics? If we look at the function of a group of faculty in orthopaedics in terms of departmental and divisional status you can analyze such a group along functional terms. I suspect that the medical school teaching load would be the same. The quantity or quality of research would be no different whether you are a department or division. There

may be space differences as Dr. Bucholz mentioned. I'm not aware of any study section that counts whether one is a department or division in its priorities.

With respect to patient care, you are already the darlings of most hospital administrators. You fill your beds; you do a lot of clinical work; you fill the operating rooms; you usually need more; and you require new clinical facilities. The hospital directors are almost uniformly happy with the orthopaedic units. When it comes to graduate training, all I can say is when you're hot you're hot and orthopaedic programs are hot. I don't think the applicants care whether they are applying to a department or division, they look at it as applying to a residency program.

The biggest differences are probably on the administrative side and we've discussed this. If you are a department chair you will likely have to attend more meetings. You would undoubtly be appointed to more committees if you are a department chair. You are likely to have more access to the dean, but I wonder, having been a dean, whether or not that's of great value. I don't think you would have more or less access to the hospital director, whether you are a department chair or division head. The issue of finances, you have talked about it. You will surely have to pay a tax. If you're a division you will have to bail out those departments of surgery in the division that are not doing so well, and if you're a department you will have to bail out the departments of pediatrics and family medicine who might not be doing terribly well. If you keep fiscal autonomy, I agree with the speaker from Alabama, that with fiscal autonomy it doesn't make that much difference.

The question of autonomy in the generic sense is also important. The good Chairman of Surgery will give you the kind of autonomy you need whether you are a part of that department or not. Accountability and longevity favors being a division head. Most division heads are almost never reviewed, and stay on forever. And surgical chairmen are being chipped away with 5-10 year reviews. The turnover is almost as great as among the deans.

Now, will you have greater influence as a department chair or as a division head? I'm not sure whether a combined department of surgery or whether a fragmented one consisting of small departments if the small department chairs are able. I have seen strong active chairs and ones that were not influential. I have never seen "block-bolting" among separate surgical departments. As the Chairman of Medicine, I was not concerned that they would suddenly gang up on the rest of us that were not surgeons. If you have a good colleagical group that won't happen.

Then there is the issue of prestige. Only you could answer that one for yourself. I have found over the years, that whether you are a division head or a department chair or dean or vice president, we all put our pants on one leg at a time. Whether you are perceived as being more prestigious as a department chair or division head, I can't tell. It certainly seems to be the aura, as mentioned by others, that when recruiting for the position they must have a department. For most of my tenure as chair, orthopaedics was a department, with one chair very influential and with another less so. When I was a hospital CEO, the thing that what mattered most with me was my interaction with the head of orthopaedics as the orthopaedist and chief of the hospital. With respect to Dr. Mankin, I didn't really care whether that person was chairman by Harvard status or not. He was the orthopaedist and chief of my hospital, and we had to negotiate about beds, clinic, space, house staff positions, and resources that the hospital would contribute and academic considerations mattered much less. As dean I would have had slightly more contact with the chairman of our panel, if he had a department, but we had plenty of contact, and it was always very pleasant. I think, again, in general in depends upon the individual who holds the post.

Finally, is orthopaedics adequately represented by general surgery? In other words, do combined departments do better? I don't know. If they are run by a good chairman who will leave orthopaedics alone and who will represent all of his surgical divisions, then the Division of Orthopaedics will thrive. If he cares only about general surgery, and some of them do, then there is good reason for departmental status. You have to ask yourselves whether you ought

to become chairs of combined departments of surgery. I wouldn't touch that one these days. Think of how little surgery has done for peptic ulcer disease, for gastric cancer and perioscopic gall bladder surgery has revolutionized that bread and butter surgical procedure. And when the urologists have to make a living in the face of the five alpha reductus? inhibitis? they're going to shrink all of our prostrates. They're going to have a tough time justifying their relatively large training programs. Should you aspire to become future deans, as far as I know, 2 of you are deans and vice presidents. You heard from one, K. Clawson is the other, with Akeson it was a near miss. There are some very good and talented administrative people among you, and I personally hope that there will be more deans coming from the ranks of orthopaedics as the years go by.

Where do I come down on this issue? I suppose on balance I favor departmental status, but the margin is not as large as some of you might indicate. Whether or not you want to be a department chair or division head, depends a good deal on your personality. Chairs are more visible, perhaps more prestigious and probably more hassled. Division heads are more likely to keep a lower profile and to do their own thing. Ultimately, what you choose to do is a matter of your own taste. Orthopaedics in 1991 is such an attractive specialty, that whether you are a department or division you're sure to be a winner.

There was a period of comments and questions from the floor answered by the panel.
After this Dr. Akeson thanked everyone for participating and special thanks was given to Drs. Evarts and Petersdorf.
Dr. Herndon then made some announcements on the committee meetings.