An Invitation to Apply
For the Position of

Chancellor for Health Affairs,
President and Chief Executive Officer (CEO) of the Duke University Health System at
Duke University

Duke University and the Duke University Health System (DUHS) invite nominations and applications for the position of: Chancellor for Health Affairs, President and CEO of the DUHS.

The chancellor at Duke leads one of the nation's most distinguished, integrated academic health centers, with highly developed research, teaching and clinical healthcare missions. Duke Medicine—referring to both the academic medical enterprise and the health system—has prospered in every dimension and in all of its missions. The university seeks a chancellor equal to Duke Medicine's history and its ambitions.

Each of the schools in Duke Medicine ranks among the top ten in the country, in both indices and NIH funding, with the School of Nursing moving up dramatically in the last decade. The Duke University School of Medicine has an annual budget of approximately $1 billion and was ranked 8th in the nation in both school rankings and NIH funding and currently boasts a sponsored research budget of over $800 million. The Duke University School of Nursing ranks 7th nationally and has moved up from number 15 in the last seven years.

The Schools of Medicine and Nursing are home to 23 members of the National Academy of Science and 34 members of the Institute of Medicine, and in the last two years members of the Duke School of Medicine faculty earned a Lasker Clinical Medical Research Award and the Nobel Prize in Chemistry. At annual revenues of $180 million, the Duke Clinical Research Institute is the largest academic, clinical research organization in the world. Duke University's largest research institute is the Duke Human Vaccine Institute (DHVI) with an annual research budget of $50 million.

Even among great health care centers, the clinical enterprise at the Duke University Health System (DUHS) is remarkable. Faculty of the highest quality, research prominence, and a commitment to patient safety and quality have driven continued strong margins and a distinguished brand. The DUHS is a fully integrated healthcare system, including Duke University Hospital and two community hospitals, that attracts a highly acute patient population, has a strong payer mix in a fee for service environment, and grows volume steadily. Net patient revenues were $2.4 billion in 2013, up from $1.3 billion in 2002, with exceptionally strong margins and bond ratings. The DUHS hospitals are routinely ranked among the very best in the nation with top ten rankings in 11 of the 16 specialties covered. Between the school and the

health system, they have a balance sheet with roughly $5 billion in reserves, endowment and quasi endowment, a number that has more than doubled in the last decade.

The Health Center possesses all of the essential elements for long term success. It has moved aggressively to improve quality and to contain costs. In its next strategic initiative, in response to the changing healthcare environment, it will re-design care to have more collaborative teams with better outcomes, experiment with new forms of reimbursement and risk sharing, and remove very substantial additional costs. Unlike most major medical centers, Duke lives in a geography where health care reform has moved deliberately, allowing for thoughtful adaptation. The Health Center has responded appropriately. The successful candidate will envision and execute solutions to ensure Duke's continued place among the foremost leaders in academic medicine.

Duke University, across the entire campus, constantly improves in every dimension. It plans strategically and iteratively, looks to the future, builds loyalty and invests substantially aided by a rapidly growing endowment and generous philanthropy. It has steadily moved into the ranks as one of the world's great universities and has maintained all of its academic momentum throughout the recession.

The university has the highest possible academic and clinical ambitions for Duke Medicine. The next chancellor will join a university and a health center with a track record of impressive aspiration, clear accomplishment and tremendous momentum.

The Role

The chancellor—nominated by the president and appointed by the Board of Trustees of Duke University—reports to the president, is a senior officer of the university, and plays a central role in the university's full range of academic and strategic deliberations.

The deans of Medicine, Nursing and the Duke–National University of Singapore Graduate Medical School report to the chancellor as do the leaders of the Duke University Health System. The faculty practice plan, the Private Diagnostic Clinic (PDC), is independent but operates contractually with the university and health system.

In 1998, Duke created the Duke University Health System (DUHS), a controlled, affiliate, legally separate corporation of the university. The DUHS was created to ensure robust revenue streams for the School of Medicine academic missions and to provide the best in innovative and state-of-the art clinical care. The Executive Committee of the Duke University Board of Trustees appoints the members of the Duke University Health System Board of Directors, a 22-member, carefully composed body—including the president and board chair of Duke—that has fiduciary responsibility for the DUHS as overseen by the Executive Committee. The chancellor in her/his role as president and CEO of DUHS is elected by the DUHS board as the leader of the corporation.

