Reframing the Modern Medical School Deanship

LEADERSHIP IN A SHARED-AUTHORITY ENVIRONMENT

2026

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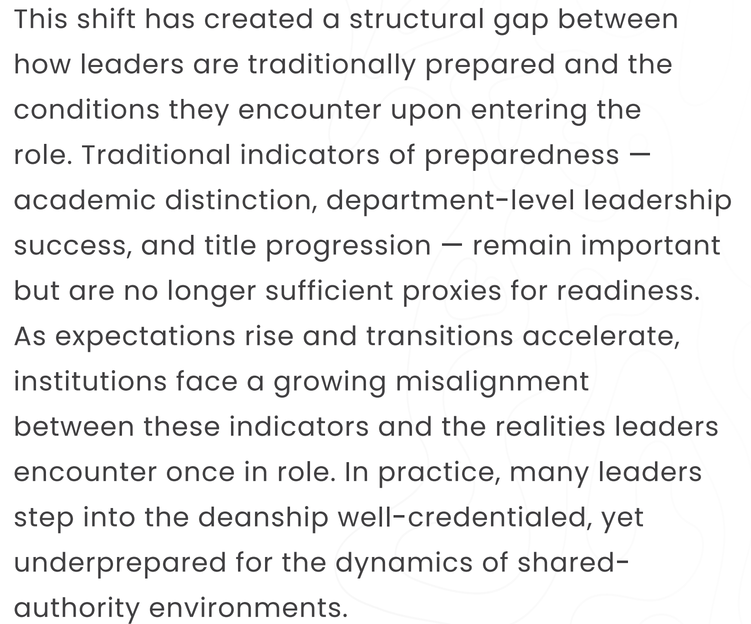
Leadership Inflection Point

The role of the medical school dean has shifted, with this transformation already underway well before recent public policy changes. As the scope and interdependence of the role have expanded, the conditions under which leadership is exercised have fundamentally changed.

National data underscore the scale of this transformation. U.S. medical school enrollment has grown by more than 30% since the early 2000s, intensifying demand across faculty, clinical training environments, and institutional infrastructure (Association of American Medical Colleges, 2024). At the same time, shorter dean tenures, now averaging approximately four to five years, have increased leadership turnover (Chatterjee et al., 2025).

Boards, presidents, provosts, communities, and system leaders increasingly look to the dean to deliver across the full mission portfolio, often simultaneously. The role now requires stewarding culture, managing complex clinical partnerships, engaging donors and policymakers, representing the institution externally, and navigating constraints beyond direct formal authority. The modern medical school dean is no longer defined primarily by positional control, but by the ability to sustain influence across a system they do not fully control.



This shift has created a structural gap between how leaders are traditionally prepared and the conditions they encounter upon entering the role. Traditional indicators of preparedness — academic distinction, department-level leadership success, and title progression — remain important but are no longer sufficient proxies for readiness. As expectations rise and transitions accelerate, institutions face a growing misalignment between these indicators and the realities leaders encounter once in role. In practice, many leaders step into the deanship well-credentialed, yet underprepared for the dynamics of shared-authority environments.

This raises a critical question for governing bodies and academic leadership alike: what does impactful leadership in the modern medical school deanship now require, and how can institutions better assess, prepare, and support those who step into the role?

This report draws on a career-pathway analysis of 143 sitting U.S. allopathic medical school deans and in-depth interviews conducted across diverse institutional contexts, integrating quantitative pattern analysis with lived leadership experience to surface how readiness and effectiveness are expressed in today's deanship.

The report introduces the Kite Model, a practical framework for understanding how leadership is exercised in modern medical school deanships. It captures the operating dimensions of the role, along with the personal anchor required to sustain impact over time, and translates these insights into implications for boards, institutions, and aspiring deans.

As you move up in academic medicine, you start making more and more impactful decisions about things you know less and less about."

— Bradley Britigan, M.D., Dean, College of Medicine, University of Nebraska

The pace and complexity of the role leave little room for purely academic leadership. Deans must be comfortable making decisions with incomplete information."

— Lewis S. Nelson, M.D., M.B.A., Dean and Chief of Health Affairs, Charles E. Schmidt College of Medicine, Florida Atlantic University

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The Modern Dean Agenda

RESPONSIBILITY WITHOUT UNILATERAL CONTROL

The medical school deanship now operates within a system of shared authority. While deans are accountable for outcomes across education, research, clinical partnerships, culture, and institutional reputation, many of the levers that shape those outcomes are governed through distributed decision-making across departments, health systems, universities, boards, and external partners. Authority is diffused rather than centralized, and the role is exercised within a matrix of overlapping responsibilities and constraints. This condition is not episodic or transitional; it defines the role's operating environment. Consequently, leadership success depends on aligning actors with distinct mandates and advancing priorities without direct control.

Successful community-based medical schools view partnerships as true partnerships, not as transactional arrangements. They rise or fall on their ability to build trust and demonstrate value to external leaders in systems they do not control."

— Paul Lyons, M.D., Dean, School of Medicine; President and Chief Executive Officer, California University of Science and Medicine

Figuring out how you set priorities — particularly relative to what you can support and resource — is a challenge from day one. You never make those decisions in a vacuum."

— Mary Klotman, M.D., Dean, School of Medicine; Executive Vice President for Health Affairs, Duke University;

INFLUENCE AS THE PRIMARY LEADERSHIP MECHANISM

In this context, formal authority is insufficient as a basis for leadership. While the deanship carries positional authority, decisions are advanced primarily through influence rather than directive control. Influence becomes the central operating mechanism of the role. Leadership effectiveness is determined less by the ability to issue decisions than by the capacity to align stakeholders, sustain trust, and move complex agendas forward without relying on hierarchical power.

Seeing the institution from the health-system C-suite fundamentally changed how I understood the role of the Dean."

— James M. Record, M.D., J.D., F.A.C.P., Dean, Elson S. Floyd College of Medicine, Washington State University

THE DEAN AS AN ENTERPRISE LEADER

The scope of the medical school deanship now extends beyond the boundaries of the school itself. In addition to academic leadership, deans routinely operate within broader enterprise environments that include health systems, universities, affiliates, donors, policymakers, and community partners.

