2 The Ever-Changing Departments of Surgery: The New Paradigm—The Roadmap to a Modern Department of Surgery

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The Different Types of Surgery Departments: The "Old" and "New" Schools

Departments of surgery are not isolated islands; they are and need to be aligned with their respective institution's mission, vision, and goals. This basic requirement defines the type of a specific department of surgery. As a result, different types of departments of surgery exist:

- *First,* the department of surgery can be part of an academic institution within a medical school or part of a nonacademic healthcare organization with little interest in academic tasks such as research and education. For academic departments, clinical programs are not only revenue-generating units but also essential components for the advancement of research and education; for nonacademic departments, the focus lies primarily on financially solid clinical programs with excellent patient outcome and satisfaction but usually without an authentic interest in research and/or education.
- *Second,* the department of surgery can represent an "old-school" department in which all surgery services and subspecialties are bundled together or a "surgery-core" department which includes general surgery and a few other specialties which are usually not represented in independent departments; this may include cardiothoracic, pediatric, reconstructive, transplant, and vascular surgical services in different combinations. The former allows one to build noncompeting clinical programs and avoids competition for the same patients because of only one departmental leadership structure; the latter almost invites the development of competing clinical programs under multiple departmental leadership arrangements because of the substantial overlap between the different surgical services. One such example is whether the surgical director of a kidney transplant program should be a transplant surgeon or an urologist.

Historically, all surgical services were frequently concentrated under one departmental roof: this included such different specialties as orthopedic surgery, gynecology and obstetrics, ophthalmology, urology, ENT, and neurosurgery. In the 1960s and 1970s, depending on the institutional vision and goals, some of the surgical specialties were organized as independent departments because of strong clinical and academic performance, continued subspecialization, and/or in order to attract

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some of the brightest faculty and residents. Over the next few decades, this splitting off of the "old-school" department of surgery continued, and, at most institutions, orthopedic surgery, gynecology and obstetrics, ophthalmology, urology, ENT, and neurosurgery have become independent departments. But even "surgery-core" departments have become smaller with cardiothoracic, reconstructive, pediatric, and/or vascular surgical services sometimes splitting off into independent departments. Only more recently, this trend seems to have stopped and some institutions have now begun to reintegrate surgical subspecialties into "old-school" or "surgery-core" departments. As always, financial considerations commonly dictate the setup of institution-specific departmental structures. Due to the explosion of surgical knowledge and techniques over the past decades, the "surgery-core" departments have also substantially grown in their own right and frequently include the following subspecialties: surgical oncology (e.g., breast, colorectal, HPB [hepato-pancreatico-biliary], skin, and soft tissue surgery), endocrine surgery, minimally invasive surgery (MIS, further divided into laparoscopic and robot-assisted services), transplant surgery, trauma, critical care surgery, and, most recently, acute care surgery. Of note, "general surgery" is hardly mentioned as an independent specialty: at many institutions it has been integrated into and absorbed by the different subspecialties.

- *Third,* surgery departments may also be defined by other factors: is the department's basis only one hospital, is there an additional VA association, or is it embedded in a system-wide, multiple hospital encompassing health system? What is the vision of the institutional leadership—to draw patients primarily from the community or to also attract patients regionally or even nationally? It is important to point out that extremely prosperous clinical programs offered by surgery departments frequently help to define the role and success of the entire institution. One such example is the transplant program that Dr. Thomas Starzl built at the University of Pittsburgh in the 1980s: he almost single-handedly created the largest transplant program of its kind not only in the nation, but in the world, which allowed his institution in years to come to grow into a multibillion health network by purchasing many others hospitals.

Institutional Reporting Structures

The reporting structures are obviously different for academic versus nonacademic institutions.

