Administration in Family Medicine Education: An Academic Quandary

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Family medicine leadership is faced with the challenge of maintaining the progressive development of a new academic discipline. Academic administration has presented a dilemma to all fields, and there has been very limited training to assist administrators in academe. A survey of department chairmen and residency directors in family medicine determined that a high percentage of leaders have moved into their positions directly from practice or from faculty responsibilities. Predominant needs were in the areas of finance, external relationships, time management, and conflict intervention. There are several implications from this study which should be considered in the selection, training, and evaluation of academic family medicine administrators.

The quandary in which administrators of family medicine departments and residencies find themselves inevitably results from the early history of this "new" academic discipline. The initial leadership in family medicine education has come from practicing physicians and recent residency graduates. Program development since the specialty of family medicine was created in 1969 has been dramatic in both community hospitals and academic medical centers.[1,2] This growth spurt has been fueled by a plethora of federal funding and a grass roots support from community physicians and the citizenry at large.[3,4] Another phenomenon which has added to the perplexity is that other medical specialties, especially those with an interest in ambulatory care, have become devotees of "primary care," and have also won financial support from government and private foundations.[5-7]

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In addition to the competitive stance which has developed between family medicine and other specialties, there has been an outcry, both within and outside the profession, that family medicine develop a scholarly research mantle in order to become a creditable discipline.[8-10]

The purpose of this article is to present an overview of academic administration and administrative competencies described in the recent literature and to report the findings of a survey of family medicine's leadership.

Academic Administration

Even though family medicine finds itself as the "new kid on the block," there is little evidence that suggests the seasoned veterans in academia have succeeded in effectively administrating their respective professions. Much of the information indicates a definite void in administrative competency within the academic professions.

Knapp[11] charges that the "spirit of amateurism permeates the academic organization from top to bottom." He concludes that this administrative amateurism leads to: inability to diagnose organi-

zational problems; false readings of priorities; strong needs to prove importance; high control needs, with little emphasis upon facilitation; and, ultimately, the administrator becomes the obstacle. Dobbins and Stauffer[12] contend that there is a disparity between the increasing complexity and growth in academic institutions, and the quantity and quality of academic leaders. Ehrle[13] describes some of the mythology which has pervaded academic centers, and may be responsible for the inadequacy of academic administration:

> Yesterday's good professor is tomorrow's good chairman. Faculty have a corner on knowing what is a good chairman. Chairmen should be elected by faculty acclamation. Chairmen should preserve the status quo. Faculty and chairmen function best in adversary roles. Programmatic continuity can be maintained only with a new chairman from inside.

Academic medical centers and medical education in general face similar dilemmas, constraints, and myths as other academic entities. Lee[14] contends that the traditional models of governance are not adequate for administering today's complex academic medical center. Weisbord[15] concludes that organizational development interventions, especially those developed from business applications, are not always appropriate in academic medicine, because of the multiplicity of goals, diffuse authority, low task interdependency, and few performance measures. Hoberman et al[16] found that few health care professionals are prepared to assume administrative tasks, especially when confronted with: the need for differing approaches when working with patients and directing colleagues; hostility in both internal and external environments; conflicts fueled by power, status, career advancement, delegation, and evaluation; absence of mutual goals; and reluctance to change.

Administrative Competencies

Management development for top level executives and administrators is well documented.[17,18] Table 1 outlines administrative competencies from three authors. Guglielmino[19] collected data from a nationwide sample of professors of management, directors of training, and mid-level managers. Wilson[20] studied managers, their superiors, and their subordinates in developing the multi-level management survey (MLMS). Ehrle's[13] competencies were developed for academic administrators with input from faculty and administrators. These competencies appear to be generic to executive functions for organizations and are worthy criteria in selecting, training, and evaluating academic administrators. The competencies presented in Table 1 were utilized in the needs assessment survey to determine specific management needs and particular areas of satisfaction and dissatisfaction.

Family Medicine's Predicament: A Leadership Survey

Since family medicine represents an educational departure from traditional medical disciplines, its leadership must call upon a high degree of creativeness and management skills to achieve its goals and respond to its constituencies. In an effort to understand the issues related to administrating family medicine and the necessary skills which chairmen and residency directors must develop, a national survey was conducted. The expectations for this study were: to gather demographic data to determine the characteristics of the administrators and their programs; to distinguish between chairmen and residency directors and academic and community settings; to determine the degree of previous administrative training; to elicit satisfactions and dissatisfactions; and to assign priority to managerial needs.