Duke University

Duke University was created in 1924 with a gift from James Buchanan Duke to Trinity College, a small liberal arts college originally founded in 1838 in rural North Carolina. Since then, Duke has grown to include ten schools and a health system comprising over 6,400 undergraduate students, 8,100 graduate and professional students, 3,200 faculty, 35,000 employees and 154,000 active alumni. The annual operating budget in FY 2013 was $4.5 billion with $2.0 billion for university operations and $2.5 billion for the health system.

With strong academic leadership, Duke has, in the last decade, built a culture of innovation and collaboration rooted in an environment that promotes interdisciplinary research and education. The university leadership has initiated and guided a process of strategic planning that established three themes to advance intellectual priorities: interdisciplinarity, internationalization and knowledge in service to society. The university has made consistent and very substantial investments in each of its strategic priorities. It plans, executes and then plans again, in an intentional cycle. The university constantly improves and has become one of the most dynamic and distinguished academic institutions in the country. Duke Medicine is a large and essential partner, with every other part of the university, in Duke's core academic strategy.

Duke Medicine: The Duke historical mission

James Buchanan Duke's 1924 will explicitly endowed a medical school and a hospital. The university leaders traveled to Johns Hopkins University, the leading academic medical center of the day, and persuaded a cadre of emerging leaders to launch Duke's academic and clinical enterprise. There were few physicians and even fewer hospitals in the rural Southeast, and Duke's founder intended for the university to make up the difference. Duke swiftly became the referral medical center of choice. It built a culture of highly trained, academically distinguished physicians and investigators, who were frequently called on for difficult cases where there were few alternatives. The medical center was built around episodic, intense, specialty care with only a limited primary care role and modest systems to support access and referral. It relied on an exemplary brand and the broad belief in the community and among referring physicians that for the most threatening conditions, Duke was the appropriate destination.

Both the School of Medicine and the hospital relied heavily on impressive clinical chairs, who drove all the three traditional missions of research, clinical care and education. The chairs benefited from an explicit link with the Private Diagnostic Clinic, (the PDC is the independent faculty practice plan) and from the consistent growth in funded research. In the past, they had many revenue streams that came from clinical procedures. The chairs were recruited carefully, had the highest clinical and academic standards and developed a physician cadre who prided themselves on their intense devotion to the highest standard of patient care which established a regional, national and international brand that this generation of leadership has used to grow Duke Medicine.

The Academic Mission: Research and teaching

The Duke University School of Medicine

The Duke University School of Medicine employs just over 2,000 faculty in seven basic science departments, 14 clinical departments and 14 centers and institutes. It has a total budget of approximately $1 billion. It is heavily dependent on sponsored research, even more than its national peers, which accounts for nearly $800 million, with NIH funding hovering around $350 million and industry-sponsored clinical trials accounting for another $180 million. Total research has grown roughly 50% over the last nine years.

The school educates 430 medical students, nearly a thousand residents and fellows, 650 PhD students, and another 380 post-doctoral fellows.

As NIH funding declines, in inflation-adjusted terms, it has stressed the school's research mission, making it increasingly difficult to start early investigator careers or to sustain senior faculty who are only partially funded. A portion of indirect cost recovery has traditionally gone to the dean, and that revenue stream has modestly eroded.

The dean has traditionally had limited central resources, though they are sufficient in a growing market. Philanthropy has been driven by individual physicians and sometimes aided by centers, institutes, or departments, and indirect cost recovery is channeled in significant part back to investigators, though some portion does go back to the school's central funds.

To sustain the school, the Private Diagnostic Clinic (PDC) has, by contract, provided a subsidy from its physician fee revenues, which in recent years has hovered around $40 million. The funds flow directly to departments and department chairs, which control their pay plans and distributions. The contribution varies considerably by department depending on professional fee reimbursement schedules and as payers pressure physician professional fees, the school expects modest declines in funds flow.

