
Faculty Development Organizational Options

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Dr. Robert D'Alessandri is the Vice President of Health Sciences and Dean of the School of Medicine at West Virginia University. During his tenure in these positions, he has created model institutional programs for development of the faculty. In his talk, Dr. D'Alessandri explains crucial principles for program development, the process of creating them, and concrete examples of how the principles and processes were applied. The text of the discussion has been edited, preserving the informal, conversational mode in which it was delivered, because Dr. D'Alessandri modeled many of the principles and processes that he was describing. The session was interactive, with excellent questions and examples contributed by the audience. These questions and Dr. D'Alessandri's answers follow the body of the main text. Also included is a list of some of the references that Dr. D'Alessandri has recommended and made available to his faculty in the library.

Instead of the lecture format, I'd like to open this up to questions at any time. Also please share experiences from your institutions. All of us would like to know how you are doing things in your institutions. If you feel that you have something relevant and pertinent, let's share it. That's the way we'll learn the best.

About ten years ago, I became Dean at West Virginia University School of Medicine. It seemed pretty reasonable to me that we had to make an investment in our faculty and in our staff. I didn't know how to do that. In fact, it hasn't been until the last few years that I've really understood the problem and the process a bit better. My learning is largely due to the fact that there is now someone in our organization who does understand and is helping me to appreciate the importance of fac-

ulty development and how we need to approach it. Faculty development is an institutional responsibility. It is the responsibility of the University and of each school to invest in their faculty. Staff must be included too, although today, we are talking only about the faculty. Each department needs to take on that responsibility. And finally, it is an individual responsibility as well. So, with every level of the organization, there is responsibility for the development of faculty and staff.

If faculty development is going to become an institutional priority, who needs to commit to it? The administration must at all levels. At the University level it is the President or the Provost. At the Health Sciences Center level it's the Vice President and at the School level it is the Dean. That is where it must start. If it doesn't, if the administrators aren't willing to make the commitment, then the program can't ever develop into what it needs to be. **So the first requirement for any successful faculty development program, is commitment at the top.**

There is a Chinese saying that goes: "If you don't know where you are going, any road will get you there." **The second requirement for a successful program is that you have to know what you want to achieve.** From an institutional perspective, faculty development must fit into the overall strategic plan of the institution. Every faculty development program must provide value to the individual to gain faculty participation and to the institution. The key to success is to bring these two goals together. Coordinating faculty development efforts is exactly what a central office can and must do.

The first step in program development is to define values and goals. At WVU we took a step

back to soundly base our faculty in a concept of shared values and viewed our shared values as the basis for management and for decision making. When we began to look at our values, we based them on one concept: being “other centered,” a student, patient and community-centered organization. We believe that if students are enjoying what they are learning and are learning well (are satisfied), the faculty will be engaged in that learning process as well. It is our belief, that if our patients are satisfied, we are successful. The money and resources will come. We didn’t want to focus on finances and resources. If we are successful in our missions, there will be funds to support them. That is a basic fundamental concept for all of our planning.

How do you think many faculty responded to the concept of a student, patient and community-centered institution? What would your response be? Many wanted to know why we consider ourselves to be faculty centered. And therein lies some of the problem. With our values, our faculty development program had to be other centered. Our discussions with our faculty have continued to focus on this point.

Last spring our department chairs and associate deans spent two days discussing our values, vision, mission and goals. We attempted to delve into the very core of what we are and what we want to be. It was a remarkable discussion. We agreed on the following values, which are at the very heart of our organization and our culture: **respect, integrity, creativity, courage, faith, hope, love, and humility.**

Leading up to that discussion last spring, within each department there was a discussion of institutional values and vision. Each department reported to the Dean the results of that discussion. In addition, each department explored the concept of core purpose. Defining core purpose forced them to explore the very essence of our organization’s reason for existence. Collins and Porras in their book,

Built to Last discussed this concept and showed that organizations that understand their core purpose are organizations that thrive.

