

## Brown Names Yale Physician as its 7th Dean of Medicine

*Pulmonologist, researcher Jack Elias, MD, to arrive September 1*

BY MARY KORR  
RIMJ MANAGING EDITOR

PROVIDENCE – Jack Elias, MD, chairman of the Department of Medicine at the Yale School of Medicine and physician-in-chief of Yale-New Haven Hospital since 2006, has been appointed seventh dean of medicine and biological sciences at Brown University.

He succeeds Dr. Edward J. Wing, who became dean in 2008, and stepped down from the position July 1.

Dr. Elias will assume his position on Sept. 1. Brown Provost Mark Schlissel, MD, who led the nationwide search for the new dean, will serve as interim dean until then.

The appointment was announced on June 27th.

In a professional career spanning more than 30 years since earning his bachelor's degree and MD at the University of Pennsylvania, Dr. Elias has cared for patients with a wide variety of lung ailments and injuries and has conducted research on conditions including asthma, chronic obstructive pulmonary disease, pneumonia, pulmonary fibrosis, and the effects of smoking.

Brown President Christina Paxson said Dr. Elias, elected to the Institute of Medicine and who has served as president of the Association of American Physicians, arrives at a time when “our medical school and research programs, for instance in brain science, are expe-



riencing significant growth, and soon we will embark on a new strategic plan to continue this momentum. As an internationally recognized biomedical researcher, educator, administrator, and practitioner, Dr. Elias is a wonderful addition to our leadership team.”

A day after the announcement, Dr. Elias sat down with the *Rhode Island Medical Journal* to answer the following questions posed by its editors.

### **Q. What will be your top initiatives as the new dean?**

A. One of my personal top initiatives is to get to know Brown, the medical school and its hospital partners better. One of the biggest issues that face the medical school and the partners is mak-

ing sure their relationship grows and matures along the lines of the changes that are taking place in health care. The challenges that hospitals and medical schools have are pretty impressive everywhere in the United States – to try and keep the educational and research missions going at the same time is very hard. I’ve been at two major places in my career – at the University of Pennsylvania and at Yale – and some of the lessons that I’ve learned from those two institutions will be directly transferable and some will not.

We’re going to need to prioritize where we are going to grow, and where we are going to invest. And we are going to have to get a strategic planning process going for the medical school.

**Q. Do you plan to practice medicine here as well as teach, do research and administer the medical school?**

A. That's a good question. I've been doing that up until now. I was 6-foot 3 when I entered my residency program and look at me now. The No. 1 reason they brought me here was to be the dean of the medical school and the program in biology so obviously that's got to be No. 1.

The other thing I'm going to be doing is bringing my research lab here, so I will have a research presence. I have a research focus that is a basic science yet translational focus. I also plan to round at the hospitals, teach and go to morning report. I'm not coming here to be a practitioner.

**Q. You will soon be the spokesperson for the state's only academic medical center. How do you plan to bring harmony to what is sometimes a fractious health care community? What message would you give to docs practicing in Westerly and Woonsocket?**

A. I come from a place where there are often heated discussions. What always bothers me is when I see energy being directed in the wrong way. If we direct our energy towards squabbling with each other, we're not putting our energy toward the right things, which is caring for patients in the right way and coming up with new knowledge.

I think the message is that healthcare is changing. Coordinated care, extended care and eventually disease-focused and capitated care are going to be facing all of us. The dream is that we have a well-integrated health care system so that we care for people the right way and with the right level of humanity and

compassion and that five and 10 years from now we have treatments for people that actually work.

We're on the verge of some very amazing breakthroughs and some have already happened. At every meeting now there's another breakthrough drug being announced. It's exciting. When I first got into pulmonary, lung cancer – if you couldn't surgically remove it – was a death ticket. Now you have a drug that actually works.

**Q. Hospitals are being reimbursed less for graduate internal medicine training programs, and as a result these training programs are being reduced, not only in Rhode Island but nationwide. Will the medical school play any role in determining which training programs will be reduced by its affiliated hospitals and health care systems?**

A. When you stop training residents, you have to replace them with something. And when you start replacing a resident with a person that's an already trained, board-certified physician, invariably it's more expensive. There's a very reasonable case to be made to the hospitals that the costs of getting rid of the educational experience is actually greater than the money that you're saving by doing that. In my hospital, they left everything alone. But again, I am not speaking about here and I need to understand the thinking here.

Primary care programs are expanding because the federal government is willing to let you add slots in primary care but not in specialty programs. That issue is not just here. I don't know what's happening here but one of my roles is to be an advocate for educational training.

**Q. What are your plans for better integration with the main campus of biomedical scientists and physicians?**

A. I am a huge believer in the integration of basic science and translational medicine. I will work as hard as I possibly can to get the physician-scientists that we have here to be interacting with the basic scientists. The tack I've always taken in my research is to figure out something at the level of basic science and then carry it into the clinic, to see if what I have discovered in the lab makes any sense in man, and then you push it as far as you can until the next question comes up and you bring that question back to the lab and you keep going back and forth.

**Q. Physician alignment and a single faculty practice plan – how realistic is that to achieve here?**

A. I don't know that it's going to be easy. Yale has two groups of physicians largely – those that are employed by Yale and those that are employed by Yale-New Haven Hospital independent of the school of medicine. The general rule of thumb is that the vast majority of the doctors at Yale-New Haven Hospital are employees of the school of medicine.

Here you've got a situation that is much more complex with many more moving parts to it. I think in the long run it's going to be in everyone's interest to simplify and to integrate and to eliminate duplication; and in the process I'm not saying it's going to be easy. I know people have already started working on it and I am cautiously optimistic that a resolution will take place that will benefit everyone. ♦