In 2006, the health system committed to transfer a quasi-endowment of $280 million to the school that was to be used over a ten year period. This provided roughly $40 million a year for support of the academic mission of the school. In 2017, the DUHS will consider making two additional commitments, $310 million, which, with growth over a ten year period, should supply the same $40 million a year, carrying the medical school until 2027. At the same time, the health system will consider transferring an additional $200 million to the medical school, which the university expects will become an endowment, available to the dean, of roughly $400 million by the end of the decade.

The school has considerable resources under the control of key departments and faculty; however, it has limited resources at the center to support the strategic priorities of the school. As NIH funding erodes, this places more stress on the overall finances of the school.

To adapt to reductions in NIH funding and changing reimbursement for clinical services, the school has reduced administrative budgets, levied modest assessments on investigator and

departmental discretionary expenditures, created new metrics for faculty effort, reduced PhD recruitment by 15%, and spread out chair and director commitments, slowing the rate of faculty recruitment.

The combination of management adaptation and increased health system support has allowed for the unprecedented recruitment of 15 School of Medicine department chairs over the last five years and has helped Duke to sustain the strength of its NIH funding and its physician/ scientist cadre.

Duke's medical school manages five other emerging, educational programs, at the Masters and Doctoral level, which together train another 600 students. The Department of Community and Family Medicine created the first Masters level Physician Assistant program in the country and it is ranked number one in the country. In addition, the school provides a Doctoral program in Physical Therapy, a Masters of Health Sciences, a Pathologists' Assistant Masters and a Biostatistics Masters. As care management evolves, employing more complex teams with highly varied training, Duke believes its emerging and diverse graduate professional health services programs will provide a comparative advantage.

The Duke University School of Nursing

Duke opened its nursing school in 1931 with a three year diploma program. It transitioned to a four-year BSN in 1953 and then in 1984, closed its bachelors programs and became entirely a graduate school of nursing. In the last decade, the school has reintroduced a bachelor's degree and nearly tripled the size of its faculty from 27 in 2005 to 84 in 2013. NIH funding grew from $1.8 million in 2004 to $5.6 million in 2013, a move from 23rd in the country to 10th. The school's position in the national rankings similarly improved from 29th in 2004 to 7th by 2012.

The school has clear strategic objectives in both its research and teaching missions. As the U.S. health system re-configures how it delivers care, it will increasingly rely on highly educated nurse practitioners as independent primary care providers and as specialists in both ambulatory and in patient settings. The school provides a clear path for "seamless academic progression," for nurses seeking higher levels of education and expertise. Most of the programs train nurse practitioners, but the school extended its education by establishing an accelerated BSN (ABSN) program in 2002, a PhD program in 2006 and its Doctorate of Nursing Practice (DNP) program in 2008. In the fall of 2013, it enrolled 20 PhD students and 127 DNP students out of a total student body of 824.

The school's research focuses on trajectories of chronic illness, symptom management, and care of vulnerable populations including the elderly and minorities. In addition, faculty develop and disseminate knowledge to support evidence-based practice which strongly reinforces its teaching and care mission. The leadership of Duke Medicine believes that an increasingly sophisticated nursing program will become an essential strategic partner in both its research and clinical missions.

The Duke – NUS Graduate Medical School

The National University of Singapore (NUS) and Duke formed a partnership in 2005 to establish a new medical school in Singapore following the launch of Singapore's ambitious Biomedical Sciences Initiative in 2000. The partnership was intended to complement the NUS's existing undergraduate medical school by building a graduate medical school based on the Duke University School of Medicine curriculum, thereby increasing the supply of doctors practicing in Singapore and growing the nation's capacity to develop a vibrant biomedical hub. The school is part of the NUS system, but unique in that it is overseen by a Governing Board, including a Duke representative who has veto power over any academic decision made by the Board. Following the exceptionally strong progress in the first phase of the partnership, in November of 2010 the Singapore government signaled their resounding support by extending the Duke and NUS strategic collaboration in education and research by another five years.

