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Title

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Permalink

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Journal

The Journal of Pediatrics, 295

ISSN

0022-3476

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Publication Date

2026-05-01

DOI

10.1016/j.jpeds.2026.115151

Peer reviewed



Published in final edited form as:

J Pediatr. ; : 115151. doi:10.1016/j.jpeds.2026.115151.

Compensation Benchmarks and Assigned Support for Leadership Positions in Academic Departments of Pediatrics

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Keywords

benchmarks; salary; children; FTE; billing; work relative value units (wRVUs); gender equity

Introduction

Academic departments of pediatrics serve multiple missions, including family centered clinical care, teaching the next generation of pediatricians and pediatric specialists, conducting innovative research, providing service to the community, and advocating for children and adolescents.¹ Chairs of departments of pediatrics rely on a variety of leadership roles to support these missions.² These leaders include vice chairs, associate chairs, division heads, medical directors, and training program directors. The Accreditation Council for Graduate Medical Education (ACGME) Pediatric Program Requirements mandate percent effort for program directors based on the size of training programs. In contrast, there are no national benchmarks for other leadership positions in departments of pediatrics, forcing department chairs to make decisions on time commitment, roles and responsibilities, and

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Conflicts of interest: The authors have no relevant conflicts of interest pertaining to this article.

compensation for these roles. The prevalence of various vice chairs in departments of pediatrics may vary from other departments such as internal medicine and psychiatry.³ Therefore, we conducted a survey of all members of the Association of Medical School Pediatric Department Chairs (AMSPDC) to understand the types of leadership positions in each department and the support provided to these roles, including compensation benchmarks used to calculate this support.

Pediatrics has the highest proportion of female providers among all specialties, with 66% of the workforce and nearly 75% of residents identifying as female.⁴ The racial and ethnic diversity of children in the US is increasing, and the pediatric workforce is also becoming increasingly diverse but is lagging behind in achieving racial and ethnic patient-physician concordance.⁵ We surveyed the departments to collect information regarding the prevalence of female and underrepresented in medicine (URiM) faculty in leadership positions.

Methods

This survey was exempt from a formal review by the Institutional Review Board (IRB) at University of California Davis. The initial survey was designed by members of the AMSPDC Clinical Care Committee and was then piloted by committee members. Following revisions based on feedback, the survey was finalized and distributed via an online survey platform, LimeSurvey®, to all 152 members of AMSPDC. Canadian members were not included in the analysis of compensation, as the compensation structure is different outside the US. The initial distribution and 2 reminders were sent out between February and May 2024. Follow-up emails and phone calls were conducted between June and November 2024 to clarify questions related to the data received. Data were analyzed using SAS 9.4 TS1M8.

Based on the number of faculty, departments were classified into four groups, including small (< 100 faculty), medium (100–200 faculty), large (>200 but < 400 faculty), and “mega” (≥ 400 faculty). Continuous data were analyzed using ANOVA to compare the 4 groups. Categorical data were compared using chi-square test or Fisher’s exact test, as appropriate. Spearman correlation test was used to study the correlation between the percentage of female faculty in leadership positions and the overall percentage of female faculty and between the percentage of URiM faculty in leadership positions and the overall percentage of URiM faculty. Linear regression was used to study the relationship between percentage of female faculty in leadership positions and percentage of female faculty overall, followed by the percentage of URiM faculty in leadership positions and percentage of URiM faculty in pediatric departments. All type 1 errors were set with an α of 0.05.

Results

One hundred twenty-six chairs responded to the survey (83%). Sixty-eight chairs completed the survey in its entirety and were included in the analysis (45%). Response rate was 25% for small departments (15/59), 47% for medium departments (21/48), and 71% for large and mega departments combined (32/45, based on dues tiers). The faculty numbers in departments ranged from 11 to 1094, with a median of 200 (interquartile range 108 to 350). Large and mega-departments (> 200 faculty) were more likely to be based in free-standing

children's hospitals. University-owned hospitals were differentiated from hospitals affiliated with the University (free-standing children's hospitals). Mega-departments were more often affiliated with a University and less likely to provide all labor and delivery services onsite, with some only providing high-risk deliveries for prenatal diagnosis of fetal malformations.