As surgery departments are solidly embedded into their respective institutions, the chair of an academic department usually reports directly to the dean of the college/school of medicine who appoints the chair and has the power to remove him/her from office as well. However, there are also "dotted" reporting lines to the CEO/president of the hospital or health organization and to the CEO/director of the practice plan. Thus, multiple reporting lines exist and strong alignment among the three entities is absolutely crucial for the success of the institution and the surgery department. If this alignment does not exist—sometimes called the "3-headed monster"—failure and turmoil are almost certain. Although it is rare at academic institutions that the college of medicine, the hospital(s), and the practice plan are united under one leader (usually the vice president of the academic health center), this structure clearly shortens and, in theory, improves the decision-making processes and strategic planning. More often, the hospital and the practice plan are united as one entity, and the college of medicine remains separate; this structure typically results in two separate leadership positions, and close collaboration between the two leaders is the key to success.

In contrast, nonacademic institutions have a different reporting structure. Here, the chair of the nonacademic department usually reports only to the CEO/president of the health organization or to his/her designee. This makes decision-making processes and strategic planning easier. However, nonacademic institutions are

not infrequently associated with medical schools and both residents and students may spend rotations away from their academic institutions. In this case, the department chair may interact with the dean of the medical school but is usually not appointed by the dean and does not report directly to him. In case of an independent residency program at a nonacademic institution, a reporting structure to a dean may not exist at all.

At both academic and nonacademic institutions, the surgery chair reports to the institution's senior administrative leadership. While the surgery chair is in charge of departmental matters, he/she holds only a mid-level management position within the whole organization. Thus, the leader of the surgery department may help to influence key decisions but usually has no final say.

Involvement of the chair or his/her designee in strategic planning, contract negotiations with insurance providers, and other key organizational committees, task forces, etc. is of mutual advantage and benefits the whole organization.

The interaction between the chair and his/her supervisors (dean/hospital CEO) should be of mutual respect and requires the chair's ability to closely cooperate and to compromise with his/her supervisors. Consensus building and a clear understanding of the issues that the dean and hospital CEO are dealing with (beyond individual departmental matters) are additional attributes to a successful tenure as chair.

Departmental Structure and Organization

The department chair is ultimately responsible for all clinical, academic, financial, and administrative activities within the department. The chair should appoint a strong and loyal deputy chair who will represent the chair in his/her absence. The deputy chair is "primus inter pares" among the vice-chairs. In academic institutions, due to the size of surgery departments, several faculty members may serve administratively as vice-chairs. While there is no definitive number as to how many vice-chairs are required, the following positions are advisable: vice-chair for clinical affairs, vice-chair for academic affairs, vice-chair for financial affairs, vice-chair for education, and vice-chair for research. Other vice-chair positions, such as vice-chair for financial affairs, vice-chair for HR issues, etc. may also be reasonable. The chair, the various vice-chairs, and the division/section chiefs form the departmental "cabinet," the senior leadership group; it is not unusual that residency director(s), the surgery service chiefs at satellite hospitals, and the administrative director of the department join this group. Sharing responsibilities among the departmental leadership group fosters team work and consensus building.

The vice-chairs are usually in charge of their respective committees which should ideally consist of faculty members from different departmental divisions/sections. The committees should meet on a regular basis and a report should be generated at least twice per year for the chair's review.

The chair should meet individually and on a regular basis with all faculty members; this is usually mandated by most institutions in order to complete the annual faculty member evaluation. Depending on the size of the department, the chair may have the division/section chiefs meet with their junior faculty, but the chair should be responsible for the evaluations of his/her vice-chairs, division/section chiefs, and senior faculty. Since most academic institutions mandate a departmental mentoring plan for faculty, the evaluations should be based on expectations and benchmarks as defined by the individual mentoring plan. In most departments, division/section chiefs are responsible for mentoring of their junior faculty.

All faculty members should be encouraged to not only be members in their respective societies but also seek leadership positions. Equally important are membership in NIH study sections, national committees, and task forces. These engagements benefit the faculty member, the division/section, and the entire department. Representation of surgical faculty in institutional (college/university) or local community committees is equally significant.

