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PERSPECTIVES

Evolution of the Departmental Chair in US Academic Medical Institutions: A Descriptive Appraisal

Anish Bhardwaj

Department of Neurology, University of Texas Medical Branch (UTMB), Galveston, TX, USA

Correspondence: Anish Bhardwaj, Department of Neurology, University of Texas Medical Branch (UTMB), 9.128 John Sealy Annex, Route 0539, 301 University Blvd, Galveston, TX, 77554, USA, Tel +1-409-772-8068, Email anbhardw@UTMB.EDU

Abstract: The strength of Academic Medical Institutions (AMIs) is founded on their academic departments, both clinical and basic science. The evolving role of the departmental chair is dictated by multitude of influences including the tectonic changes in the terrain of US healthcare and academic medicine with wanning revenue sources, complexity of administrative constructs in AMIs, situational needs, and regional competitive market trends. These subtleties underscore the importance of rigorous screening and recruitment of a departmental chair whose stance will be congruent with an AMI's mission, vision, values in alignment with the institutional leadership, in addition to possessing the requisite professional qualifications and personal attributes. Success of a departmental chair is determined by meeting expectations as a manager, leader, and scholar with performance metrics for the role against benchmarks in specific domains of academic medicine. This descriptive treatise expounds on the important implications of numerous elements and anticipated challenges contributing to the inexorable evolution of the departmental chair's role in US AMIs.

Keywords: Academic Medical Institutions, chair, leadership, scholar, manager, department

Introduction

The strength of US Academic Medical Institutions (AMIs) is firmly grounded in their clinical and basic science academic departments. The crucial academic position of a departmental chair in an AMI requires an unremitting focus of attention on unique obligations and professional relationships.[1,2] Frequently, there is minimal formal preparation for the role and the position can be fraught with significant hazards and challenges.[1–3] For comprehending and embracing the necessary evolution of departmental chairs over the past two decades, it is critical to appraise the myriad factors influencing AMIs contextually including the incessantly shifting landscape of US healthcare and academic medicine with constricting revenue streams, increasingly prohibitive costs, challenges with accreditation and certifications, and a shifting workforce.[3–6] Additionally, it is critical to grasp the complexity of governance structures with inexact lines of authority in AMIs, situational organizational needs, and environmental pressures including regional market competition that necessitates selecting and recruiting an appropriate candidate with meritorious accomplishments and leadership attributes.[7–9] Following recruitment of the departmental chair, allocating appropriate resources, providing ongoing coaching and mentorship, and having well-articulated expectations with Key Performance Indicators (KPIs) are critical to ensuring the selected chair's enduring success in the role for the sake of the department and of the AMI.[2]

The Evolving Topography of US Academic Medicine and AMIs

While the US healthcare system is undergoing tectonic changes,[3,4] the overarching goals of AMIs play a key role in maintaining their mission of excellence in clinical care, education, and training (undergraduate, graduate, and post-graduate), and research. Essential to these missions is incessant acquisition of knowledge in a journey of improvement, innovation, and mentoring and developing the next cohort of clinicians, educators, scientists, and scholars. To these traditional missions for AMIs, community involvement, diversity and inclusion have recently been added. Myriad influences herald a rapidly changing terrain of US academic medicine. Firstly, health-care costs in the US are growing