As a result, the deanship functions as a boundary-spanning position, requiring sustained attention to external governance, partnerships, and institutional positioning alongside internal academic responsibilities. For many deans, enterprise leadership is no longer an extension of the role; it is central to it. In many contexts, this expanded scope is formalized through concurrent roles or enterprise-level responsibilities, further embedding the dean within a wider set of institutional obligations that shape both decision-making and accountability.

You have to sell your vision, and you have to get people to buy in and to want to be part of the process."

— Richard J. Barohn, M.D., Hugh E. and Sarah D. Stephenson Dean, School of Medicine; Executive Vice Chancellor for Health Affairs, University of Missouri

LEADING UNDER CONSTANT VISIBILITY

The medical school deanship is exercised within a setting of sustained complexity and visibility. Competing academic, clinical, financial, and relational priorities must be addressed simultaneously, making triage a standing condition of the role rather than a response to crisis. Decisions are highly visible and interpreted across multiple constituencies, each viewing outcomes through different institutional lenses. Leadership is expressed not only in what is decided, but in how decisions are framed, paced, and sustained under continuous scrutiny.

I remember sitting at my desk trying to do the Dean's job, and people kept knocking with crises and decisions. That's when it clicked — that's the job."

— Amy L. Waer, M.D., F.A.C.S., M.P.S.A., Dean, Naresh K. Vashisht College of Medicine, Texas A&M University

The Kite Model: Leadership in Shared Authority

As the deanship has evolved, readiness for the role is no longer signaled solely by domain expertise, academic accomplishment, tenure, or positional authority. Instead, readiness is increasingly defined by a set of leadership capabilities that develop as scope expands and control becomes increasingly distributed. To capture this shift, we introduce the Kite Model.

It's the responsibility of the Dean to make sure that you set up your team and your day to allow reflection, a sense of direction, and true strategy development."

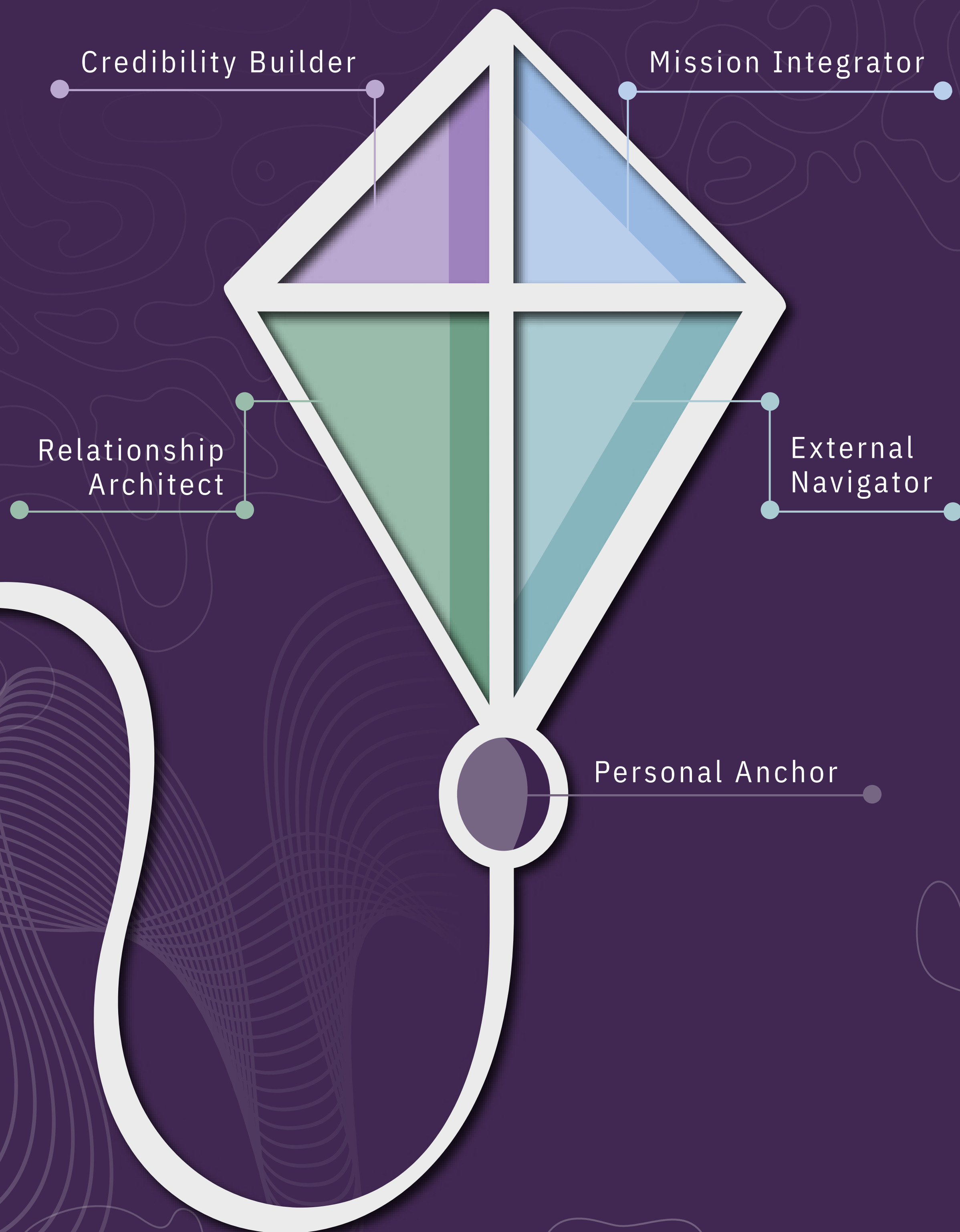
— Arturo Saavedra, M.D., Ph.D., M.B.A., Dean, School of Medicine; Interim Provost and Executive Vice President for Academic Affairs, Virginia Commonwealth University

The Kite Model reflects the reality that leadership impact is generated through the productive management of tension rather than balance, with opposing forces held in dynamic alignment. It translates these lived leadership realities into four interdependent operating dimensions, sustained by an always-present personal anchor. The central premise is integration: leadership capability is expressed not through isolated strengths, but through the ability to hold these dimensions simultaneously as institutional conditions shift. Together, these dimensions help explain why the deanship is often experienced as more complex in practice than it appears by title or mandate alone. That complexity is not abstract; it is experienced daily in how leadership is exercised.