Compensation benchmarks

The survey included questions about the use of compensation benchmarks from the Association of Administrators in Academic Pediatrics (AAP), the Association of American Medical Colleges (AAMC), the Medical Group Management Association (MGMA), the American Medical Group Association (AMGA), and Sullivan-Cotter.^{6, 7} Most departments used national benchmarks as compared to regional benchmarks (Table 2), and most departments used a blend of multiple benchmarks. The most common benchmark used by small and medium departments was AAMC, reflecting a preference to use a common benchmark across all departments in the school of medicine. The most frequent combination of benchmarks used in small and medium departments was AAMC for most specialties and AAP for specialties that were not represented in AAMC (such as pediatric interventional cardiology). In large and mega-departments (especially departments in free-standing hospitals), AAP benchmarks alone were most commonly used and were used significantly more often than in smaller departments. When a combination was used, the most frequently used combination in large and mega departments was AAP and either MGMA or Sullivan-Cotter.

Gender and under-represented minority faculty

Nearly two-thirds of faculty across pediatric departments identified as female (Table 3). The percentage of department leaders (defined as chair, vice chairs, division heads, program and medical directors) identifying as female was lower in mega-departments compared to smaller departments (Table 3). The percentage of female faculty in leadership positions had a weak positive correlation with the percentage of female faculty overall in departments ($r = 0.27$, $p = 0.02$), similar to previous observations in pediatric critical care.⁸ In general, there was a 0.67% increase in female leaders for each 1% increase in female faculty ($p = 0.01$). The correlation between percentage of female leaders and the percentage of female faculty was strong only in small departments ($r = 0.7$, $p = 0.003$) and was negative in mega-departments ($r = -0.3$, $p = 0.26$).

Among department leaders, 8–15% identified as URiM. The percentage of faculty overall in departments who identified as under-represented in medicine was similar (11–15%). These numbers are akin to the results from a recent AMSPDC survey on diversity.^{9, 10} The relationship between the percentage of URiM leaders and the percentage of URiM faculty overall in each department had a positive correlation ($r = 0.66$, $p < 0.01$). There was a 0.85% increase in URiM leaders for each 1% increase in URiM faculty.

Leadership positions and support

Vice Chairs

Except for a third of small pediatric departments, all departments had at least one vice chair of pediatrics. The number of vice chairs per department increased with the size of the department ($p=0.0003$). The time assigned (effort protected) to vice chair duties increased with the size of the department (Supplemental Table 1). The method of support for vice chair positions was mostly as a percentage of salary in small departments but was often a fixed dollar amount as a stipend in medium, large, and mega departments (Table 4). The annual stipend was variable and increased with the size of the department. The main source of financial support for vice chair positions came from the department, with some contribution from the University or the hospital, via a funds flow process. Some vice chair positions, especially clinical affairs and quality/safety, were more likely to receive financial support from the hospital. Large and mega departments were more likely than small or medium departments to have goal-oriented metrics for vice chair roles ($p=0.04$).

Types of Vice Chairs

Supplemental Table 1 outlines the different categories of vice chairs that are generally mission-based and the percentage of departments with a particular category of vice chair. Among departments with vice chairs, vice chair of research was the most common category (85%) and vice chair of education (79%) was the next most common type across all departments. This number is consistent with the 81% prevalence of vice chair of education in a previous survey.³ Vice chair positions aside from executive vice chairs received a median time assignment or percent effort of 20%, while executive vice chairs, who were second to the chair in leadership responsibilities, received a median time assignment of 25%. Mega-departments had a larger variety of vice chairs encompassing missions such as clinical, research, administration, and community.