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exponentially (~19% of gross national product)[4,5] with profound ramifications, and placing enormous strain on myriad stakeholders (patients and the public, health-care providers, government, AMIs, and the economy in general). Growing administrative costs (~30% of all US healthcare costs) and ever-dwindling reimbursements by third-party payers (ie, Medicare, Medicaid, and commercial payers) for clinical care also play a major role.[4,5] Present revenue streams for AMIs include clinical service, research grants from federal and state sources, organizations, and philanthropy (ie, gifts and endowments), tuition dues, and state support. Of these, clinical revenue is the most rapidly growing, robust, and pliable revenue source for AMIs and denotes the major allotment of cross-subsidy toward accomplishing an AMI's other missions. However, for most AMIs, the contribution margin from clinical revenue is negligible at best due to mounting costs. Secondly, research programs funded principally by the National Institutes of Health (NIH) are precipitously contracting due to both the federal budget deficit and a turbulent political climate that poses an unclear future for this revenue stream. The NIH salary limit necessitates cost-sharing by AMIs to support the research faculty compensation that surpasses this cap. Furthermore, issues related to indirect cost recovery (facilities and administration) such as developing and maintaining research programs (eg, protected time for clinical faculty, unfunded and bridge funding, supporting core facilities). In the past, allocation of state funds and tuition have supported the core educational mission of medical schools for state AMIs with accompanying costs related to administrative functions and infrastructure.[4,5] State budget deficits have resulted in reduced support to AMIs financed by public and state universities over the past two decades. Therefore, the clinical revenue stream alone is now insufficient as a cross-subsidy for non-revenue generating education and teaching missions and cannot circumvent gaps in funding for research programs. Consequently, faculty are under ever-increasing pressure to support their own salaries via research funding and clinical activities.[3,4] For this reason, AMIs are increasingly becoming like community hospitals where the emphasis for clinicians is augmenting contribution margin through enhanced clinical activity.

Thirdly, the wide gamut of administrative and organizational structures in US AMIs are frequently siloed, which has been characterized as the "corporatization" of academic medicine.[7,8] Professional and financial partnerships between the medical school in an AMI and its clinical enterprise (hospital and ambulatory services) are also highly varied.[8] However, each medical school has an executive dean responsible for faculty and for undergraduate, graduate, postgraduate fellowship medical education and training. Faculty group practice is frequently a collaborative entity between the clinical enterprise and the medical school.[8] Funds-flow methodology is also heterogenous with contractual agreements between the clinical enterprise and medical school. The dean of the medical school typically reports to the provost or directly to the university president, who in turn is accountable to the AMI's board and to the university chancellor. Chairs of clinical departments typically have had dual reporting to the dean and to a designated senior leader within the clinical enterprise, which is the largest revenue generator, and the most powerful entity in this complex matrix of governance architecture.[8] Against that backdrop, this treatise expounds on the important implications for increasing complexity of US AMIs and ensuing transformation of their departmental chairs.

Departmental Chair Recruitment and Appointment Process

An AMI's prowess is grounded in the bedrock of its academic departments. Depending on size, there are as few as eight and as many as twenty-five departments (clinical and basic sciences) in an AMI. In the milieu of such variability, recruiting a departmental chair with the suitable "cultural compatibility" in its leadership team is critical.[7] The slate of vetted possible aspirants is often from a group of highly proficient academics who have typically excelled in more than one domain of academic medicine (clinical, education, research) and who have merited a national or international reputation in their field(s) of expertise. Characterizations such as "triple threat" (ie, excellent clinician, educator, and researcher) and "quadruple threat" (additionally being an excellent administrator) have been posited to highlight professional attributes and accomplishments for a potential departmental chair (Figure 1). Business acumen has also become highly desirable for the role of managing the department in the larger context of the AMI's budget. The archetypal M.D. or M.D./Ph.D. scholar has evolved to embrace a track record of management and leadership experience with added qualifications of Master of Business Administration (MBA), or Master of Health Administration (MHA), Fellow of the *American College of Healthcare Executives* (FACHE), and Fellow of *American College of Medical Practice Executives* (FACMPE). Frequently, an AMI's situational needs and strategic goals may influence selection of