Leadership within the modern deanship is exercised under conditions of continuous triage, visibility, and constraint. Deans navigate multiple, simultaneous demands that are all legitimate and time-sensitive, with decisions interpreted across constituencies that hold different — and often competing — definitions of success. Effectiveness depends less on executing a fixed plan than on sustaining judgment, prioritization, and forward momentum under the conditions of constant interruption and constrained authority.

THE KITE MODEL

The Kite Model reflects dean leadership as the active management of competing forces, rather than static balance.



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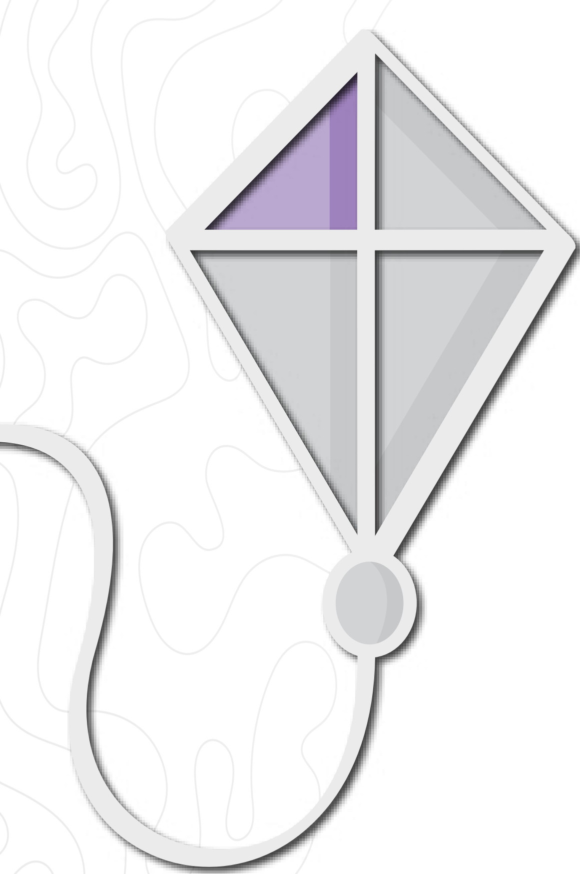


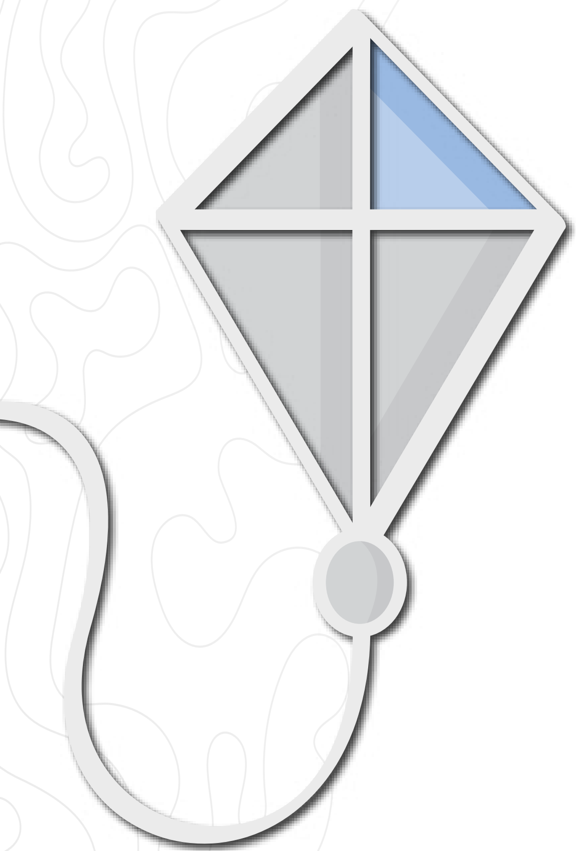
MISSION INTEGRATOR

Deans succeed or fall short based on their ability to hold education, research, and clinical care as a coherent agenda rather than allowing them to compete as parallel priorities. It is expressed through disciplined prioritization and the ability to translate broad mission ambition into a focus that can be sustained across constituencies.

Where this integration is less established, the role becomes harder to execute because leadership attention is pulled into competing internal definitions of success, and institutional momentum becomes increasingly dependent on continual negotiation rather than sustained direction.

There is still a tension between academics and clinical realities. They're very interested in RVUs and patient satisfaction. We're very interested in protected time, publications, teaching, and research. Trying to thread that needle is challenging."

— Lewis S. Nelson, M.D., M.B.A., Dean and Chief of Health Affairs, Charles E. Schmidt College of Medicine, Florida Atlantic University



CREDIBILITY BUILDER

Authority may be conferred by title, but influence is earned through credibility across constituencies. Credibility is built through fluency, judgment under constraint, and the ability to communicate decisions in ways that remain persuasive to groups with different expectations.

It is not singular; it is rather assessed differently across constituencies. Faculty often look for academic judgment and respect for scholarly norms. Physician and nurse leaders look for operational understanding and appreciation of clinical realities. University leadership seeks alignment, sound judgment, and the ability to represent the institution externally. As these expectations coexist, credibility must be established in parallel rather than sequentially, placing early and sustained pressure on new deans.

Where this trust base is still being established, progress often slows, not because leadership is absent, but because influence has not yet consolidated across the constituencies required for sustained execution.

I tell people not to take things personally. When you're behind closed doors and having real, heated conversations, it's rarely personal. Most often, it's because people are passionate about what they believe in or they're advocating for resources."