Geography and Market

North Carolina is a largely rural, certificate of need state that has carefully controlled program development. In addition, it has an overall cost of living and cost of service that is lower than national averages and much lower than Duke's urban peers. Duke, as the most acute provider in the state, still registers at 90% of the national average for Medicare cost in the Dartmouth Atlas. Duke salaries are improved, in comparisons in the industry, when adjusted for cost of living. Local providers tend to endure with strong market share. There is an explicit premium for the assets of an approved program and an inherent conservatism in the system and the geography. Duke has prospered in that context.

Duke has three hospitals. The Duke University Hospital is its traditional, tertiary care, anchor facility. Duke Regional Hospital is a former county hospital in Durham which Duke leased for 20 years and then re-leased for 40 years with a perpetual commitment from both the county and the university. The health system has invested $70 million in the hospital and has plans for substantial future investments. Eighty percent of Duke Regional Hospital revenue now comes from Duke faculty. In addition, in 1998 Duke acquired Duke Raleigh Hospital, one of three acute care providers in nearby Wake County. Seventy-five Duke specialists now work in the hospital and there are 17 Duke primary care clinics in the area. The hospital has acquired a clearer Duke identity. Each of the hospitals has a traditional share of the market and each has opportunities to use its position for growth in volume. All three DUHS hospitals have been awarded Magnet status, an internationally recognized accreditation which connotes excellence in nursing practice and quality care.

To extend its reach, the DUHS, in the last few years, has built a primary care network of 185 physicians, broadly dispersed in the region. The PDC, in the same period, has persuaded community specialist physicians to join its community physician plan, a movement that nearly doubled total physician membership from 800 to 1500 physicians. In addition, Duke specialists have built relationships with community hospitals and multi-disciplinary groups and hold clinics both at Duke and at community sites. Each extension of the Duke brand has added incrementally to referral.

In the last two years, Duke has created an innovative joint venture with LifePoint Hospitals, a for-profit, national hospital chain. Duke will supply quality improvement and clinical guidance for specialty programs embedded in LifePoint's hospitals. Together, the two partners have built operating programs in five hospitals in the Southeast and expect to expand their efforts to 11 hospitals, with a more national reach, by the end of 2015.

Duke explicitly offers specialty referral as part of its appeal and anticipates a broader network for its brand.

The Research Triangle (Raleigh, Durham and Chapel Hill) has become one of the fastest growing areas in the nation, fueled by a knowledge-intensive economy and the presence of three large universities, two medical centers and very considerable corporate R&D investment. Wake County, which contains the City of Raleigh, is expected to grow 28% in population over the next ten years, three times the national average. Despite Duke's ownership of Duke Raleigh Hospital, Wake County provides only 13% of total inpatient admissions to the system. By contrast in Durham County, Duke's home, the DUHS, through its two hospitals, controls virtually all the licensed beds and in-patient case volume. Durham, however, has grown much less rapidly than Raleigh.

Duke faces considerable competition, though nothing on the scale of other university-based health systems in large urban areas. It has three core competitors. Two of these competitors, UNC Healthcare and WakeMed Health and Hospitals, are in the immediate area, each with considerable market share. The third, Carolina Health based in Charlotte, has very deep penetration which largely challenges expansion in that direction. While each competitor has its own embedded, local strength, none quite rivals Duke's brand or academic eminence. As a result, Duke can traditionally draw a disproportionate share of the most complex care. That trend has continued, in stark contrast with national trends, with total volume in the system growing 4-5% each year. The strongest growth is in ambulatory care, with volume growing from 1.2 million out-patient visits in 2004 to 1.8 million in 2013. Both ambulatory and inpatient care are disproportionately acute, require a high volume of procedures that generate a significant margin.

Blue Cross Blue Shield of North Carolina has 60% of the state's private insurance. A few for-profit insurers have a presence, and Duke has put a narrow network offering on the state's health exchange through Coventry. By and large, North Carolina has retained its commitment to fee-for-service medicine, but Duke has negotiated some of the highest reimbursement rates in the state, rates that would be competitive nationally. The payers are increasingly interested in narrow networks, tiered pricing, or shared savings programs and have put increased pressure on reimbursement. All the payers and the major systems are experimenting with risk models, though none have yet done it at scale.