This process reveals some surprising findings. Across the institution, across the different schools, even among the staff, our values were similar and consistent and our understanding of core purpose was too. Respect and integrity were at the heart of the values that the faculty discussed. One of our strongest commitments is service to the state. That formed a major part of our defined mission. In my view, this is very consistent with the core purpose of an academic health center and at the heart of our professionalism.

It was a long process, taking almost seven months to complete all departments. It also required a major time commitment of faculty, chairs, and associate deans who helped to facilitate many of these meetings. All of this culminated in the values discussion with the chairs and senior leadership last spring.

How will we know that we are successful? Can you create a vision of what will be? At a general faculty meeting we asked each person to answer these questions. What is your vision for the School of Medicine? This is a question that most faculty have never been asked before. In fact, our faculty couldn’t conceive of what a vision really was. Some of them referred to problems in the clinics or in the labs. When pressed to describe a vision for the school, many would not get beyond their immediate problems.

It is very important to help people conceptualize a vision for the future. Even the process of doing this leads to personal growth. After the meeting, many faculty told me that this was a new experience for them and a really good one to begin to think about the school and the future in this way. Since it is an evolving process, we shouldn’t expect immediate answers. Our faculty has come to realize that it is important for them to have a vi-

sion, their vision, for the School of Medicine. It is also important for them to help to shape the institutional vision. It needs to be an iterative process of involvement.

The values and vision discussions were unit-based, although we wanted people to think broadly beyond their units. In some departments the focus was on problems and not on values. A facilitator who understands the process can help a great deal.

Once you define the values and the vision, you can use them as the basis for decision making.

Values and vision form the basis for defining mission, goals and strategies. Understanding your values and mission is critical in making resource decisions. Your values help you understand your mission and identify where the resources should go. For example, if service is a mission, given the values that I mentioned earlier, then the strategies and goals you develop must be consistent with your values in the context of this mission.

Of course, knowing where you want to go begins with knowing where you are. An environmental or needs assessment is often helpful in this process. We've used formal surveys, Medicare data, just about anything we can to help us define where we are today. Understanding where you are and where you want to go can define the gap you must close to achieve your goals.

How do we close the gap? Closing the gap helps you understand your priorities and helps to define your strategies. The "closing the gap" discussion is a very important one to have with faculty. Simply saying we need to change doesn't work. Closing the gap between vision and action is the agenda for change.

How do you overcome the resistance to change?

Developing plans and strategies to narrow the gap is the key. If you start with "you need to change," there is resistance because the implication is that there is something wrong with you or that you are doing something wrong. Faculty development is

not remediation. What you want faculty to do is to aspire to something greater and this in the context of closing the institutional gaps can be very productive. Faculty will need assistance in understanding how to accomplish this.

Resources must be committed to faculty development.

Financial support for decentralized faculty development initiatives is essential. Sometimes the Dean's office picks up the cost and sometimes it is a combination of department funds and Dean's office funds. In short, we look to many sources of support for faculty development. Another question arises, and that is, are we currently using resources in support of career development activities wisely and cost effectively? The traditional research faculty development tool has been the sabbatical. Most of your organizations provide sabbaticals for faculty. Have any of your organizations ever looked at the value or the return on investment? We studied this several years ago and reviewed publications, grants, and research that were related to or attributable to faculty sabbaticals over a ten year period. The benefit or return on investment was actually very substantial. However, we approve sabbaticals selectively based on a clear plan and expectations of return for the individual and the institution.

The most common form of faculty development at medical schools is attending meetings. Do you have any idea what this costs? The story goes that since the end of the Cold War it is no longer necessary to have a third of the medical school faculty in the air at any one time. If you are spending a great deal on travel, what does the individual or the institution get back for this expenditure? Are these resources that might be better used to fund faculty development programs that can be demonstrated to show benefit? Many institutions have begun to look more carefully at travel and have attempted to assess potential benefits of attending meetings.