— LaTanya Jones Love, M.D., Dean, McGovern Medical School; Executive Vice President, University Affairs, UTHealth Houston

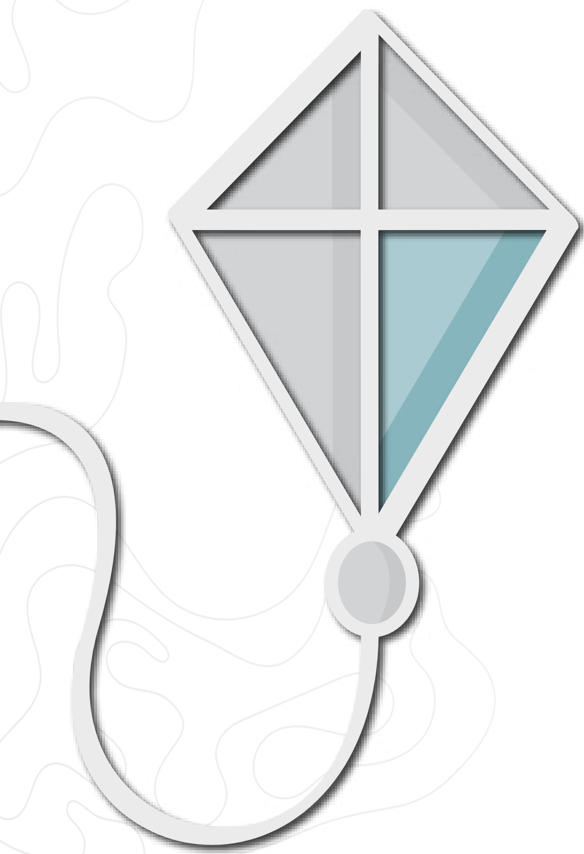
RELATIONSHIP ARCHITECT

Sustained mission execution depends on the deliberate design and stewardship of a broader partnership ecosystem. This includes the health system, affiliated hospitals and clinics, community partners, donors, and external collaborators. The emphasis is not on transactional engagement but on the sustained stewardship of relationships that evolve over time and often determine institutional capacity.

Where partnership capability is less embedded, the role is more exposed to volatility because alignment can become overly person-dependent and vulnerable to transition, rather than reinforced through durable relational infrastructure.

I don’t control the things I’m trying to do strategically. I have to build relationships with partners who have their own interests — and that’s the work.”

— Lewis S. Nelson, M.D., M.B.A., Dean and Chief of Health Affairs, Charles E. Schmidt College of Medicine, Florida Atlantic University



EXTERNAL NAVIGATOR

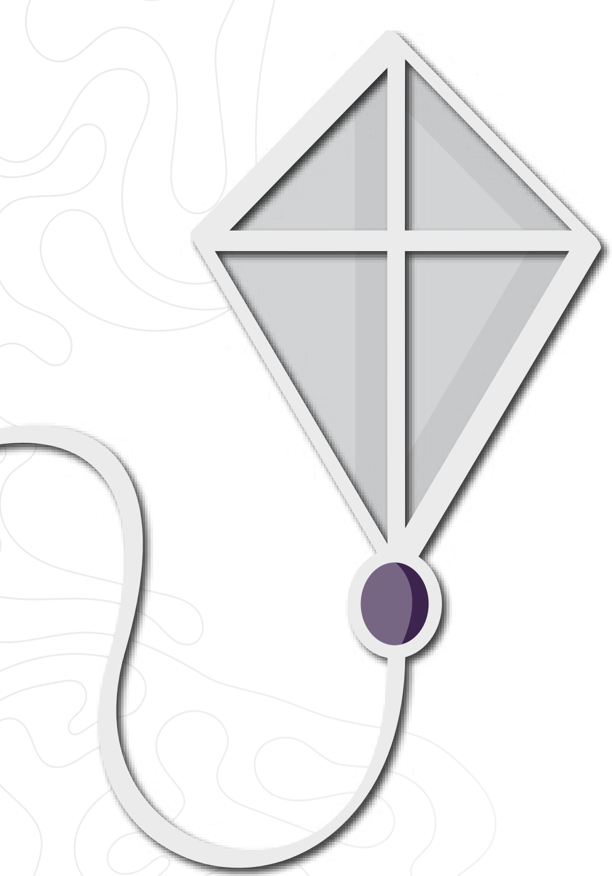
The deanship now extends decisively beyond the medical school, requiring sustained, outward-facing leadership across health systems, universities, donors, policymakers, regulators, and civic stakeholders. This external scope is not simply additive; it reshapes how the role is exercised, how attention and time are allocated, and how institutional credibility is represented beyond the academy.

As a result, responsibilities increasingly include philanthropy, government relations, system-level governance, and partnership development, placing deans in settings where decisions carry enterprise-wide implications and authority is largely indirect. External audiences often evaluate leadership through lenses that differ from traditional academic norms, emphasizing responsiveness, clarity, and alignment with broader institutional goals. Navigating these expectations requires adaptability and judgment, as well as the ability to translate academic priorities into frameworks that resonate beyond the academy while sustaining internal confidence and continuity of execution.

Where external navigation capability is still developing, the role can become internally focused, even as external forces increasingly shape resources, partnerships, and institutional positioning. In these contexts, limited fluency or credibility beyond the school constrains the dean's ability to influence outcomes that are central to long-term institutional viability.

The job really is external-facing. You need the right people internally, and then you have to focus on government relations, donors, and enterprise leadership."

— Jonathan McCullers, M.D., Dean, Tilman J. Fertitta Family College of Medicine; Vice President for Health Affairs, University of Houston



"There's truth to the idea that the role can be isolating. You have to remain accessible and trusted, while also maintaining enough distance to make difficult decisions without the perception of favoritism. That tension is inherent to the role."

— John Dalrymple, M.D., Dean and CEO, Kaiser Permanente Bernard J. Tyson School of Medicine

PERSONAL ANCHOR

Effectiveness in the deanship is not sustained by operating capability alone; it depends on the strength of the leader's personal anchor over time. While the four dimensions describe how the role is exercised, the personal anchor reflects what enables leaders to remain successful, credible, and intact over time as demands accumulate.

It is an inward orientation that governs how leaders interpret pressure, regulate their responses, and maintain coherence when decision authority is dispersed, outcomes are contested, and expectations continue to expand. This anchor consistently appeared through three reinforcing capacities: clarity of purpose, self-regulation under constraint, and relational endurance in a role defined by impartiality and isolation.

Where the personal anchor is underdeveloped or erodes over time, leaders may continue to perform across the operating dimensions for a period, but often at increasing personal cost. Fatigue, narrowing perspective, and decision compression commonly follow, not because capability is lacking, but because sustainability has been compromised.

The role also imposes a structural tension around relational positioning. Deans must remain broadly trusted across constituencies without becoming aligned with any single group. This requires maintaining access and credibility while preserving the independence needed to make contested decisions. Many leaders therefore develop support structures outside the immediate decision environment, including trusted peers and external relationships, to sustain reflection and judgment without compromising neutrality.