Duke adopts risk for the self-insured university employee group, a 64,000 person plan, and has taken on a Medicare Shared Saving Program for an additional 47,000 lives. The Coventry Plan with predominately Duke Medicine Providers is a narrow network plan, offered only on the Exchange. Surprisingly, with little marketing, it attracted 17,000 people. Duke has had limited prior experience with risk contracting. It experimented in the 1990s and learned to move carefully and to work hard to acquire appropriate skill.

In the not too distant future, the Duke leadership anticipates volume growth and declining unit margins. The broad trends of population growth, population age and pervasive chronic disease in key demographics will feed competitor and insurer experiments with variations on value-based and population health pricing. Duke has begun its own learning curve and experiments with risk but takes explicit care not to move faster than its expertise or its market.

Duke Medicine Finances

In an era of declining NIH budgets and increased pressure on medical school finances, Duke relies on the strength of its clinical mission to provide the margin of safety for its academic mission.

Fortunately, the DUHS has prospered. Total revenue in 2002 was $1.3 billion with a very modest operating profit from operations of $43 million, or 3.3%. In the decade since, the health system attended carefully to its operational cost structure and systematically took $160 million out of its base cost budget at a time when acute and complex volume expanded dramatically. Total revenue grew steadily to $1.8 billion in 2008 and $2.4 billion in 2012 and still grows. The system's margin expanded, rising on a steady curve to $190 million in 2008 and $257 million in 2012.

With strong results, in 2007 the system committed to three historic capital investments. The construction of the Duke Medical Pavilion and the Duke Cancer Institute, which cost a combined $900 million, added 18 new operating rooms and 160 intensive care beds as well as a wholly integrated ambulatory cancer center. The installation of EPIC, a system-wide electronic medical record, required an additional $550 million. It went live in 2012 and was completed across the entire enterprise in early 2014. These three investments, plus the Trent Semans Center for Health Education, a new Eye Center and the new wing to the School of Nursing constitute the core physical plant and electronic infrastructure of the future.

Duke's operating profit from operations has remained exceptionally strong. Free cash flow continues undiminished from the 2012 level, but charges from depreciation now reduce the GAAP net income from operations by half. Looking to the future, Duke has once again dedicated itself to cost reduction. A focused effort called "Transforming Duke" will work on additional administrative savings and will then launch care-design efforts that are expected to reduce operational costs by taking $200 million out of the base budget over a three year period, preserving a margin after depreciation of roughly 5%.

Duke Medicine has an exceptionally strong balance sheet both on the university side and in the Duke University Health System. In the School of Medicine, reserves, endowment and quasi endowment have grown to over $2.5 billion as of March 31, 2014. The clinical departments and centers and institutes control nearly 60% of the total. Reserves have been built up over the years from departmental operations and physician-driven philanthropy. The dean and central operations have modest resources, and large portions of the central reserves are restricted.

The system regularly sweeps all its free cash flow, on both the university and the health system side, into investment accounts. Solid profitability over the years in the health system have been added to the reserves and invested along with philanthropic contributions.

The reserves, for both the schools and the system, are invested by DUMAC, the Duke University investment arm. Since 1990, DUMAC has had the second best investment record of any university endowment, averaging a 16% return from 1990 to 2008. Recovery since 2008 has also been exceptionally strong.

By 2014, the DUHS has built reserves worth $2.5 billion, a number that grows steadily, powered by free cash flow and strong investment returns. The entities in Duke Medicine have roughly $5 billion total in reserves.

Challenges and Opportunities for a New Chancellor at Duke

The university seeks a new chancellor who can build on the university's and the health system's traditional strengths as Duke and the nation enter a new, exciting but highly uncertain era in health science and healthcare delivery.

Lead Duke Medicine to still-higher levels of excellence by maximizing the alignments and balance of the three missions

The chancellor's overarching work—the sum of her/his actions—will be to affirm the vision and aims of Duke Medicine as a unified, exemplary academic health center committed to all three missions: the highest quality clinical care, the education of tomorrow's best clinicians and scientists and groundbreaking scientific discovery that will improve human health.