Departmental faculty meetings or retreats should be conducted semiannually. It is important that all faculty members have access to key

departmental information including departmental finances—the willingness of the chair to share "sensitive" financial information frequently results in faculty "buy-in" if unpopular measures (most commonly to balance the budget) need to be taken. The more transparent and accountable the chair acts, the greater the support of his faculty. "Cabinet" support for the chair is also essential. The chair has the obligation to be the best departmental steward possible and recognized as such—once the faculty members realize that the chair works diligently and honestly in his/her own and the department's best interest, support for the chair comes naturally.

The chair depends on the expertise of his/her financial team. Most chairs know relatively little about how to run a mid-size company such as a surgery department financially until they are on the job. Having the departmental financial team work with the college/hospital financial teams in close collaboration is the key to departmental and institutional success.

The chair should be fair and objective in distributing the scarce resources among the different divisions. Although it is the prerogative of the chair to set departmental priorities, it appears prudent to support his/her programs in an equal fashion. It frequently helps the chair's overall reputation if he/she is still clinically active and operates on patients. That way, the chair remains in the loop with regard to issues in the clinics, operating rooms, etc. In contrast to nonsurgical disciplines, surgeons develop a high degree of respect for their leader if the clinical programs that he/she directs are successful and if the faculty knows of the chair's excellent technical skills. Given the background of great clinical accomplishments, the chair should ordinarily be the one who runs the departmental morbidity and mortality conferences as well as grand rounds.

In contrast to departmental chairs, system chairs overseeing surgical services at several hospitals within a large health network tend to be mostly administrators with little or no clinical responsibility. The role of a system chair is more frequently found in nonacademic institutions and focuses on developing smooth algorithms and operations within the organization to ensure an effective and productive work environment for all surgeons that are affiliated.

Being a chair can be very satisfactory, but you have to pick your battles wisely and always remember that the average chair survival is no longer than 10 years. A chair should steadfastly stand by his principles and moral convictions and realize when the time has come that he is no longer a good fit for the organization that he serves. Ultimately, despite the power and authority that the chair enjoys in his/her department, the position of a chair is that of a mid-level administrator. Rarely does a chair have final say in institutional matters; it is important for the chair to realize his/her limitations with regard to extra-departmental issues and the willingness to cooperate and compromise with his/her supervisors and peers.

Departmental Infrastructure and Resources

Provision of adequate space has become a top priority and top concern for departmental leadership; basically, there is never enough space to accommodate all departmental needs. Space is needed for faculty offices, administrative support staff, residency quarters, and laboratories. Conference rooms and auditoriums are usually shared between departments within the college of medicine.

The number of support staff depends on the department's financial circumstances and that of individually funded faculty. The administrative assistance to faculty ratio can range from 1 to 10.

Additional administrative support staff is required for residency, clerkship, and fellowship programs.

Due to the close interaction, the chair's office(s) should be in close proximity to the administrative offices—the chair meets regularly and frequently several times per week with the department's administrative director who oversees all financial matters and reports directly to the chair. In contrast to the administrative offices, coding and

billing offices are frequently no longer departmental units, but rather centralized. Unfortunately, this is a shift towards less departmental autonomy and commonly dictated by financial considerations.

To fulfill the educational mission, academic support staff is essential. Depending on the funding opportunities, financial support for a (bio-) statistician, research nurses, data manager, and an editor is desirable. Sometimes these resources need to be shared with other departments. Because innovative and rare surgical procedures have a high PR effect, the recruitment of a departmental PR manager/director and a fundraising director will enhance the department's regional/national reputation and increase the number of donation and gifts. In times of financial tightness, the role of the latter two positions is controversial; however, financial analyses commonly show that a successful departmental fundraiser generates enough income through donations to justify his/her salary. A PR manager or marketing director is not only responsible for disseminating departmental news (through newsletters or the departmental web site) but also coordinates meetings with both established and newly referring physicians. Both fundraiser and PR manager are crucial in developing good relationships with the local/regional communities and can frequently establish new national connections.