Division Heads

Except for 3 small departments, all departments had at least one division head position (Table 4). The number of divisions in each department increased with the size of the department. Very small departments did not have divisions or division heads. Divisions of general pediatrics and neonatology were the most common among all departments (Supplementary Table 2). Time assigned to division head duties varied from 5–10% in small departments to 10–40% in mega departments. The stipend for division heads increased with the size of the department (Supplemental Table 3). The department was the main source of support for division heads. The primary factor influencing the additional stipend for division heads was the number of faculty in the division. Inpatient unit size, outpatient office visits, and presence of a fellowship also influenced the stipend but to a lesser extent.

Inpatient medical directors

The number of inpatient medical directors increased with the size of the department. The pediatric intensive care unit (PICU) and neonatal intensive care unit (NICU) were the two most common medical director positions across all departments. The time assigned

to inpatient medical director positions increased with the size of the unit and varied between 10 and 25%. The presence of other directors within these units (such as transport director, quality and safety director, etc.) increased with the size of the unit and the size of the department but did not influence the stipend or time provided for directorship of the inpatient unit. The source of support for inpatient medical director positions was predominantly the hospital (Table 4 and Supplemental Table 4). Some hospitals supported medical director positions with an hourly rate subject to a maximum of approximately 440 hours/year.

Outpatient medical directors

The number of outpatient medical directors increased with the size of the department (Supplemental Table 4). The time assigned ranged from 10 to 15% in small departments to 10 to 30% in larger departments. The number of annual visits to the subspecialty was the main factor influencing support. The source of support was either the hospital or the department, with contributions from the University or funds flow in a few departments.

Discussion

Administrative decisions in academic departments of pediatrics are often based on department size and nature of the affiliated hospital systems. Using a detailed survey of department chairs, we classified departments into four categories based on faculty numbers. We evaluated the compensation benchmarks, faculty composition based on gender, race and ethnicity, and financial and time support given to leadership positions based on departmental size.

Departments with ≥ 400 faculty (mega-departments) are relatively distinct, often a free-standing children's hospital with > 400 beds that is independent and not owned by a university. Mega-departments commonly used national AAP benchmarks for compensation. This preference might reflect the greater sample size included in the benchmarks and the availability of more specific data for a greater variety of subspecialties and sub-subspecialties, such as pediatric interventional cardiology (not surveyed in AAMC benchmarks). It may also reflect lesser control that can be exerted by deans of schools of medicine upon faculty salary structure, given that the major financial support arises from a free-standing children's hospital.

Consistent with other surveys and reports, the majority of faculty in departments of pediatrics identify as female. In 2023, 63% of certified pediatric subspecialists identified as female.⁵ According to American Board of Pediatrics (ABP, data updated to December 2025) maintenance of certification data, 43,782 out of 61,429 providers (71.3%) maintaining general pediatrics certification and 63,394 out of 94,261 providers (67.3%) maintaining any ABP certification are female. One of the key contributors to increased pay is having a leadership position. While there is a positive correlation between the percentage of female leaders and the overall percentage of female faculty in the department, this percentage of female leaders is lower, especially in mega-departments. In a previous survey conducted in 2015, the percentage of women among pediatric residents (73%) was higher than the percentage among clinical fellows (64%) and faculty (54%).¹¹ The percentage of division

heads (33.6%), vice chairs (37.7%) and chairs (26.2%) that were female was lower in 2015 compared to our survey (overall leadership, median-55%, IQR 43%, 65%). Although we did not collect gender distribution within each type of leadership role, these numbers suggest an increase in female leadership within departments of pediatrics. However, the current survey shows a persistent disparity between the overall percentage of female faculty and the percentage of female leaders (63% of faculty and 55% of leaders are female), and efforts must continue to achieve faculty-leadership congruence in gender distribution.

The percentage of URiM faculty also had a positive correlation with percentage of URiM faculty in the department overall. Attempts to enhance diversity in leadership should achieve ethnic, racial, and gender composition that is reflective of the overall faculty composition in pediatric departments.