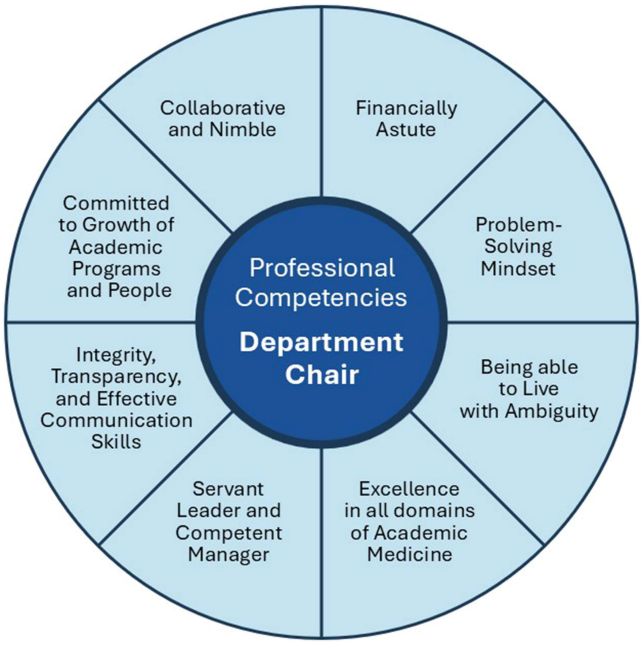

Figure 1 Professional Competencies necessary for a Departmental Chair.

suitable candidates for the role of departmental chair ("Situational Leadership"). Academic prowess and achievement are essential for departmental chairs in AMIs and merit appointments as Associate Professor or Professor with tenure commensurate with the AMI's *Appointment, Promotion*, and *Tenure* guidelines and due process. Of course, such a record of academic accomplishment does not guarantee leadership ability.[7,9]

For an AMI's departmental chair to be successful, there must be alignment in two major spheres: 1) possessing the abilities required for the position and job prerequisites, and 2) avowing and upholding the AMI's values ("cultural fit").[7] Both are equally obligatory. Conventional attributes of academic success include intellectual aptitude, recognition, and reputation in a focused and defined area of expertise, and high self-motivation with an emphasis on individual accomplishment and success. Prudence is recommended, however, that such a profile of sustained success does not support the Peter Principle (ie, "Everyone rises to their level of incompetence") in the evaluative process.[2] More recently, there has been a shift toward candidates of greater erudition and with a holistic view of academic medicine and institutional mindedness, along with a mentoring, nurturing, and problem-solving mindset as valuable attributes for a departmental chair.[7,10–13] Additional leadership attributes such as high emotional intelligence, fortitude, empathy, resilience, listening skills, loyalty, gratitude, fairness, transparency, embracing diversity and inclusivity, being able to live with ambiguity, and having a collaborative approach can greatly enhance a departmental and AMI's success (Figure 2).[10–14] Abilities related to "people management" are deemed much more important than having individual excellence or successes in the aforementioned domains of academic medicine. It has been shown previously that "trust" is recognized as the most important of all leadership attributes for a departmental chair.[7,15]

Many challenges accompany the screening of candidates. Recruitment of departmental chairs is frequently unsound with poorly conceived search committees that do not amply reflect the AMI's culture congruent with its mission, vision, and values.[7] Professional recruitment firms can provide a more effective screening and selection process.[1] Appointment on the search committee by the dean and institutional leadership that reflects a balanced representation of key constituencies (8–10 members) is critically important, each member being provided with a definitive charge with a disciplined, confidential process with clear metrics and milestones.[7] The interview process with the AMI's key leaders and the department's faculty can be rigorous and protracted over several months. The final candidate's negotiations with the dean and the AMI's leadership must encompass offering a thoughtful recruitment package including resource allocation and succinct commitments commensurate with AMI's expectations, measurable strategic goals, as well as the chair's and departmental faculty