Becoming a Medical School Dean

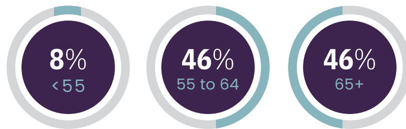
PATHWAYS TO THE DEANSHIP

Pathways to the medical school deanship are shaped by institutional context, timing, and need — not a single linear sequence. Pathways reflect distinct starting conditions that shape early expectations and transition demands, rather than predictors of performance once in position.

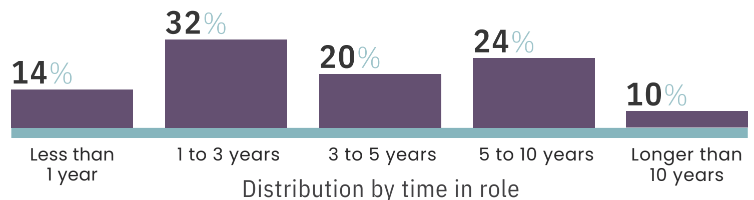
A PORTRAIT OF ALLOPATHIC MEDICAL SCHOOL DEANS

PROFILE

63Y
Current age, on average



Distribution by age



Distribution by time in role

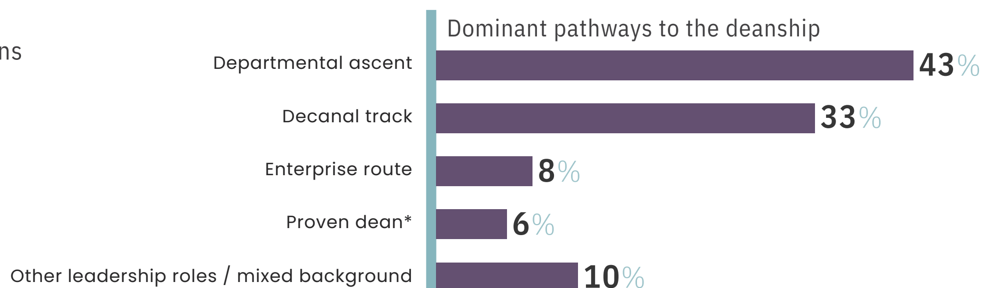
57%
hold a concurrent role

PATHWAYS TO THE DEANSHIP

53% External appointments

47% Internal promotions

Among internal appointments, **51%** had prior interim experience



*Observed exclusively in newer medical schools (<10 years accredited)

Source: WittKieffer proprietary research on the career pathways of 143 sitting U.S. allopathic medical school deans, based on publicly available information from institutional websites, press releases, BoardEx, and LinkedIn profiles. Analysis conducted as of December 2025. Pathways groupings reflect observed career patterns rather than perspective routes to the medical school deanship. ©WittKieffer, all rights reserved.

THE DEPARTMENTAL ASCENT

This pathway is grounded in unit-level leadership, spanning academic department chairs and clinical or division chiefs. While these roles differ in emphasis, they share accountability for defined units where academic and clinical performance is delivered. Leaders arriving through the departmental ascent have held responsibility for people, resources, and outcomes close to mission execution, not institutional coordination.

The departmental ascent is most prevalent in medical center-based and stand-alone institutional environments, where authority is built upward from departments and service lines rather than centralized within the dean's office. In these settings, department leadership serves as a primary proving ground for senior authority. Chairs and chiefs are expected to balance mission priorities, navigate governance dynamics, and manage operational tensions within high-visibility units before being considered for broader roles.

The transition into the deanship is shaped by shifts in operating conditions. Leaders accustomed to decision-making within defined units enter a role in which authority is more diffuse, and outcomes depend on alignment across multiple actors. Issues previously resolved through direct management now require coordination across missions and governance settings. Early traction depends on the ability to adapt unit-level decision habits to shared-authority environments.

THE DECANAL TRACK

This pathway is grounded in school-level academic administration, most commonly among assistant deans, associate deans, and vice deans. Leaders arriving through the decanal track operate within the dean's office and frequently have direct exposure to health system and university dynamics, particularly in integrated academic health systems. These roles provide a front-row view into institutional decision-making, governance, and cross-mission coordination while anchoring responsibility in agenda-setting, integration, and alignment.

The decanal track is most prevalent in medical school-based institutional environments, where the dean's office serves as the primary coordinating center for academic leadership and mission integration. In these settings, senior decanal roles are core leadership infrastructure, translating institutional priorities into coordinated action across education, research, faculty affairs, and connected enterprise functions. When authority is centralized, progression through these roles becomes a natural precursor to the deanship.

The transition into the deanship from this pathway is shaped by an expansion in scope. Leaders accustomed to coordinating priorities within the medical school assume accountability that extends across clinical partners, university leadership, and external stakeholders. The central shift is from internal coordination to managing interdependence across actors with distinct incentives and decision rights, requiring influence to extend beyond the dean's office.

THE ENTERPRISE ROUTE

This pathway is grounded in enterprise-level leadership, most commonly among individuals whose immediate prior roles include chief academic officer, vice chancellor, executive vice president, or comparable system-level positions. Leaders arriving through the enterprise route enter the deanship having already operated across multiple missions, entities, and stakeholder groups within an academic health system or university enterprise.

The enterprise route appears most often in medical center-based and stand-alone institutional environments, where the medical school sits within a broader clinical or enterprise structure rather than operating as a self-contained academic unit. In these settings, interaction with system governance, financial decision-making, and cross-organizational coordination is a routine feature of institutional leadership. Leaders who arrive through enterprise-level roles step into the deanship with prior exposure to the operating context in which the medical school is embedded.

The transition into the deanship from this pathway requires refocusing rather than expansion. Leaders accustomed to broad enterprise portfolios concentrate their influence on the medical school while remaining accountable within a larger system. The leadership challenge lies in translating an enterprise perspective into academic legitimacy while navigating shared governance and faculty culture.

THE PROVEN DEAN

This pathway reflects leaders appointed to the deanship after serving as deans at other medical schools. It represents individuals whose prior role included full accountability for academic leadership, faculty governance, and institutional stewardship within a medical school context.

The proven dean appears almost exclusively in newer medical schools, where leadership teams are often assembled quickly, and the tolerance for extended learning curves is limited. In these settings, the appointment of a sitting or former dean serves as a stabilizing mechanism, providing immediate operational fluency and external credibility as foundational structures, partnerships, and governance norms are still being established.