“One-minus” system refers to the Clinical, Administrative, Research, Teaching, and Service (CARTS) model for scheduling and calculating clinical full-time equivalents (cFTE).¹² It defines 1.0 FTE as the total workload and then subtracts non-clinical responsibilities (such as research, teaching, and administrative time) to determine the time remaining for clinical duties (the cFTE). With increased adaptation of the one-minus or CARTS method for determining the cFTE^{13, 14 12} and non-clinical activities in academic medical centers, optimal assignment of time and financial incentives for administrative tasks is essential to promote transparency and provide objectivity within departments.

The ACGME provides guidance for program directors of residencies and fellowships based on trainee numbers. This study provides data on vice chairs, division heads, and medical directors to assist department chairs and administrative leaders to make informed decisions. While the responsibilities of vice chairs of education include mentoring faculty in education, educational administration, and educational scholarship, providing oversight and support to educational programs, the responsibilities of other vice chairs are not well reported.³ However, the responsibilities of vice chairs of research, academic affairs, clinical, quality, wellness, advocacy, community, diversity equity and inclusion (DEI), and ambulatory overall encompass establishing unified strategic vision, administration and implementation of specialized programs in their service area and mentoring and provision of oversight. Vice chairs are senior academic leaders who support the department chair in achieving strategic, financial and operational goals.

Time assigned to vice chairs, division heads, and inpatient and outpatient medical directors was variable. The factors determining percentage time assigned for these duties are provided to assist chairs and administrative leaders in optimizing the time and stipend associated with these positions. Time assigned to medical directorships may also enable chairs to negotiate more effectively with hospital administrators to optimize time necessary to supervise and direct inpatient and outpatient clinical enterprises in health systems.

A balanced, transparent allocation of time and resources to support departmental leaders is critical to the success of departments of pediatrics. Knowledge of benchmarks for salary and time assignments is one step in advancing towards this goal. Further efforts to clearly

define clinical FTE are underway through various initiatives at AMSPDC and AAAP that will provide clarity and guidance, thereby promoting faculty wellbeing.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

Abbreviations:

ACGME	Accreditation Council for Graduate Medical Education
AMGA	American Medical Group Association
APPD	Association of Pediatric Program Directors
AMSPDC	Association of Medical School Pediatric Department Chairs
AAAP	Association of Administrators in Academic Pediatrics
AAMC	Association of American Medical Colleges
MGMA	Medical Group Management Association
URiM	Under-represented in medicine

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Table 1.

Baseline Characteristics of small, medium, large and mega- academic pediatric departments [data are shown as median (IQR) or number (%)]

Department Faculty	Small (< 100)	Medium (100–200)	Large (> 200 but < 400)	Mega- (≥ 400)
Number of departments	15	21	17	15
Number of clinical faculty	80 (50–88.5)	150 (129–165)	274 (232–332)	550 (480–665)
Number of non-clinical faculty	5.5 (1–20)	7 (3–11)	15 (8–15)	58 (25–107)
Number of affiliated hospitals	1 (1–3.5)	2 (1–4)	4 (2–7)	4 (2–8.5)
Affiliation with a free-standing children's hospital	2 (13%)	4 (19%)	10 (59%)	11 (73%) *
University- owned hospitals	5 (33%)	8 (38%)	10 (59%)	4 (27%)
University-affiliated (but not owned) hospitals	10 (67%)	10 (48%)	8 (47%)	11 (73%)
Inpatient beds	77 (65–119.5)	152 (100–199)	300 (220–390)	475 (404–629)
Beds covered by the Department of Pediatrics	71 (64–107)	121 (80–194)	300 (235–417.5)	462 (364–578)
Labor and delivery -All services	13 (87%)	18 (86%)	13 (76%)	7 (47%) *
Labor and delivery – high risk services only	0	1 (5%)	1 (6%)	3 (20%)

p < 0.05 * by Chi-square test

Table 2.