Another source of potential resources for faculty development is the university itself. Often faculty

of health science centers fail to realize that the University has programs and may even provide resources for faculty development. Each year our University sponsors programs on grant writing, teaching methods, computers and new technologies in education, and many more programs open to all faculty. Learning about this and taking advantage of it can help a great deal.

Of course, there are funding sources outside the university and the health science center that include private industry and of course, the federal government. Many of your have programs are funded by the Health Services Resources Administration (HRSA). Funding from these sources can provide the necessary resources that start programs and help them get on their feet.

The difficulty with programs funded by the federal government is that they often circumscribe the effort and define limitations to meet specific needs. That may help raise institutions to a certain standard. But it is often a problem, because it may inhibit creativity. It is important to recognize that the goals of your program shouldn't necessarily be the goals of the funding agency. However, a funded program may help you achieve your broader development goals.

Finally, we must be accountable. One of the first steps in getting the support of your Dean or your chief administrator is to help them understand the value of faculty development. Sitting down and talking to administrators sometimes helps. But as you know, they are not great listeners. You have to demonstrate the value that faculty development programs have. Using a strategic plan model can be the basis for demonstrating to administration what you want to do to prepare the faculty to meet their strategic needs. Then you must be able eventually to show that your program has accomplished this goal. It is important to show that faculty will do a better job at teaching, that faculty enjoy their jobs more, and are more productive. It is enhancing productivity that is on the

minds of most administrators today. Emphasizing that, can get even the most resistant administrator to buy into faculty development.

Our outcome measures must be more concrete than intervention satisfaction and self report data. Looking at board scores and pass rates for specialties are a start. We all agree that these scores are not the gold standard. However, when the LCME or RRC visit, these scores are examined carefully. Administrators also respond to fixing problems. Improving or correcting student or patient dissatisfaction is considered a good investment by deans and administrators. Have the data and use it to support your plans. Then evaluate and report the results.

Clinical effectiveness is an important component of productivity. You know faculty who take an hour with each return patient, and you know faculty that take 15 or 20 minutes with similar patients. The quality of the care may well be the same for both. In fact, the quality of care may actually be better in those shorter visits. Often patients are more satisfied with shorter visits. Improvement and enhancement of clinical skills can actually be measured. We just haven't bothered. We can't afford not to anymore.

Our institutions must recognize the value in faculty development and make necessary commitments to it. **Define your values, your vision, and your mission. Use these to develop your goals and use your needs assessments to define where you are in relationship to your vision and goals.**

Once you have defined the gap, you can establish priorities for resources to help faculty be more successful.

Examples of Faculty Development Programs At West Virginia University

Curricular Changes and Problem Based Learning. Like most medical schools these days we are in the process of substantial changes in our curriculum. As a result there has been greater focus on the educational aspects of faculty development. We introduced problem-based learning (PBL) into our curriculum. Initially it was limited and experimental. Now it is a significant part of the education of both first and second- year medical students.

When we started PBL, we heard from the facilitators as well as the students that there were problems. There was little consistency from group to group and some facilitators missed the point entirely and were more interested in giving answers to clinical problems, than having the students work through them. We had trained a few of the facilitators, but not all of them. We greatly underestimated the preparation needed for facilitators and for students. Even our faculty saw little need for this, in part, because many were negative to the concept of PBL, and in part because, of course, they are faculty and they know how to teach. In fact, some of our department chairs were the most negative, fearing that PBL would be a tremendous burden on faculty.

We have attempted many strategies to overcome this. We encouraged and sponsored faculty to attend national meetings for medical education, particularly those sponsored by the Association of American Medical Colleges. At these meetings they were likely to engage other colleagues with more experience in PBL and in other less traditional methods. This interaction proved to be very valuable because they received a more balanced view of the changes in medical education. As a result there was less resistance to change. Coordinators began to plan curriculum together. For the first time they were introduced to other faculty

in other departments. Now understand that we are a relatively small medical school, and I had believed that all of our basic science faculty knew each other. But obviously this wasn't the case. Faculty members established a real bond and a relationship with faculty in other departments. From there on out, change moved at a rapid pace, driven by the faculty. Our chairs seemed to resist this and it was my job to help them get over it. They did.