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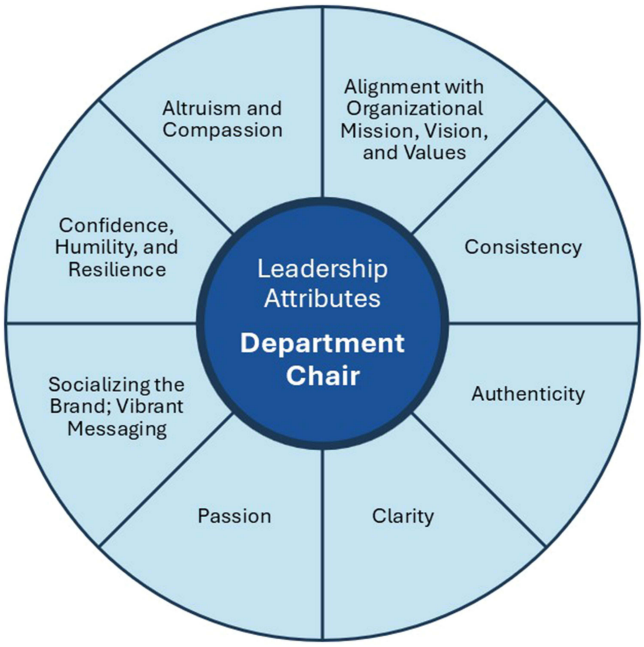

Figure 2 Leadership Attributes for a Departmental Chair.

compensation and incentive plan. Even after recruitment of the departmental chair, there is a learning curve in the position, especially pertaining to the institution's culture which may be different in public versus private AMIs.[2] For the new chair, understanding the predecessor in the position is also critical, especially if he or she is still on the departmental faculty. Indeed, the predecessor may continue to have a loyal following with legacy among faculty and staff members but can also have a stake in the success of the new chair. Giving due respect and seeking advice from the predecessor is an astute strategy.[2] Formal and enduring mentoring or coaching can greatly enhance the success of the chair toward the department's and AMI's being characterized as a "learning organization".[7] In one study, over 60% of departmental chairs responded that a designated mentor would be very helpful, with preferences given to the dean followed by an external executive coach, or a chair of the same department from another AMI in that role.[16]

Numerous AMIs are now resorting to term-limited appointments of 5–10 years with options of re-appointment contingent on performance. Still others have a rotating roster among senior faculty in the department.[17] These new paradigms are a departure from previous appointments where the departmental chairs had longer tenures, occasionally for few decades. For more recent cohorts, the median time for tenure for a departmental chair is approximately 8 years, which has decreased from 10 years for earlier cohorts.[2] A study of internal medicine departments reported the average tenure for chairs dwindled from 5.272 years in the 1970s to 3.997 years in the 2000s.[18] Also, increasingly interim chairs from within the departmental faculty ranks are being appointed for longer periods of time, of whom several assume permanent chair positions with due process.[19] Anecdotal reports (unpublished data) suggest that internal candidates or interim chairs who take on the role at AMIs have far more meager recruitment packages than external candidates. Following the completion of their tenure, many departmental chairs step down to return to their faculty positions, or some may transition into leadership administrative positions within the AMI or other institutions.[2] Interestingly, in one study only 23% of departmental chairs desired to become a dean as a step in their career progression.[16]

Manager, Leader, and Scholar

Commensurate with the evolving terrain of academic medicine, there has been inevitable progression of the departmental chair's roles and responsibilities. It has been suggested that with centralization of governance for better control owing to shrinking revenue streams in AMIs over the past two decades, the role of departmental chair has been branded a "middle management administrative position".[2] In this role the chair serves as an interface between faculty, house staff,

administrative staff, and the dean's office and AMI's leadership.[2] This assertion can be countered however. With increasing complexity of AMIs, the departmental chair of both clinical and basic science departments must encompass and embrace all three roles effectively as manager, leader, and scholar.[1,15]

As *manager* with task-orientation, focus is on setting and meeting budgets, managing revenue streams, meeting quantifiable accreditation standards for educational (undergraduate and graduate) and clinical programs, faculty and staff recruitment, retention, promotions and career development, compensation and incentive plans, staffing levels, resource allocation, ensuring faculty and staff well-being,[6] and oversight of service provisions that are aligned with mission, vision, and short- and long-term institutional goals.[1] It is imperative that the chair collaborate closely with the departmental administrator as a "dyad"[20] to ensure alignment with the AMI's leadership and strategic goals. Nurturing professional relationships with colleague chairs of other departments is critical toward building collaborative programs in all domains of academic medicine and enhancing "institutional mindedness" with a collective purpose. Some AMI's have developed "Service Lines" (eg, neurosciences, cardiovascular medicine, gastrointestinal) with the departmental chair as the lead for a more comprehensive service with budgetary restructuring.