Compensation benchmarks adopted by academic pediatric departments [data are shown as median (IQR) or number (%)]

Department Faculty	Small (< 100)	Medium (100–200)	Large (> 200 but < 400)	Mega (≥ 400)
National benchmarks	11 (73.3%)	16 (76%)	14 (82%)	12 (80%)
Both national and regional	3 (20%)	3 (14%)	2 (12%)	2 (13.3%)
Regional benchmarks	1 (6.7%)	2 (9.5%)	1 (6%)	1 (6.7%)
Most common compensation benchmark[^]	AAMC (56%)	AAMC (52%)	AAAP (67%) – 8 (38% - exclusively AAAP)	AAAP (93%) – (one center unclear on benchmark)
AAAP	7 (39%)	12 (44%)	14 (67%)	14 (93%) *
AAMC	10 (56%)	14 (52%)	8 (38%)	7 (47%)
MGMA	5 (28%)	6 (22%)	4 (19%)	6 (40%)
AMGA	1 (6%)	1 (4%)	0	2 (13%)
Sullivan-Cotter	6 (33%)	8 (30%)	4 (19%)	6 (40%)

[^] Most departments use combination of various salary benchmarks. The most common combination is AAMC with AAAP for specialties not listed in AAMC.

Data compared using Chi-square test or Fisher's exact test as appropriate.

p < 0.01 * by Chi-square test

Table 3.

Gender and under-represented minority faculty and leadership distribution

Department Faculty	Small (< 100)	Medium (100–200)	Large (> 200 but < 400)	Mega- (≥ 400)
Percentage of faculty identify as female gender (% median – IQR)	61–65% (56–60% to 66–70%)	66–70% (56–60% to 71–75%)	61–65% (56–60% to 66–70%)	61–65% (56–60% to 66–70%)
Percentage of departmental leadership identifying as female (% median – IQR)	60 (50–71.5)	55 (44–66)	54 (44–65)	43 (34–60)
Percentage of departmental faculty identifying as URiM (% median – IQR)	12 (7 to 13)	13 (8 to 32)	13 (7 to 18)	13 (7 to 18)
Number of institutions that preferred not to answer regarding URiM	2	1	2	1
Percentage of faculty in leadership identifying as URiM (% median – IQR)	12 (1–21)	15 (6–24)	8 (5–15)	13 (9.5–18.5)

Table 4.

Pediatric department vice chairs, division heads, inpatient and outpatient medical directors

Position	Vice Chairs	Division Heads	Inpatient medical directors	Outpatient medical directors
Number per department median (IQR)	5 (4–7)	17 (14–19)	7 (4–12)	3.5 (2–10)
Most common categories for this leadership position	Research Education	General pediatrics, Neonatology	PICU, NICU	General Pediatrics clinic, Subspecialty clinics, Emergency Medicine
Time assigned (% FTE)	Min: 12.5 (10–21) Max: 25 (10–42)	Min: 10 (5–15) Max: 25 (20–38)	Min: 10 (5–10) Max: 20 (10–30)	Min: 10 (5–10) Max: 20 (10–30)
Most common mode of support (and % of departments using that mode of support)	Fixed dollar amount (43%)	Fixed dollar amount (41%)-	No stipend (only assigned or protected time) – 38%	No stipend (only assigned or protected time) – 53%
Median minimum support (\$ or %)	\$ 8,000 or 12.5 (10–22)% of salary	\$ 12,500 or 10 (5–15)% of salary	\$ 5,000 (0-\$ 9,122)	\$ 6,489 (3750–20,000)
Median max support (\$ or %)	\$ 13,000 or 25 (10–40)% of salary	\$ 45,000 or 22.5 (14–40)% of salary	\$ 27,500	\$ 35,000 (16,489–55,000)
Most common source of support (%)	Department (71%)	Department (69%)	Hospital (83%)	Hospital (72%)