IT support staff is essential for the various faculty, resident, and staff needs and is usually shared with other departments within the college of medicine or the hospital. Advertising on Google, Twitter, Facebook pages, etc. has become important departmental tools to connect with physicians, patients, and communities.

Departmental resources are usually scarce; major recruitment or retention packages (see below) are generally not possible without hospital/college/university support. Many surgery departments have little or no financial reserves. Interest from endowed chairs is ordinarily used to support faculty salaries rather than research endeavors. Successful fundraising and other departmental activities as described below have become increasingly important avenues to accrue additional revenue.

Financial Requirements

Financial stability of any surgery department is pivotal to its academic and clinical success.

By and large, surgery departments depend on the following types of income: (1) clinical revenue as generated by faculty, residents, mid-level providers etc.; (2) financial support from the hospital and the college of medicine/university; (3) grant funding and research dollars; (4) donations, gifts, departmental reserves, and interest (endowed chairs); (5) patents, device development, telemedicine services, and industry support.

Clinical revenue usually contributes the most to departmental income. However, most surgery departments cannot rely on clinical income alone: faculty salaries, specifically in competitive markets and recruitment of highly qualified staff, require additional hospital and/or college/university support; depending on the institution, additional support may add another 25–50 % to the department's budget. Strong funding of grants and research is important to the department's national reputation and to attract highly talented faculty and residents, but departments themselves usually do not profit financially from research funding unless some of the indirect costs are redistributed to the department. Donations and gifts can add substantially to a department's bottom line if successful departmental fundraising is accomplished. Interest from endowed chairs usually contributes little to the overall bottom line; the same is true for income from patents or device development.

On the downside, departments are facing increased taxation specifically from the college of medicine (e.g., dean's tax) and the practice plans (e.g., for central coding and billing). Close interaction between the departmental administrative/financial director and the hospital and college CFOs is crucial to establish a balanced budget. Since surgical services attract a high-margin, elective patient clientele the downstream effect that surgery generates is not only substantial for the hospital itself but for many other departments such as anesthesiology, pathology/laboratory medicine, radiology, medicine, etc.

It is important to educate hospital and university administrators about the downstream effect generated by the surgery department particularly for surgical programs that at first sight appear not to be profitable (e.g., surgical breast cancer or wound healing programs). If the downstream effect is taken into consideration, a money-losing surgical program may still be an essential part of a multidisciplinary and financially profitable program and should not be closed. Under these circumstances, the chair may ask for additional support from the institution for such programs in order to avoid a (potentially steep) salary cut for the affected faculty member and growing faculty frustration and dissatisfaction.

Providing financial information to individual faculty members on a regular basis (preferably monthly) regarding their billings and collections is essential to keep faculty members up-to-date and educated as to their individual financial performance. Regular information about the individual faculty member's financial performance also allows for his/her timely adjustment(s) of clinical activities or for coding/billing corrections. It also provides the basis for salary alterations based on clinical activities or funded support for research, education, and administrative duties. It is important to emphasize that the financial support for educational and administrative responsibilities is unfortunately the weakest of all due to the scarce financial resources of most surgery departments.

Faculty Recruitment and Retention

Successful recruitment of excellent faculty at academic departments and successful recruitment of outstanding surgeons at nonacademic departments is critical to the mission and vision of most surgery departments and institutions. Recruitment efforts have to be aligned with the existing infrastructure and the strategic objectives of both department and institution. It is usually easier to recruit a new faculty member or a surgeon to an already existing and established clinical program. Recruitment(s) for new clinical programs is more complex and frequently requires flexibility, patience, and persistence on part of the recruited faculty/surgeon as well as on the hospital side. To make new clinical programs successful, market and pro-forma analyses need to be performed: they are essential to define clinical, financial, and academic expectations and benchmarks. New clinical programs may require costly investments in cutting-edge devices (e.g., daVinci robot) or expensive renovation and expansion of operating rooms (e.g., construction of hybrid ORs). Appropriate funds (usually from the hospital) have to be available before the recruitment commences.