Method

A 77-item questionnaire was mailed to 112 chairmen of departments of family medicine and 188 family medicine residency directors, using mailing lists provided by the Society of Teachers of Family Medicine. This represented a 100 percent sample of chairmen and a 50 percent sample of residency directors. One hundred sixty-eight completed questionnaires were returned for an overall response rate of 55 percent. However, examination of these returns revealed that six were completed by residency faculty, neither chairmen nor residency directors. These six responses were excluded from the analysis, as the intention of the study was to examine the administrative needs of chairmen and residency directors. Eliminating these returns produced 64 responses from chairmen and 98 from residency directors, for response rates of 56 percent and 52 percent, respectively. The similar response rates from chairmen and res-

Table 1. Administrative Competencies

Top Level Executive Development (Guglielmino, 1979)	Multi-Level Management Survey (MLMS) (Wilson, 1980)	Department Chairman Evaluation (Ehrle, 1975)
Conceptual Skills	**Direction of Work**	**Communications**
Decision making	Clarification of goals	Timely, responsive
Identifying opportunities	Encouragement of upward communication	Decisive conferences
Innovating	Orderly work planning	Sensitive to others' needs for information
Monitoring business environment	Expertise	Presents ideas clearly, concisely
Thinking and planning	Work facilitation	
Structuring the organization	Feedback	
Human Skills	**Control**	**Decision Making**
Writing and speaking	Time emphasis	Gathers pertinent facts
Handling grievances	Control of details	Consults on important issues
Leading and monitoring	Goal pressure	Sound and timely decisions
Negotiating	Delegation	Consistent and fair
Controlling change		Participatory decision making
Analyzing oneself	**Interpersonal Relations**	Alert to potential problems
Self-directed learning	Fair and enlarging work allocation	
Technical Skills	Approachability	**Operations, Delegation**
Understanding financial statements	Team building	Makes time to plan
Using zero-based budgeting	Interest in subordinate growth	Initiates and sustains action
Preparing cost-benefit analysis	Recognizing and reinforcing performance	Calls meetings appropriately
Planning one's career		Maximizes others' capabilities
Managing time and effort		Effectively utilizes committees
Researching information		Encourages initiative and performance
		Human and Public Relations
		Establishes rapport easily
		Resolves conflicts
		Receptive to suggestions
		Judges perceptively
		Does not discriminate

idency directors indicated that any self-selection bias was the same in both groups.

The questionnaires were edited and coded and, after keypunching and verification, were analyzed using the Statistical Analysis System (SAS) programs available at the University of North Carolina Central Computation Center.

Characteristics of Chairmen and Residency Directors

The most common organizational setting of the respondents was the family medicine residency program located in a community hospital: 55 percent of the respondents were located in that setting. The next most frequent location, representing about 25 percent of the respondents, was the family medicine department in a university medical school. A cross tabulation of organizational setting and position of each respondent is seen in Table 2. Eight respondents were chairmen of family medicine departments located in community hospitals, not in university structures. The seven respondents from military programs were split between residency directors and chairmen. The analyses that follow separate the responses of

Table 2. Position and Organizational Setting

Position	Organizational Setting				
	University Department	University Division	Community Hospital	Military	Total
Chairmen	44	8	8	4	64
Residency Director	10	4	81	3	98
Total	54	12	89	7	162

chairmen and residency directors in community hospitals from those in military programs because of the unique nature of each of these settings.

Three important variables in understanding the needs of chairmen and residency directors for administrative training are their age, their tenure in their current position, and their last position prior to becoming chairman or residency director. The age distribution for chairmen was significantly different from that of residency directors ($P<.01$). The age distribution for chairmen centered around the 40- to 49-year age group, while the residency director distribution was bi-modal, with one third being 39 years or younger and more than one half being older than 50 years. The tenure distributions were not significantly different, though twice as many chairmen had been in their positions for six or more years, compared to residency directors, 27 percent vs 14 percent. The previous positions of chairmen were significantly different from the previous positions of residency directors ($P<.01$). Far fewer chairmen than residency directors came directly from previous practice, 30 percent vs 55 percent, and chairmen were more likely to have been directors or departmental chairmen, 35 percent vs 10 percent, compared to residency directors. Taking these three variables together, the following picture emerges: chairmen tended to be in their late 40s or early 50s and to have been in other academic positions prior to becoming departmental or division chairmen. Residency directors tended to be either younger than 40 years or older than 50, and more than half had become residency directors by moving directly from private practice.