The transition into the role is shaped by contextual adaptation. Leaders entering through this pathway bring familiarity with the demands of the deanship itself, but must recalibrate to a different institutional maturity, mission profile, or governance environment. Early effectiveness depends on applying prior experience flexibly rather than assuming direct transferability.

THE INSTITUTIONAL DRAFT

The pathway to the medical school deanship is best understood as non-sequential rather than linear. Instead of a predefined series of roles, readiness consolidates through cumulative exposure to consequential responsibility, where expanded scope and demonstrated judgment function as the clearest signals of readiness.

Leaders who ultimately become deans are repeatedly asked to assume responsibility beyond their formal remit. These assignments do not replace core roles. They sit alongside them. Over time, this pattern of parallel responsibility becomes a visible signal of capacity for broader stewardship, particularly when leaders are asked to manage technically complex work under constraint, sustain alignment across constituencies, and absorb institutional pressure without escalation.

This 'institutional draft' dynamic is adaptive, but it also represents a material succession and leadership-continuity risk. When leadership development and succession rely heavily on unplanned stretch assignments and interim coverage rather than deliberate pipeline design, institutional continuity becomes vulnerable to timing, individual availability, and disruption. Interim service functions as an institutional stress test that allows readiness to be proven before a formal appointment. Still, it also signals that formal succession mechanisms are often activated late rather than built early.

Across pathways, a consistent pattern emerges: readiness is built through a set of recurring experiences rather than a defined sequence of roles.

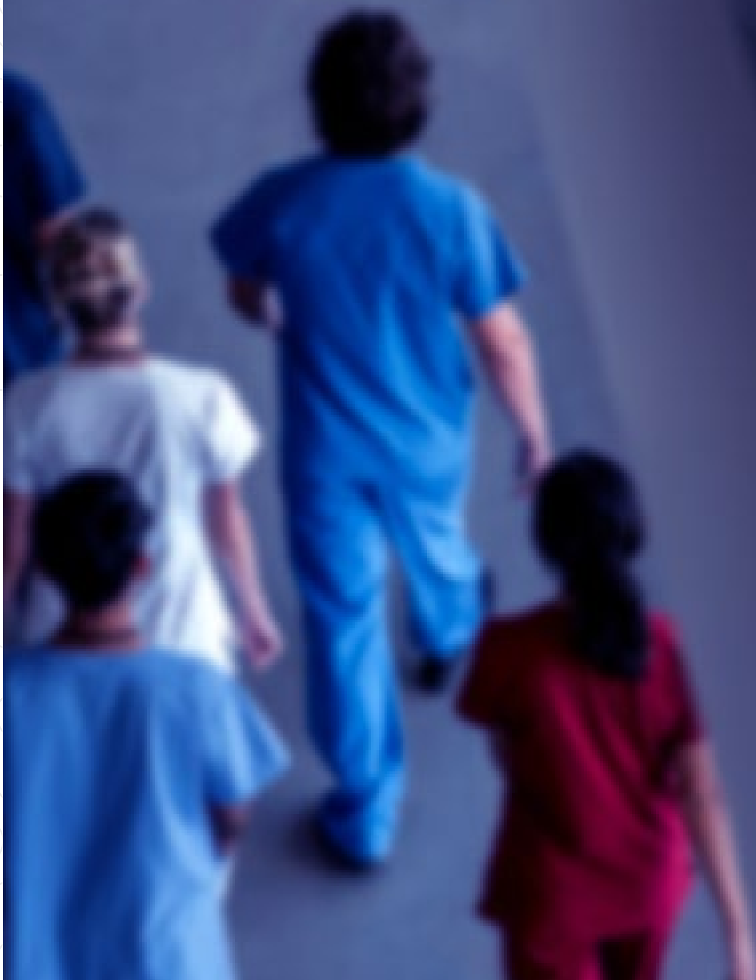
What Actually Builds Readiness for the Deanship

- Leading institution-wide initiatives while holding a primary leadership role, such as accreditation, curriculum redesign, or major strategic planning efforts.
- Operating at the interface of the medical school and health system, including responsibility for clinical integration, practice plan governance, or service line performance.
- Managing enterprise-level complexity following leadership disruption, such as stepping into interim oversight during periods of transition or instability.
- Working directly with senior university leadership and boards, gaining exposure to governance, capital decisions, and political dynamics beyond the school.
- Representing the institution externally, through partnerships, philanthropy engagement, or community and government relations.

Administrative leadership is a skill set. Just because you're a strong faculty member doesn't mean you're prepared to lead a group or organization. What mattered most to me was taking on stretch responsibilities and learning how institutions function from the inside out."

— Nita Ahuja, M.D., M.B.A., F.A.C.S., Dean, School of Medicine & Public Health, Vice Chancellor for Medical Affairs, University of Wisconsin

Leadership in Practice



In practice, leadership in the modern medical school deanship shows up in how success is defined, resources are allocated, partnerships are managed, and institutional continuity is sustained. These areas reflect how the operating dimensions of the deanship are exercised under real-world conditions.

DEFINING AND ALIGNING PERFORMANCE

SUCCESS MEASURES

Success measures reveal how ambition is translated into operating discipline and aligned accountability, making institutional performance more predictable and less dependent on individual heroics.

Performance is assessed across four recurring domains that reflect the academic mission and the realities of the clinical enterprise. The leadership challenge lies in translating these measures into a coherent set of priorities that guide decision-making, resource allocation, and accountability.

I pay close attention to whether people are developing. Seeing faculty progress, move into leadership roles, or grow into national profiles matters to me, and I consider that an important signal alongside more traditional measures."

— Terence R. Flotte, M.D., Dean, T.H. Chan School of Medicine; Provost and Executive Deputy Chancellor, UMass Chan Medical School

- **Education and learner outcomes:** accreditation readiness, learner progression, match outcomes, and the quality of the learning environment.
- **Research vitality:** funding trajectory, pipeline strength, and the institution's capacity to sustain discovery amid volatility.
- **Clinical and enterprise alignment:** the stability of clinical partnerships, the financial conditions underpinning the academic mission, and alignment between the school and the broader health system.
- **Institutional strength:** faculty and leadership recruitment, retention, and cultural signals that indicate the institution's ability to execute strategy over time.