How can the best faculty/surgeons be attracted? It is usually easier to attract outstanding faculty/surgeons to institutions that have an established track record of high performance, stimulating work environment, and financial stability. Outstanding recruitment candidates are usually attracted by the presence of like-minded and similarly performing faculty/surgeon(s), nationally reputed departments, and prestigious institutions. But an attractive recruitment package and a grand organizational vision may sway reluctant but exceptional candidates to even less reputable institutions: such enticements may include above-average AAMC salary, salary guarantee for several years, strong program support (e.g., mid-level providers, administrative assistance, etc.), sign-on bonus, incentive payments, and/or additional administrative responsibilities.

In general, recruitments should be pursued in such a way that all stakeholders within the department, the hospital, and the college of medicine are involved in the interview process and the candidate selection. The broader the consensus is between the different stakeholders, the greater the chance is of successful recruitment and buy-in from all sides. Broad initial support is also necessary if the program fails eventually. In that case, it is not the "fault" of the surgery chair alone (or whoever is in charge of the recruitment) but of everyone who was involved and agreed to the recruitment.

Consensus in faculty recruitment is important to pick the "right" candidate: this may not necessarily be the one with the most outstanding CV but an individual who understands the importance of teamwork and his/her role within the system.

The recruitment of exceptional faculty and building/expansion of excellent clinical programs have an important ripple effect: it facilitates the department's recruitment of top medical students, residents, and fellows alike and it allows other departments to recruit faculty of similar caliber.

Retention of respected or key faculty is as important as is recruitment—and, in most cases, it is usually financially more prudent to retain a valued faculty member than to recruit a new one. Retention packages frequently include salary increases, additional program support, and/or additional administrative responsibilities and titles.

In contrast to whole departments, individual faculty members in this day and age are no longer "triple-threats" because of the complex and time-consuming challenges in clinical, research, and educational activities. At most academic institutions, faculty members are "dual-threats." Beyond the traditional big "3 s," administrative duties represent now an independent yet equally important and demanding field.

Clinical Services and Programs

Like with faculty recruitment, expansion of existing and development of new clinical programs has to be aligned with the institutional goals and infrastructure. First and foremost, the institutional goals should be defined by the needs of the local/regional community and are frequently in competition with other hospitals. As programs or centers of excellence develop, regional or even national recognition may result in further expansion. Institutional support is critical to provide the necessary infrastructure which may include additional personnel, additional space (clinics and/or operating rooms), and/or purchase of new, and frequently expensive, surgical equipment. Institutions tend to more readily support multidisciplinary programs or programs that generate substantial downstream revenue. The key to institutional support is the development of a robust financial model and broad consensus among the program stakeholders which should include the department chair(s) and the institution's senior leadership. A market analysis needs to be the basis for expansion or development of new programs. There also needs to be an institutional willingness to invest into PR activities, ranging from TV commercials and advertisements to education of referring physicians and patients. At regular meetings, the clinical service or program director has to provide updates to his administrative partners and/or supervisors within the hospital and college. These status reports are important to let the stakeholders know about potential issues, additional needs or modifications of benchmarks, and financial projections or adjustments. Finally, the success of financially viable programs is also measured by patient outcome and satisfaction—these factors usually determine a program's future.

Education

In academic departments, residency and fellowship programs as well as the education of medical students are essential components of the academic mission. All departmental faculty members must have a sincere interest in education and enjoy their involvement in educational activities. A solid clinical training experience is the foundation of any residency program. This includes sufficient and adequate operating experience, excellent patient care and management, as well as participation in all types of teaching activities. Residents expect valuable feedback from faculty, and faculty expect a genuine interest in all aspects of surgical care from their residents. Faculty evaluations and annual in-service tests are critical tools for resident assessment.