Analysis of variance tests determined if there were any statistically significant differences between the chairmen and residency director groups. Results for the age of respondent showed that while there was no significant difference between chairmen and residency directors in their mean age, the chairmen and residency directors of divisions were significantly younger than their counterparts in departments or community hospitals ($P<.01$). The results for tenure showed that chairmen had significantly longer tenure than residency directors, 5.0 vs 3.7 years ($P<.01$), and residency directors in community hospitals had longer tenure than their counterparts in departments and divisions ($P<.01$). The average tenure of previous chairmen is significantly higher than the average tenure of previous residency directors, 3.8 vs 2.6 years ($P<.01$). The predecessors of chairmen and residency directors in departments also had significantly higher tenure than their counterparts' predecessors in divisions or community hospitals ($P<.01$). Finally, the previous positions of chairmen and residency directors showed considerable variation with setting. Three quarters of the chairmen in community hospitals came from private practice, vs one quarter of university department chairmen. A similar pattern appeared when residency directors in community hospitals were compared to residency directors in university departments.

Characteristics of Programs

The number of years a family medicine residency program has been in existence and the rate of turnover in its top administrative position are two important characteristics of these programs. University departments tended to be in existence longer than university divisions and community hospital residencies. Over 55 percent of the departments have been in existence seven or more years, whereas 70 percent of residencies are less than six years old. The distribution of the years in existence was not significantly different for pro-

Table 3. Program Staffing
[Mean (M) and Standard Deviation (SD)]

		Organization			
		University Department	University Division	Community Hospital	Total*
Number of Faculty	M	9.8	13.4	4.0	6.8
	SD	(6.9)	(19.8)	(3.2)	(7.7)
Number of Residents	M	25.9	35.3	17.4	21.6
	SD	(17.3)	(28.3)	(8.4)	(14.6)
Number of Office Staff**	M	7.2	9.2	3.7	5.2
	SD	(6.5)	(10.6)	(4.4)	(5.9)
Number of Family Practice Staff†	M	15.9	26.3	10.8	13.5
	SD	(14.7)	(25.6)	(9.1)	(12.9)
Total Personnel	M	57.9	83.7	35.5	46.1
	SD	(36.7)	(56.0)	(20.6)	(31.9)
Number of Programs		54	12	89	162*

*Includes military
**Office staff=secretarial and clerical staff
†Family practice center staff=nurses, receptionists, laboratory technicians

grams in different settings. University divisions and residency programs indicated higher turnover rates, with 38 percent of divisions and nearly 20 percent of residencies reporting at least three different directors. The distribution of the number of predecessors in the top administrative positions was significantly different between settings ($P<.01$). Military programs had the highest executive turnover.

Staffing patterns for the four program settings are shown in Table 3. Variation between programs in the numbers of faculty, residents, office staff, and family practice center staff are all statistically significant ($P<.01$). The largest settings were university divisions, and the smallest were community hospitals. There was a great deal of variation in the size of each type of staff within each type of setting. An alternative way to characterize the staffing of a family medicine residency program is to compute and examine the various staffing ratios. Three such ratios were computed for the programs. These are the ratio of faculty to resident, the ratio of family practice center staff to residents, and the ratio of office staff to faculty. The average ratios for the four types of settings are shown in Table 4. Statistical tests showed that the faculty to resident ratio differed significantly between settings ($P<.01$). The university departments had the lowest mean ratio of faculty to residents (1:2.1), while the community hospital programs had the highest mean ratio (1:4). The ratio of office staff to faculty was significantly different ($P<.01$) among sites. The highest ratio was in university divisions, which had 1.4 office staff for each faculty member, while the lowest ratio was in military programs which had one office staff for every 2.5 faculty members.

The community hospital and military programs were younger, had fewer personnel, and reported higher executive turnover. They were also characterized by higher ratios of faculty and staff to residents than the university departments or divisions.

