

Rethinking the Triple Threat Faculty Member

Speaker

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In the past, the traditional “triple threat” faculty member contributed to all three major areas of the medical school: medical discovery (ie, research), education, and clinical service. The nature of medical school has become much more complicated and the triple-threat concept has had to evolve with it. Medical discovery, for example, now comes in many different flavors, ranging from molecular-based research through translational discovery, clinical discovery, and different population-based discovery. Medical education can involve education of researchers as well as of individuals in the preclinical, undergraduate, graduate, and maintenance of certification phases. Medical service can include medical missionary work in Uganda, community-based medical service, hospital-based service, or purely ambulatory service.

In addition, work may no longer be done by one person in one setting. Medical discovery, for example, can be done by an individual or by a department. It can be center-based or collaborative and truly interdisciplinary. It can be within a single institution, across multiple institutions or around the world. Similarly, education can be distance learning, lecture-based, small-group, problem-based, at the bedside, or in the operating room. Medical service can be delivered by a single practitioner, a group, a division within an academic department, a full department, or by physicians practicing in a clinical center.

Faculty rank and title have also changed. Historically, there were assistant, associate, and professorial ranks. Then the concepts of full-time, part-time, or what we now call community-based were introduced. The term voluntary faculty has been eliminated, in many instances, because they are not truly volunteer. Many faculty also have administrative roles—division chiefs, center directors, service chiefs—or they are chairs of very important committees. Academic promotion can vary from a purely scientific track to a clinical track and to the new educator track. In addition to the basic science and clinical scholar track, there can be a clinical educator track, basic science educator track, or even clinical practitioner track. Tenure is available in all of the tracks except the clinical practitioner track.

It used to be that an academic appointment was what interested physicians, but there needs to be more than that to address issues with faculty satisfaction. All full-time and part-time faculty and some community-based faculty get a practice-based stipend. Perhaps physicians could be offered a university stipend that cuts across all the different categories. Or they could be offered some of the following benefits: access to university marketing and public relations, the use of university-based professional liability insurance, free or reduced tuition, faculty development services, and the use of the clinical research center. In addition, a university with a large group of employees in a health insurance plan can set up incentives for these employees to use designated faculty physicians.

In the classical department, where each faculty member was a triple threat, the various tasks of each member could be relatively easily interwoven. Nowadays, the department is very different. Each member has a different task. Some perform clinical trials, some epidemiology. Then a geneticist could be thrown in, a couple of hospitalists, the residency program director, clinical faculty, subspecialists, the clerkship director, a generalist here and there, and somebody who manages the quality improvement program. Instead of encouraging triple-threat individuals, the goal today is to create a triple-threat department out of individual faculty members who may have totally different interests and dimensions. What complicates this is that faculty change over their careers. They start off with one set of interests—clinical practice, research, or clinical education—and then their needs

and functionality morph into something else. Over time, their new functions will have to be woven back into the overall functionality of the department. Then one has to think institution-wide.

It is one thing to weave together changing functions within a department or even within hospital services, but it's another to do this across the medical school or academic medical center. Individual faculty can be put together in different formats, such as a research center, a practice group, a clinical service delivery model, or even in an educational model. It is important to think about how the faculty get woven into the ultimate mission of an academic medical center. Therefore, the overall mission of the whole enterprise needs to be clearly defined. There should be expectations of the department, centers, division, and other pieces of the whole. To do this well, measurements of faculty performance need to be standardized and focus on the expected outcome, not the process. There has to be flexibility in the process—many different ways to get to the same outcome—and there must be linkage of resources to the outcome that is wanted.