Departmental compliance with residency requirements is essential for continued program accreditation. Although the work hour limitations are not infrequently questioned by both faculty and residents (e.g., residents not being able to participate in an operation despite their interest and willingness because of possible duty hour violations), the regulations have to be honored and individuals who violate against them have to be reprimanded and/or face other consequences.

What elements make a specific residency program more attractive than others? In their

interviews, resident candidates tend to focus on excellent training, a friendly and collegial climate, a productive and successful work environment, and a reliable and honest interaction between faculty and fellow residents. Without doubt, these factors are important but so are the residents' academic accomplishments which only few at that early stage in their career fully understand. To get residents started in their academic endeavors, there should be a departmental policy that within the first year each resident has to identify a faculty mentor. There should also be a requirement that each resident has to author or coauthor 1 scientific manuscript per year. This ensures that each resident at the end of the residency has at least five publications to his/her credit which positions any resident very competitively when applying for a fellowship or a junior faculty/staff position. Residents should also be encouraged to present their research at local, regional, and national meetings specifically if departmental resources are available. If possible, academic departments should make ongoing research opportunities available to residents. For those residents that are interested in basic science research, under optimal conditions, a 1–3 years laboratory experience to obtain an MS or PhD degree is preferably offered after the third year. Acceptance into such a departmental research program should be considered an extraordinary achievement in itself: it requires the resident to work with the academic mentor in such a way that a resident research grant within the first 2 years should be submitted. Depending on the funding opportunities, the resident may then pursue a scientific career aside from the clinical training. Departmental honors and awards for clinical or research accomplishments create further incentives for the residents to excel.

Another attraction to residents and resident candidates is a functioning departmental animal lab. Such facilities allow residents to acquire for example minimally invasive or robotic techniques in large animals and help to avoid technical unpreparedness in the clinical setting. It is preferable to offer these courses to residents 1 week at a time and relieve the residents from all clinical duties during the course duration. A decrease in operating times, a decrease in cost, superior clinical resident training, etc. are commonly the results of these animal lab courses.

Fellows are usually attracted by strong clinical programs and should be encouraged by their faculty to engage in clinical and translational research. As mentioned below, easy access to databases as well as biostatistical and editorial support are crucial ingredients for fellows to become academically prolific.

Medical students need to be engaged in the field of surgery. All too often, faculty and residents are not genuinely interested in time-consuming training of medical students because they are still so early in their career. However, to get them interested in applying for a residency in surgery, they should not only do H&Ps and busy work but also participate in the operating room and learn basic surgical tasks (e.g., skin closure, placement and removal of drains, etc.). Because the quality of life of surgeons is frequently considered to be lower than that of other specialties, it is important to demonstrate to students the great personal satisfaction that comes from the surgical profession. Getting medical students interested in all aspects of surgery and convincing them to apply for a surgical residency is crucial for our profession since our nation will face a critical shortage of surgeons in the near future.

Presence at morbidity and mortality conferences, didactic sessions, journal club meetings, and grand rounds should be mandatory for all residents and medical students on surgery rotations. The results of the annual resident in-service exams provide a tool to the residency leadership to identify weak performers and to focus on improving their results.

Surgery departments should regularly organize meetings and conferences for educational purposes where faculty and residents present. Such activities help to expand ties with the local community and attract referring physicians specifically if CME credits are awarded.

Research

For academic departments the research component is of fundamental importance as it, more than almost anything else, defines the department's national reputation. The recruitment of researchers has to be aligned primarily with the vision and goals of the college of medicine. The development of new research programs should be coordinated in such a way that interdepartmental or even intercollegial cooperation is accomplished. This approach usually increases the chances of extramural funding.

A department's national research ranking is a reflection of the overall research money that is available from all types of grants but specifically from NIH funding. For clinically active surgeons, it has become increasingly difficult to obtain NIH funding. The right choice of co-investigator(s) (Ph.D., biostatistician, etc.) is a crucial decision that frequently determines if funding is obtained or not. Junior faculty with research support as part of their recruitment package should be encouraged to seek collaboration across the college of medicine or across campus, specifically with college of science faculty. Junior faculty funding is usually provided by the department or the college of medicine for 1–2 years, with benchmarks attached and the expectation that continued funding will be obtained. This puts tremendous pressure on junior faculty who, at an early stage in their career, are also expected to become increasingly clinically active.