Administrative Training and Managerial Needs

At least one half of the respondents in any subgrouping reported no formal administrative train-

Table 4. Personnel Ratios

	Faculty : Resident Ratio	FPC Staff : Resident Ratio	Office Staff : Faculty Ratio
University Based Programs	**Faculty Resident**	**Staff Resident**	**Staff Faculty**
Departments	1 : 2.1	1 : 1.4	1 : 1.3
Divisions	1 : 2.4	1 : 1.3	1.4 : 1
Total	1 : 2.1	1 : 1.4	1 : 1.2
Non-University Based Programs	**Faculty Resident**	**Staff Resident**	**Staff Faculty**
Community Hospitals	1 : 4	1 : 1.5	1.1 : 1
Military	1 : 3.1	1 : 1.7	1 : 2.5
Total	1 : 4	1 : 1.6	1 : 1
Grand Total	1 : 2.9	1 : 1.5	1 : 1

ing; three quarters of the chairmen in university programs reported no formal administrative training. Only ten percent of the residency directors in community hospitals reported training in both their previous and current positions, and this was the group that had the highest percentage of training in both current and previous positions. The types of previous training reported consisted mostly of seminars and workshops at national association meetings. Only two respondents reported having such degrees as Masters of Public Health or Masters of Health Administration. These results show that the respondents have had little formal administrative training.

The administrative needs of the respondents were elicited by a set of 32 questions. As a first measure of administrative needs, the items in each category were averaged, to produce overall measures of need in the areas of finance, management, personnel, and communications. These four measures were then analyzed to determine if there was any difference in needs for respondents in different positions or with different administrative training. Overall, the area with the highest average level of need was finance, followed by management, personnel, and communications. Chairmen had slightly lower average levels of need than residency directors, but the ordering of the areas of need remained the same. When the respondents were categorized by their administrative training, it was found that those with previous administrative training had the lowest average levels of need. The ordering of the areas of need again remained the same, indicating that this ordering was not affected by organizational role, program setting, or amount of formal administrative training.

The nine most prevalent needs are presented in Table 5. The proportion of respondents who indicated that a need was of moderate or great importance was calculated, and the nine needs that were so indicated by 40 percent or more of the respondents are listed in descending order. The development of research functions and support staff for research was the most prevalent need. Almost 90 percent of the chairmen in community hospital programs indicated that this was an important need. Faculty development and recruitment were two important needs that were in the top five. Financial issues of particular importance were alternative methods for increasing revenues and the development of skills in grantsmanship and in relationships with funding sources. Personal issues, such as work stress, role conflicts, and time management, were also mentioned as prevalent needs.

Satisfiers and Dissatisfiers

An important issue in the development of continuing education programs in administration for chairmen and residency directors is the determi-

Table 5. Most Prevalent Administrative Needs of Respondents (Percent of Respondents Indicating a Moderate or Great Need)

	Number of Respondents	Most Prevalent Administrative Needs: Developing Research Functions and Support Staff	Faculty Development	Alternate Methods for Increasing Revenue	Grants and Funding Sources	Faculty Recruitment	Personal Work Stress and "Burnout"	Management Development for Subordinates	Role Conflicts and Work Stress	Time Management
Chairmen										
University Based Programs*	52	69	50	62	46	49	49	42	33	42
Community Hospitals	8	88	75	63	38	13	25	50	50	25
Total†	64	70%	55%	58%	42%	42%	44%	45%	36%	41%
Residency Directors										
University Based Programs*	14	50	54	50	64	50	43	43	36	43
Community Hospitals	81	72	66	67	60	54	48	49	51	47
Total†	98	67	63	61	57	52	46	48	48	45
Grand Total†	162	70%	61%	60%	51%	50%	50%	46%	44%	43%

*Departments and divisions
†Includes military

nation of those components of their administrative work which produce the most satisfaction, and those which produce the least. Given 11 items, respondents were asked to indicate the 4 most satisfying and dissatisfying aspects of their administrative work. The items were presented in such a way that an item could be both a satisfier and a dissatisfier. Five items emerged as major satisfiers, and three emerged as major dissatisfiers, as shown in Table 6. These results show that chairmen and residency directors are in agreement on the aspects of the administrative role that produce dissatisfaction, but their views differ with respect to what areas elicit the most satisfaction.