Last year, we rolled out our new curriculum for first year medical students. Some of it is problem-based learning, not all of it. We have gone to a different model, which is not discipline based but module based. We had to train our faculty to be ready for this. At this conference, there is someone talking about how you train faculty to implement these models. There are several of our faculty members attending that presentation. The core of our basic science teaching faculty understands the new models and now has experience with them. Unfortunately, only about ten percent of our clinical faculty has been involved in this process.

The Managed Care University. Until recently West Virginia had almost no managed care penetration. In one year, we became the "fastest" growing managed care market in the country. It went from zero percent penetration to five percent. The next year from five to ten percent. The growth is slowing now. However, our primary care departments are most affected, having the largest percent of managed care patients. We were very concerned about getting into risk contracts with managed care organizations, since our faculty had no experience whatsoever with managed care. There are only two faculty from California with managed care experience.

We set as a goal to educate our faculty and residents about managed care. We then created six modules each dealing with different aspects of managed care. Each module was available at dif-

ferent times, usually in the evening. We wanted our residents and faculty to participate. We also opened it to community physicians who were extremely interested and concerned about managed care. They believed that the health sciences center was causing all this to happen and bringing managed care into the community. In fact, what we were doing was warning them about the impact managed care could have on their practice. This curriculum went a long way to overcome these perceptions.

Our needs assessment helped us to construct the modules and the content. The hospital and the practice plan supported this project. Both groups saw the value of it. We had over 300 faculty and residents participate in a two-year period. We have and continue to monitor utilization and to assess impact.

Our planning and strategic initiatives group (PSI) coordinated the program. PSI is jointly funded by the hospital, the practice plan, and the School of Medicine. Our faculty gave the majority of the presentation and PSI helped them prepare and learn about managed care. This is a significant commitment and faculty members were paid for each presentation. This is still less expensive than importing guest lecturers.

Part of this curriculum has been incorporated into our medical school teaching. In our new curriculum, there is a section that looks at issues in medicine and is broadly based including economics and ethics of healthcare.

Mentorship in Basic Sciences and Teaching Scholars Program. Mentorship programs should be partnerships. As with any partnership, the terms must be agreed upon up front. A few clinical and basic science faculty have been paired and this has been very successful. It requires a commitment of time, space and other resources.

A visionary group of faculty created the teaching

scholars program. After defining the program and the parameters for participation, six faculty have been chosen to be a part of this. Each will commit the equivalent of a day a week for a year participating in seminars on education, improving learning techniques and skills, and exploring new models in education. Three scholars will come from medicine and one each from nursing, pharmacy, and dentistry. This program is in its first year currently so our evaluation at this time is incomplete.

Leadership for department chairs. Our department chairs are expected to lead change in the organization. For some years now, all new department chairs have been required to attend the AAMC conference for department chairs. They are also to revisit that program every five or six years. The hospital and the dean's office pay for this. All new associate deans attend, and I, as the dean, have attended these development programs as well.

In order to lead change, our chairs wanted to understand their roles better. A committee of chairs and faculty examined the role of the chair and the attributes needed to be a department chair. The committee also recommended a 360° type evaluation for department chairs and for the dean. Such evaluations go a long way toward defining accountability.

Last year our school had its first ever evaluation of the dean. A small committee and a management consultant developed the instrument and to ensure confidentiality, the consulting firm administered the instrument to seventy faculty, chairs, administrators, and students. There was eighty-percent participation.

I reviewed the results, shared them with all and developed a plan of action to improve performance. Frequent follow-up and progress reports are critical to this process. Soon a similar evaluation for chairs will be implemented. We are in the final phase of developing the instrument.

Questions and Answers

Question: You briefly alluded to getting data on how you know your faculty development programs are working. Can you comment a bit more on that, on how you can set that up so you can measure your success?