In practice, impactful deans define institutional success with precision and then simplify. Institutional performance gains traction when broad mission ambition is distilled into a limited set of outcomes that can be clearly articulated and consistently reinforced. This functions as a governance discipline, reducing diffusion of attention and limiting conflict over competing definitions of success.

These success measures are also used to sequence decisions and investments over time. Rather than advancing all priorities simultaneously, deans use performance measures to determine which initiatives move first, where resources are concentrated, and which efforts are deliberately deferred. Sequencing translates broad ambition into a set of intentional, time-bound choices.

Finally, internal and external constituencies are aligned around a joint definition of success. In a shared-control environment, success measures must function as a common language. A consistent performance frame supports alignment with university leadership, health system partners, donors, and external stakeholders, particularly when difficult or contested decisions are required.

Early on, financial and operational fluency mattered most. Demonstrating an understanding of funds flow and clinical margins created the space to then lead the broader vision."

— Fredric Edward Wondisford, M.D., M.S., M.B.A., Dean, College of Medicine, University of Arizona

CLINICAL PARTNERSHIPS

Clinical partnerships reveal how the dean's role is exercised within a highly interdependent environment. When partnerships are led as value systems grounded in credibility, reciprocity, and sustained engagement, the academic mission is better positioned to endure volatility and pursue long-term ambition.

In shared-authority environments, clinical partnerships function as a structural determinant of academic viability, not a supporting condition. These are long-horizon, interdependent relationships in which academic and clinical success are mutually reinforcing rather than transactional.

Credibility at the enterprise level is a foundational condition for effective clinical partnerships. Partnership strength depends on the dean being viewed as an enterprise actor rather than an academic advocate seeking accommodation, particularly by senior clinical leadership, who control strategy, resources, and operating priorities.

Academic priorities are translated into value propositions that support durable alignment with clinical partners. Durable alignment emerges when education, research, and faculty priorities are framed in terms that resonate with clinical partners' needs, including workforce development, quality, growth, and institutional reputation.

Institutional advocacy and enterprise stewardship are held in ongoing tension. Clinical partnerships surface persistent tension between advancing the medical school's interests and sustaining enterprise-wide viability, with credibility depending on the ability to hold both obligations simultaneously rather than resolving them into false trade-offs.

SUCCESSION PLANNING

Succession planning reveals how medical schools understand leadership as a collective, time-bound responsibility rather than an individual tenure event. When succession is embedded as an ongoing governance discipline, continuity becomes more resilient and less dependent on incumbents, reinforcing leadership stewardship across transition rather than treating succession as an episodic disruption. Succession functions as a standing governance condition rather than an episodic event, shaping institutional stability, continuity, and the capacity to sustain momentum through leadership change.

Leadership depth functions as institutional resilience. Succession readiness is closely tied to the credibility and depth of the medical school's leadership bench. Visible internal capacity supports confidence among governing stakeholders, reduces disruption during transition, and provides institutions with greater flexibility when leadership change occurs under time pressure or uncertainty.

Informal signaling further shapes transition dynamics. Succession trajectories are often influenced well before formal processes begin. Informal signals about readiness, perceived credibility of internal leaders, and stakeholder confidence frequently shape how transitions unfold.

Role clarity influences successor readiness. Succession risk increases when the scope and expectations of the medical school dean's role are ambiguous, personalized, or inconsistently understood across stakeholders. Clear articulation of enterprise responsibilities, decision authority, and leadership expectations enables more consistent assessment of readiness, fit, and development needs.

Internal development and external credibility remain in tension. Medical schools balance cultivating internal leadership capacity with the need to maintain credibility with external stakeholders, including university leadership, clinical partners, and donors. How this balance is managed shapes both continuity and confidence.

AI AS A LEADERSHIP STRESSOR

AI-related decisions reveal how the dean's role is exercised when expectations advance faster than evidence, consensus, or institutional readiness. Within this operating reality, AI functions less as a technical challenge than as a leadership stressor, making judgment, pacing, and signaling highly visible across constituencies.

Leadership in AI-related decisions requires holding divergent perspectives without premature convergence. AI amplifies variation in faculty expertise, conviction, and concern. Leading in this context requires setting a deliberate pace that absorbs disagreement while resisting reactive decision-making driven by comparison or fear of falling behind.

Timing and choice function as visible leadership signals. Decisions about whether, how, and when to engage with AI signal how the institution balances innovation with stewardship and governance discipline.

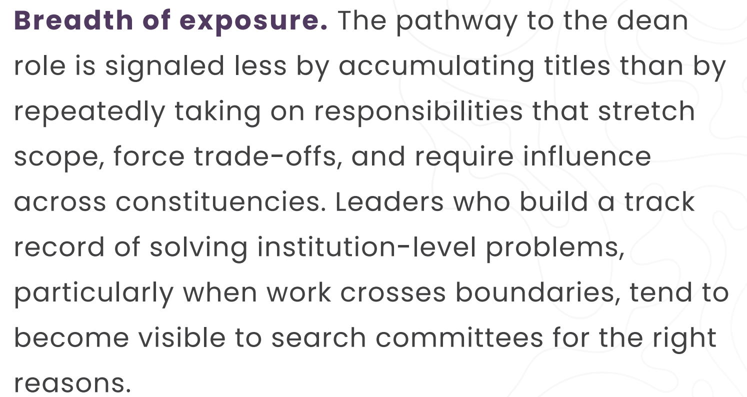
Implications for Aspiring Deans and Institutional Leadership

A single reality anchors the findings: the modern medical school dean's role is no longer defined by excellence in one domain. It is defined by the capacity to integrate multiple, structurally interdependent demands exercised largely through shared authority. The implications that follow translate this reality into practical considerations for those preparing for the role and those responsible for selecting and supporting them.

IMPLICATIONS FOR ASPIRING DEANS

Aspiring deans are already accomplished leaders. The differentiator is not seniority, credentials, or disciplinary stature, but whether a leader has begun to develop capability across the operating dimensions that now define how the role is exercised, particularly in the face of ambiguity, external visibility, and enterprise interdependence.

The implications for aspiring deans are consistent and cumulative. They reflect how readiness is built over time through exposure, capability, and alignment.