Declines in NIH funding, stalled federal graduate medical education (GME) support, and payment reform all pressure the mission equilibrium. The chancellor will affirm the value of all three and actively engage leadership, faculty and staff to creatively and collaboratively find solutions that sustain the success and balance of the three missions. Duke has the organizational structure and core values of a traditional medical center. The next decade will require effective administrative, research and care-giving teams that are organized around populations, procedures, disease categories, research opportunities and integrated administrative systems. Duke Medicine abounds with talented and high-minded people across the health disciplines. It enjoys a favorable resource position. It needs research eminence to reinforce its reputation and care excellence to sustain its prominence. This is the opportunity for the next chancellor to fully benefit from the commitment and talent driving Duke's success and build the trust, engagement and mutual commitment across Duke Medicine that will drive essential invention.

Champion the academic mission in a challenging environment.

Across all health science centers nationally, education and research missions are stressed. Federal dollars and resources supporting these crucial activities are declining, and clinical margin essential to their support will likely shrink. The education and research enterprise faces disproportionate retrenchment amid fiscal difficulty. The impact can be seen in lower morale of

young scientists, unfunded research, and pressure to contract PhD programs. In light of national trends, however, Duke is in a relative position of strength. It enjoys strong clinical research and industry support. It continues to attract impressive NIH funding, and the outgoing chancellor personally championed science.

The next chancellor will need to fully embrace science and health professional education, marshaling efforts to ensure Duke expands its share of the NIH budget. She/he will clearly be required to develop—and generate support across the university and the health system for—the priorities and funding mechanisms that will generate resources to recruit basic, physician and nurse scientists and to update the space housing them. In addition, the chancellor should explore opportunities to connect the academic medical enterprise even closer to the university, to create shared facilities, and combine strength in competitive sponsored research. There is great promise for collaboration throughout Duke, particularly in engineering, arts and sciences, business, public policy and the environment. Finally, the next chancellor will need to be successful at raising funds and ensure a robust philanthropic support for all of Duke Medicine's academic missions.

Ensure Duke's success as the clinical market shifts; redesign care to improve outcomes and reduce cost.

An exceptionally talented and well planned clinical enterprise feeds the DUHS's success, which is the product of generations of excellent work. Like all other health systems, Duke will see both greater volume and decreased margin for every unit of production. These twin pressures have not yet weighed heavily on Duke. North Carolina, as a relatively low cost state, has been sheltered from payment reform. The industry is experimenting with value-based pricing, population coverage, and shared savings models with payers. Duke cannot predict either the timing or the direction of all the innovations, but most observers believe that fundamental change will occur in the next decade. These will require adaptations that the chancellor will judiciously engage. DUHS will need to treat patients in the most effective and cost-efficient settings, to build operational excellence and lower cost for routine procedures, to redesign care for most complex procedures and to experiment with population healthcare and assumptions of risk. The work will take organizational skill of the first order.

Strengthen Duke's educational programs to ensure the next generation of clinical success.

In order to compete in the new healthcare landscape, the Chancellor must shepherd change from the ground up starting with education. It will take funding and close attention to develop new pedagogy and curricula for students across all health care disciplines. Success will require a culture that engages the full range of health training and maximizes their use to the full limit of their license in entirely new methods of care.

Expand Duke Medicine's geographic footprint and its position as a referral care system.

Duke was built as an acute, tertiary, referral system. It has moved to build primary care that complements its highly developed specialty practice. Today it runs 39 primary care sites and five urgent care sites in communities statewide and is building the partnership with Duke LifePoint. As DUHS expands its network and competes for geography, it must defend its referral base and

primacy as the location for highly specialized care. The chancellor will empower clinical leadership to build the appropriate networks, partnerships, and alliances that together constitute a coherent clinical system delivering the right care in the right location and one that, when needed, enables patient flow to the specialty care for which Duke is known.

Develop the strongest possible academic alliances with Duke's schools.

Duke Medicine and all the schools of Duke University share the same contiguous campus, a layout that presents uncommon possibilities for both teaching and research. There are strong and constantly improved collaborations across the campus, particularly in basic science with Arts and Science and with the Pratt School of Engineering, which has one of the best biomedical engineering programs in the country that has been built in concert with Duke Medicine. In addition, there are impressive opportunities in the other professional schools. Twenty percent of Fuqua School of Business students are in the Health Sector Program, and the Sanford School of Public Policy has healthcare expertise. The physical campus layout, collaborative nature of deans and support from university leadership create a strategic advantage for learning and discovery at Duke compared with other leading health science centers. With the new trend and success of productive research being carried out in teams, the chancellor will need to join the president, provost and the deans to develop interdisciplinary programs, recruit jointly and innovate across the entire university.