Each academic department should have a few well-funded laboratories in place, also to provide research opportunities to residents and medical students. Individual laboratories should be aligned with core facilities and laboratories to avoid costly duplication of services and to foster collaboration. A sore subject to all researches has been the topic of high indirect costs; a solution to this problem is not on the horizon.

Aside from basic science research, surgery departments need to be engaged in translational and clinical research as well. Not infrequently, clinical trials may generate additional income to the department if effectively conducted. Sharing of research nurses and administrative staff when multiple clinical trials or studies are conducted at the same time is one such way that can contribute to greater cost-effectiveness.

Challenges

It is evident that the challenges for surgery departments are multiple and frequently not easy to overcome. Departments of surgery are expected to be leaders in generating hospital income and downstream revenue for other departments and the organization. With dwindling reimbursement rates, diminished institutional support, etc. it is all but impossible to fulfill these expectations particularly in light of absent financial resources within the department. The chair's negotiation skills, additional institutional support, and a strong chair recruitment package are all necessary to provide a positive bottom line. Ongoing institutional support remains the key to departmental growth and success.

Centers and multidisciplinary programs frequently weaken departmental positions by tapping into their resources and increasing their financial burden. One such example is the department's responsibility for faculty salaries but income generated from clinical services staying with centers or programs. Another example is open-staff hospital policies that may cause issues when surgeons that are associated with the department and/or a single practice plan compete with private practice surgeons for operating room availabilities and capacities. Hospital directorship positions are frequently not standardized in terms of financial support and may cause friction among faculty. And a high faculty turnover is definitively not wanted as it indicates departmental instability and volatility. All these challenges require a high degree of persistence, determination, and perseverance on part of the chair and the departmental leadership to stay course and lead the department successfully.

Finally, on a personal level, an advice to future chairs: it is lonely at the top. You have to almost

constantly compromise: usually, if both sides are equally happy or unhappy with your decision(s), you are "leading from the middle," using common sense. You will notice that no one ever comes to your office to tell you that he/she is absolutely happy, has no requests whatsoever, and is not interested in a salary increase. And no one will honestly tell you that you are doing a great job. You, the chair, are constantly challenged, in the middle of controversies, and forced to make unpopular and difficult decisions. The chair has to be guided by objective, transparent, and reproducible decisions based on facts and evidence and be documented as such. Strong support for the chair's decisions should come from the cabinet after appropriate consultation, from task forces, special investigators, and various committees.

Summary

Surgery departments have evolved remarkably over the past century from relatively simple constructs providing primarily clinical services to "triple-threat" (clinical, educational, and research) units and ultimately to complex, multimatrix-embedded entities that must withstand, and adapt to, the numerous challenges of our constantly changing health system. The financial survivability of surgery departments has added yet another dimension that severely impacts the traditional departmental tasks both in positive and negative ways. What has not changed over time is that the departmental reputation continues to depend on the quality of surgeons/faculty which in turn determines the quality of the residents. Departments remain the foundation of progress in surgical research and education and the place to train the next generation of surgeon leaders. Clinical service lines, multidisciplinary programs, and center designations have not eliminated the need for surgery departments which remain the "home" to surgeon faculty. Most surgery departments can no longer survive on clinical income only, and financial support for research and education is dwindling. Nowadays departmental leadership is forced to attract new sources of income in form of industry collaboration, gifts and donations, patents, device development, and other creative activities. Most importantly, surgery departments are not isolated islands but important components of healthcare-providing institutions; surgery departments have to be aligned with the institutional vision, mission, and goals in order to successfully provide the highest service to both the institution and the community that they serve.