As a *leader*, the chair must articulate a clear departmental vision, mission and values, leading by example, transparency, ensuring accountability, empathetic listening, communicating effectively, seeking feedback from constituents, displaying humility, being skilled at conflict resolution, fostering influence and inspiring others, cultivating a culture of engagement and preventing burnout, managing change, developing professional relationships, and promoting the success of others including succession planning.[7] Leadership styles (autocratic, democratic, transformational, servant, etc) may differ and adopting a multidimensional dynamic ("situational") leadership is highly valuable in varying circumstances and situations without compromising core values.[7] Appointment of faculty in leadership positions within the department (eg, vice chairs, division directors, director of quality improvement, or select fellowship training programs) allows for leadership development and provides opportunities for succession planning. A "distributive model" of leadership with a clear governance model (vice chairs for clinical affairs, research, and division chiefs) with shared responsibility and accountability cultivates the growth and development of future leaders within the department.[15]

Continued contributions as a *scholar* are a formidable challenge for departmental chairs, though typically basic science departmental chairs maintain their research programs and extramural funding. It is not unusual for chairs to feel trapped between the conflicting and exhausting roles of scholar, administrator, manager, faculty developer, and leader. They must address their fiduciary responsibilities and at the same time work to protect their scholarly pursuits. Cumulatively, these create stress and pressures with the position. It is not unusual for chairs to lament and regret the diminution in their scholarly output.[1] Nevertheless, in the spirit of leading their department by example, it is critically important for chair(s) to continue their scholarly pursuits with peer-review publications, presentations at national and international clinical and scientific meetings, service on committees at national societies and forums, and editorial activities. Many chairs eventually suffer burnout from the strain of attempting to be effective administrators, productive scholars, and managing their personal lives.[2]

Performance Metrics

For a departmental chair, it is important to understand the parameters of their evaluations (formal and informal review criteria) and the AMI's criteria for success.[2] Typically, there is an annual evaluation of a departmental chair by the dean. In one study, over 75% of departmental chairs desired more feedback from the dean to improve their job performance, and evaluations from their own departmental faculty.[16] Additionally, in various AMIs there is a rigorous mandatory departmental review (every 5–6 years) by a peer-review committee comprised of internal and external reviewers selected from other AMIs. The peer review of a departmental chair may vary in terms of academic productivity of the department (eg, extramurally funded and pharma-sponsored translational and interdisciplinary research, clinical trials, peer-reviewed publications), clinical service with a multi-specialty, value-based care, and patient-focused teams (ie, patient volume targets, quality and outcomes such as length-of-stay, readmissions, mortality, complications, and patient satisfaction), faculty recruitment, retention and academic promotions, career trajectories for their faculty, mentees and trainees and importantly, productivity (clinical and scholarly output) of each faculty member against benchmarks and the departmental "bottom line" (ie, contribution margin and meeting budgetary targets).[15] Occasionally, there may be a "360-

degree" evaluation for some departmental chairs to identify areas of relative strengths and weaknesses for continuous learning and improvement.[21] Several AMIs have local resources such as access to executive coaching, leadership development and refresher courses and workshops by scientific and professional organizations (eg, *Association of American Medical Colleges*, Harvard University) focused on academic departmental chairs.

Anticipated Challenges

Departmental chairs are presented with predictable but formidable challenges in leading their departments in the AMI.[1,2] It is critical for departmental chairs to be aware of these challenges (Figure 3) and work toward finding pre-emptive solutions.

Financial and Budgetary Constraints

AMIs continually face constricting revenue streams with thin margins that percolate down to various departments and may be a major source of frustration for the chair due to myriad consequences (eg, challenges with recruitment and retention of faculty and staff). This requires close monitoring of budgets and targets and being nimble in meeting departmental goals in the larger context of an AMI's financial state.