Continue to strengthen Duke's relationships with community organizations, local governments and the state of North Carolina.

The chancellor and the Duke Medicine leadership have invested substantial time and effort to attend to the interests of the immediate community. Duke Medicine is one of the largest employers in the area. It provides the care for most of the residents in Durham. It plays a critical role in the community. The community greatly appreciates the effort that the leadership has made, and the next chancellor must continue the efforts that Duke Medicine has made to sustain an atmosphere of trust and responsibility. Similarly, Duke Medicine has crucial relationships with both state and local government. Medicaid is an essential payer and the Certificate of Need program governs Duke's expansion plans. The next chancellor will attend carefully to state and local government leaders and will play a constructive role in helping to develop healthcare in North Carolina.

Lead the development of philanthropy in Duke Medicine.

Duke Medicine lags peers in comprehensive fundraising, and it is a critical channel of resources that must be engaged. The next chancellor should focus on development, support the construction of a strong development program, encourage philanthropy across all the lines of the Duke Medicine and invigorate private support from industry and private donors.

In the next decade, philanthropy will be essential to the research, education and caregiving missions. The university will expect the next chancellor to provide personal leadership of Duke Medicine's philanthropic effort.

Qualifications and Experience

The chancellor position requires a leader with both a distinguished academic record and strategic healthcare experience, proven intellectual leadership skills, demonstrated executive management experience, and the interpersonal ability to lead and inspire diverse constituents working across a large, health-science enterprise. The chancellor must possess a clear vision for how Duke can fulfill its clinical mission through research and education, both locally and internationally. The desired qualifications and experience of an ideal chancellor include the following:

- A distinguished record of academic achievement, leadership and success in advancing academic health center research, education and patient care missions. An M.D. is required;

- Experience leading transparently, fairly, collectively and responsively;

- A deep understanding of both academic medical centers and universities and the broad threats and opportunities facing both;

- An uncompromising commitment to academic excellence in recruiting and developing faculty, assessing academic programs, commitment to adequately supporting health professional education programs and supporting exceptional teaching and research;

- Strong and demonstrated desire, ability and commitment to broadly engage the university community, to collaborate with deans and schools, and to function as a key member of the university's senior management team;

- Effectiveness in a complex system of distributed leadership; experience developing clear systems and organizational structures and then delegating appropriately;

- A deep understanding of the operational and infrastructural needs of a modern health science and research institution;

- Demonstrable success in fostering and supporting programs that address inclusion and diversity;

- The capacity and inclination to work effectively with both local communities and state and local governments,

- A record of success in managing and building clinical, research and tuition revenues; experience in financial management in a large academic health science institution;

- An outstanding record of effectively managing people; a strong team orientation, along with a willingness to circulate widely and listen well;

- Excellent interpersonal and communication skills, including the ability to speak to and interact with scientists and non-scientists and to operate at the highest levels of academic, business and government leadership;

- The capacity to represent Duke compellingly to donors and to lead a constantly improved advancement effort; the ability to energize all constituencies to support Duke Medicine at a level consistent with that of top tier institutions;

- And genuine understanding and respect for the tradition and culture of success at Duke.

TO APPLY

Duke University has retained Isaacson, Miller, a national executive search firm, to assist in this search. All inquiries, nominations and applications, should be directed in confidence to:

John Isaacson, Chair – Isaacson, Miller
Phillip Jaeger, Vice President
Ariannah Mirick, Senior Associate
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Boston, MA 02210
www.imsearch.com/5111

Electronic submission of materials is strongly encouraged.

Duke University prohibits discrimination and harassment, and provides equal employment opportunity without regard to race, color, religion, national origin, disability, veteran status, sexual orientation, gender identity, sex, age, or genetic information. Duke is committed to recruiting, hiring, and promoting qualified minorities, women, individuals with disabilities, and veterans.