Breadth of exposure. The pathway to the dean role is signaled less by accumulating titles than by repeatedly taking on responsibilities that stretch scope, force trade-offs, and require influence across constituencies. Leaders who build a track record of solving institution-level problems, particularly when work crosses boundaries, tend to become visible to search committees for the right reasons.

Beyond domain expertise. A consistent pattern emerges: expertise in a subspecialty or a single mission domain is foundational but insufficient. Aspiring deans gain from purposeful exposure to unfamiliar institutional terrain, including enterprise governance, health system realities, partnership ecosystems, and external engagement. The objective is to build fluency and judgment in the settings where the dean's role is actually exercised.

Alignment with mission. Long-term effectiveness depends on the alignment between personal motivation and institutional mission. The personal anchor in the Kite Model is not rhetorical. It is a prerequisite for sustainability in a role that is increasingly external, political, and public. Aspiring deans benefit from being explicit about their 'why' and from assessing institutional fit with equal seriousness. Misalignment between personal values and institutional mission is not a secondary consideration; it becomes a constraint on long-term impact.

Leading without direct control. The dean's role is exercised differently. Influence is mediated by credibility, relationships, and the ability to hold competing obligations without defaulting to positional authority. Leaders who have already operated successfully in shared-authority environments are better positioned to translate intent into execution once in role.

There are weeks when external demands dominate. Fundraising, partnerships, and external engagement can easily consume all available time, reshaping how attention is allocated across the role."

— Juan C. Cendán, M.D., Dean, Herbert Wertheim College of Medicine; Senior Vice President for Health Affairs, Florida International University

I just said yes to opportunities that needed to be done. Running a clerkship, then a residency, then a department, each step built credibility. It wasn't planned, but that's what built the path."

— Sam J. Marzo, M.D., F.A.C.S., Dean, Stritch School of Medicine, Loyola University Chicago

My advice is to focus on doing what you are doing in the moment well. People notice that, and new opportunities arise from that usefulness. If you are a great chair or clerkship director, search committees will find you."

— Timothy H. Dellit, M.D., Paul G. Ramsey Endowed Dean, School of Medicine; Executive Vice President for Medical Affairs; CEO, UW Medicine, University of Washington

If faculty don't believe you understand the pressure of a clinic or the difficulty of securing research funding, credibility erodes quickly. I spent my first months listening in individual labs and rounding with different ward teams to demonstrate that I understood the language of the people I was leading."

— Robert Hromas, M.D., F.A.C.P., Dean, Joe R. and Teresa Lozano Long School of Medicine; Vice President for Medical Affairs, University of Texas Health Science Center at San Antonio

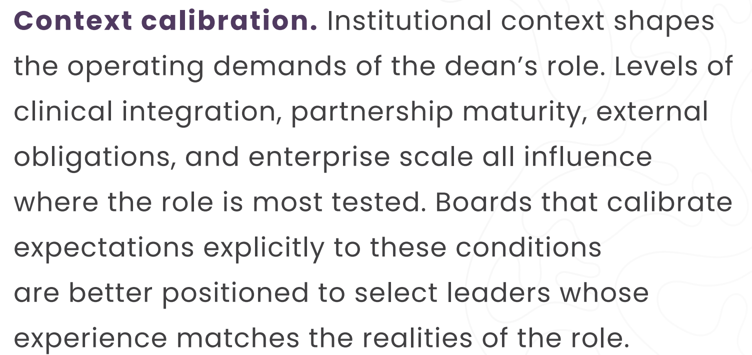
IMPLICATIONS FOR INSTITUTIONAL LEADERSHIP

For boards, university presidents, and provosts, the medical school dean role is an integrative position exercised within complex, distributed governance environments. Governance effectiveness depends on recognizing these realities early and acting accordingly, particularly in how the role is designed, supported, and sustained over time.

The implications for institutional leadership are similarly grounded in role clarity, assessment discipline, and ongoing governance support.

Role clarity. Institutions seeking deans are better served when they begin with role clarity rather than candidate comparison. Ambiguity around reporting relationships, decision rights, and enterprise responsibilities often leads to misaligned expectations once a dean is appointed. Explicit articulation of how the role operates within the academic health system provides the foundation for assessing readiness and fit.

Assessment beyond roles. Readiness is most clearly signaled by how leadership roles are exercised, not just which roles are held. Senior academic and clinical leadership roles remain important indicators of experience and progression. Boards gain deeper insight by examining how candidates exercised those roles, particularly when navigating complexity, shared authority, and enterprise-level tradeoffs.



Context calibration. Institutional context shapes the operating demands of the dean's role. Levels of clinical integration, partnership maturity, external obligations, and enterprise scale all influence where the role is most tested. Boards that calibrate expectations explicitly to these conditions are better positioned to select leaders whose experience matches the realities of the role.

Governance support. Institutional leadership, including boards, plays a consequential role beyond selection. Establishing clear expectations, aligning authority with accountability, ensuring access to resources, and engaging thoughtfully during the transition period are not discretionary acts of goodwill. They are core governance responsibilities that determine whether a dean can succeed.

Institutional leadership is best positioned when it approaches the medical school dean role as a complex leadership system rather than a single appointment decision. Sustained success depends not only on selecting an accomplished leader, but on aligning role design, expectations, governance support, and transition planning with the realities of shared authority and enterprise interdependence. Institutions that treat readiness, support, and succession as ongoing governance disciplines are better positioned to protect mission continuity and enable strong leadership over time.

The findings of our research point to a clear reality: impact in the modern medical school deanship is shaped less by title sequence or role tenure than by the capacity to lead within shared-authority environments marked by interdependence, visibility, and constraint. Capability becomes legible through experience navigating enterprise-level complexity, integrating competing priorities, and sustaining influence across constituencies without direct control.

The Kite Model offers a practical lens for interpreting these leadership conditions, clarifying how capability is exercised in practice and what sustains performance over time. For aspiring deans, this reframes preparation as cumulative exposure to consequential responsibility rather than linear advancement. For boards and senior leaders, it reframes selection and support as an ongoing governance discipline, anchored in role clarity, aligned expectations, and sustained institutional support.

The question for institutions is no longer simply who is ready for the deanship, but whether the institution is prepared to match the realities of the role. Institutions that make these dynamics explicit are better positioned to strengthen leadership continuity and protect mission performance amid recurring transitions.

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