Training Preference

Respondents were asked what type of administrative training they preferred, given the choice of fellowships and offsite and onsite workshops. With the exception of a very few, the chairmen and residency directors did prefer one of the three choices. Nearly three fourths of the respondents preferred an offsite workshop. Onsite programs were preferred by slightly over half. Fellowships received more preference from chairmen than from residency directors. Overall, residency directors and chairmen most clearly preferred the offsite workshop, while chairmen expressed a somewhat higher interest in the other two types of programs.

Discussion

The desired competencies for senior management merit consideration by the people who currently perform administrative tasks, as well as by those who aspire to these top level positions. Perhaps the two most pertinent messages to educa-

Table 6. Administrative Satisfiers and Dissatisfiers (Percent of Total)

	Satisfiers		Dissatisfiers	
Chairmen (N=64)	Achieving Organizational Goals	77	Relationships with the Political Structure	69
	Residency Graduates' Success	70		
	Developing Plans and Policies	63	Intervening in Conflict	59
	Rapport with Subordinates	63	Time Management	52
	Faculty Accomplishments	50		
Residency Directors (N=98)	Residency Graduates' Success	74	Relationships with the Political Structure	69
	Achieving Organizational Goals	64		
	Rapport with Subordinates	60	Intervening in Conflict	57
	Developing Plans and Policies	51	Time Management	49
	Faculty Accomplishments	31		

tional administrators would be: (1) the history of academic administration may not provide much direction or support for future demands, since the "track records" of predecessors may be suspect; and (2) the qualities, skills, and needs of administrators are considerably different from those of educators, clinicians, and other more independently oriented professionals. Physicians should realize that the move to administration in academe will be a major professional challenge and career change.

The survey of chairmen and residency directors uncovered several empirical findings which have implications for the present and future leadership of family medicine. These include the lack of previous administrative training, a high incidence of administrators coming directly from private practice, a higher turnover of residency directors compared to chairmen, the relatively young age of many residency directors, a prevalent financial management need, concerns about research functions and development of faculty and subordinates, satisfactions with achieving goals and success of graduates, and dissatisfactions with external relations and conflict intervention.

The survey results also point out considerations for proposed administrative training. These are that chairmen and residency directors have differing needs, organizations, and backgrounds, and would probably benefit from different training (Table 7); location of the setting—university or community hospital—will have an impact upon competencies; training programs must be designed for individuals with little or no previous formal training; and content and process training must be directed to the realities of administration, both internally and externally.

Fortunately, administrative development for academic professionals has been a subject of concern in recent years, resulting in several educational programs. The American Council on Education (ACE) has established a Center for Leadership Development for faculty who leap into academic administration (Dobbins and Stauffer).[12] The University of Utah conducts Department Chairman Training Programs (Ehrle).[13] The Institute of Higher Education at the University of Georgia conducted programs on administrative team development and evaluated their results in a four-year follow-up study (Feltner).[21] An Administrative Development Fellowship Program is being conducted/sponsored by the Ohio Board of Regents (Projects for Educational Development).* Administrative skills in medical education are being developed by management advancement seminars sponsored by the American Association of Medical Colleges,** management training programs for family physicians,[22-26] and mental health professionals.[16] There is also the National Health Care Management Center at the University of Pennsylvania† which is committed to educating health care managers.

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†University of Pennsylvania, 3641 Locust Walk, Philadelphia, PA 19104

Table 7. Profiles of Family Medicine Chairmen and Residency Directors

Characteristic	Chairmen	Residency Directors
Age (years)	Late 40s	Late 30s; mid 50s
Tenure	4-5 years	2-3 years
Previous Position	Residency Faculty/ Residency Director	Private Practice
Location	University	Community Hospital
Tenure of Predecessor	4 years	Less than 3 years
Total Personnel	60	35
Number of Faculty	10	4
Number of Residents	26	18
Number of Staff	30	23

Conclusion

The quandary facing academic leaders, especially those in medical education, is well documented. However, it is not apparent that a concerted effort is underway to resolve the aforementioned concerns and problem areas. Physicians who choose to administrate, while maintaining their scholarly and patient care responsibilities, must be willing to expand their professional capabilities to include administrative competencies. The question remains, will family medicine and medicine at large develop their leadership to meet the challenges of administrating their profession?

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