Dr. D'Alessandri: Well, I'll give you one example, and that's the introduction to PBL into our curriculum. Immediately we got the feedback from the facilitators as well as the students that it wasn't working. We had trained a few people, but not all of the facilitators that we were using. We underestimated the need initially for facilitators. We then defined that we needed to train the rest of the facilitators. Another example is our study measuring the effectiveness of sabbaticals by looking at papers and research. You must tailor the evaluation to the program you develop and unlike the above example, make the evaluation a part of the planning process.

Question: Can you comment about how you get your little G (goals) into the big G, when the leaders of your institution haven't got a big G?

Dr. D'Alessandri: Well, it gets back to what you're trying to achieve. I think the first step is to try to get your dean or your chief administrator to understand the value of faculty development. What you can point to is the faculty member does a better job teaching and is more productive.

Question: How much does the LCME look at faculty development activities as criteria for judging programs?

Dr. D'Alessandri: Not as much as it should. What the LCME tends to look at is faculty morale. That's an indirect measurement. The LCME should require a distinct plan for faculty development.

Question: You mentioned at the beginning that you had staff training. How do you pay for it and what kinds of things do you do with the staff?

Dr. D'Alessandri: Staff development is more difficult. It's something that we've begun to take a look at. For the clinical staff support comes from clinical funds. For office staff in the School of Medicine, the school supports that. The greatest emphasis has been on the clinical professional staff. Staff development in our clinical practice has been a commitment for some time. When we took on the management of a large clinical faculty of two hundred thousand plus patient visits, one of the things we built into the budget early on was staff development. Most of your administrative CEO-types will recognize the need to do this. It's another topic really, and there are many issues and concerns.

Question: How do you hold the chairs and division heads accountable for their faculty development?

Dr. D'Alessandri: I think that's a critical component of what we're trying to do. The real issue is, is there a process, an open process that clearly defines our goals and then holds people accountable for achieving those goals? The evaluation of chairs will be a critical step.

Question: If chairs don't live up to their commitment, are you going to link their performance to their salaries?

Dr. D'Alessandri: Eventually. This is very threatening, and the way I would suggest you introduce an evaluation process is not to tie the results to compensation. You may have to do that for two evaluations, depending upon how anxious people are. After that, the evaluation becomes one of the tools to use in assessing compensation.

Question: This whole process in your institution was initiated at a very high level of the organization. I'm listening to this with great interest, but am at the other end of the spectrum, responsible for faculty development of a small group of primary care faculty in a clinic-based residency-training program. If you were initiating a program at a lower level of the institution, would you start with

a different objective, the individual goals or that unit's goals and objectives?

Dr. D'Alessandri: The values discussion was really unit-based. Although we wanted people to think broadly, it really was unit-based. It came out to be fairly broad, as it should be. The values of one department shouldn't be dramatically different than the values of another department. They could, but they shouldn't be.

Question: To what extent did you deal explicitly with conflict between the differences in values that units within any organization are likely to have?

Dr. D'Alessandri: Our institution must be very unique because we haven't seen great conflict in our values. In part, understanding what one means by the words we use helps to break through the apparent misunderstandings and disagreements. And finally, individuals must decide that if their values are not shared by the institution, particularly an academic institution that employs them, they should consider finding another institution with which their values are more consistent.

Suggested Readings

Collins, James C. and Jerry I. Porras, Built to Last: Successful Habits of Visionary Companies. Harper Collins, 1994.

Freiberg, Kevin, Jackie Freiberg, and Tom Peters, Nuts!: Southwest Airlines' Crazy Recipe for Visions and Personal Success, Bard Press, 1996.

Greenleaf, Robert K., Servant Leadership: A Journey into the Nature of Legitimate Power and Greatness, Paulist Press, 1983.

Morris, Thomas V., If Aristotle Ran General Motors: The New Soul of Business, Henry Holt and Co., 1997.

O'Toole, James, Leading Change: The Argument for Values – Based Leadership, Ballcentive Books, 1996.