Time Constraints and Burnout

With countless meetings, overseeing budgets, managing faculty and staff, and scholarly pursuits, traveling for invited speakerships and committee participation at national forums, as well as fundraising activities, time and effort demands can be overwhelming. Some chairs are more adept at time management, multitasking, and prioritization than others. The inability to keep up with the pace and demands of the position frequently leads to burnout from emotional and physical strain. High burnout rates of up to 84% are reported in department chairs.[2] Countless chairs of clinical departments lament the diminution in their scholarly pursuits and productivity (extramural grants, peer-reviewed publications) with a genuine sense of loss in their academic prowess. Coping mechanisms require delegating duties to other departmental leaders without micromanaging by seeking advice and guidance from an executive coach and the dean and refresher courses on leadership development. A more proximate decision by the departmental chair is if the leadership position is externally- or internally (institutionally)-focused. The balance of the two is paramount. While representing the

Figure 3 Anticipated Challenges for a Departmental Chair.

department and AMI at national and international forums is important as a senior ambassador for the AMI, it is advised that the chair first and foremost cater to the needs of departmental members ("charity begins at home") to maintain high morale by their presence and engaging with effective communication.

Recruitment and Retention of Faculty and Staff

With shortages of clinicians and scholars, and evolving expectations of a workforce of younger generations and lifestyle considerations,[6] recruitment and retention of faculty and staff can be challenged in more competitive markets, particularly in a distributive model of clinical care with multiple hospitals and ambulatory clinics. This may adversely affect meeting departmental missions and their growth in select areas. Utilizing recruitment firms with the AMI's support can circumvent this challenge, although it may significantly add to cost. Investing in retention of trainees on the faculty can yield superior results. With an increasing emphasis on revenue-generating activities focused on clinical productivity with resource constraints (monetary support, laboratory space, protected time for research and teaching), recruitment of clinician-scientist archetype is increasingly becoming difficult and labeled as a "dying breed" leading to further "dilution" of the intended aspirational goals of academic medicine.[7–9,22] Following recruitment and on-boarding, the chair must pay close attention to faculty and staff wellness via open feedback or with anonymous longitudinal surveys to attenuate rates of attrition.[6,21]

Alignment of the Department with the AMI's Vision and Strategic Goals

This involves constant re-evaluation and keeping abreast of the AMI's mission and strategic goals, especially with short tenures with frequent changes in the leadership and governance that have destabilizing downstream and deleterious effects on overall faculty and staff morale.[7] Departmental chairs should actively seek an AMI leadership's changes in strategic vision and communication via periodic meetings, intranet, town hall presentations, and regular face-to-face meetings with the dean. A healthy working relationship with the dean is critical for a departmental chair to be successful and therefore regular, extensive, and transparent communication with the AMI's leadership and with their faculty and staff should be expected, even on topics that may be difficult or awkward.[16,23]

Managing Disruptive Faculty and Conflict Resolution

"People management" skills will help the departmental chair lead the department with reasonable expectations and nurturing a culture of professionalism.[5,15] An algorithmic incremental approach to address recurrent behavioral infractions (insubordination, micro-aggressions, racism, sexual harassment, etc) is needed with escalation to the AMI's *Professionalism Committee* with an appropriate action plan including written reprimand, counseling, probation, or suspension.[24]

Conclusions and Future Directions

The foundational strength of AMIs is firmly rooted in their academic departments. The evolving role of the departmental chair over the past two decades has been due to a multitude of influences including the rapidly changing terrain of US academic medicine with dwindling revenue streams, complexity of matrix governance structures in AMIs, and situational organizational needs and environmental pressures. A grasp of these factors is vital for the thoughtful selection and recruitment of a departmental chair whose stances are congruent with those of the AMI. The departmental chair must also hold the requisite professional credentials and personal qualities. The success of a departmental chair is gauged by meeting expectations as a manager, leader, and scholar with KPIs for the role in identified domains of academic medicine. Support by the AMI with ongoing mentorship and coaching is paramount for guaranteeing a department's and AMI's mutually dependent success.

Disclosure

The author reports no conflicts of interest in this work.

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