

Chapter 7

Faculty Resilience and Career Development: Strategies for Strengthening Academic Medicine

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Abstract This chapter outlines a number of promising directions for leaders in academic medical centers, who are forward-looking enough to place faculty vitality high on their list of priorities. Because the intersection of gender and generational issues is putting particularly complex demands on senior faculty, this chapter emphasizes both the work that remains to facilitate women realizing their potentials and the newer challenge of bridging generational differences.

Keywords Resilience, gender, generation, career development, mentoring

Introduction

Resilience is the capacity to remain robust under conditions of stress and change. Institutions that take a laissez faire attitude toward faculty resilience are putting their futures as academic institutions at risk [1]. This chapter outlines a number of promising directions for academic health center leaders forward-looking enough to place faculty vitality high on their list of priorities. Because the intersection of gender and generational issues is placing particularly complex demands on senior faculty, this chapter emphasizes both the work that remains to facilitate women realizing their potentials and the newer challenge of bridging generational differences. Recommendations for addressing this intersection include: (1) more flexible personnel structures; (2) updated approaches to mentoring and career development; and (3) greater support for department heads to improve faculty development practices.

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Why Focus on Faculty Resilience?

During conditions of high stress and rapid change, professionals who can adapt will thrive. Those who cannot become less productive and less satisfied, and are more likely to burnout [2]. Resilience has been found to depend on: (1) remaining free of denial, arrogance, and nostalgia; (2) sound risk-taking and strategic experimenting with alternatives; (3) building one's community; (4) remaining guided by a high professional standards and one's core values; and (5) reflection and renewal. These indicators apply both to individuals and to organizations [3].

What does a resilient department look like? A primary characteristic is being forward-looking with respect to developing the talent it needs. In too many academic health center departments, the opposite holds true. Junior faculty are often treated more as expendable "fuel" for the clinical engine or as grant-writing machines than as junior members of an academic community and future leaders deserving of guidance and support.

Why should academic health centers be concerned about the resilience of its faculty?

- (a) Baby Boomer faculty are graying and will soon begin retiring. Many departments already have long-standing unfilled vacancies. With many clinical departments resembling group practices more than academic communities and with the growing gap between salaries offered by private practice/industry compared to medical schools, many gifted physicians and scientists are opting out of academia. And over the course of their training, residents are becoming less rather than more interested in a faculty appointment [4]. With many schools under pressure to expand class sizes, will there be a sufficient supply of faculty, especially faculty who are academically productive and whom students view as excellent role models?
- (b) Momentum in academic career development is not the force it used to be, and medical school faculty are less satisfied with their careers than in previous eras [5, 6]. Rising demands on faculty to see more patients and to generate more revenue and accelerating competition for grant funding are challenging many faculty beyond their capacities to succeed. Some have taken up residence in "Bitterness Valley," becoming vocally and visibly cynical.

A large Western region school of medicine recently measured the prevalence and determinants of the intent of its faculty to leave academic medicine. Over 40% were seriously considering leaving academic medicine in the next five years. Women and members of clinical departments were more likely to consider leaving than men or members of nonclinical departments [7]. A four-school study found that at least 20% of faculty had significant levels of depressive symptoms, with even higher levels in younger faculty. Over 20% of faculty reported thinking often of early retirement [8]. Clearly, depressed individuals or those intent on leaving are not likely to be great role models or very productive.

Academic health centers' lack of attention to its human resources is also expensive in terms of turnover. The costs of faculty turnover have been estimated to be

5% of ACADEMIC HEALTH CENTER budgets (not including costs of lost opportunity, lost referrals, overload on other faculty, and reduced productivity and morale) [9]. While some turnover is predictable and healthy, too often it is the most rather than the least-valued individuals who leave.

- (a) The educational programs of health care professionals and scientists do little to equip trainees to develop insight into their strengths, values, and motivations, or to take responsibility for their own career development. And faculty at many academic health centers find few resources or supports along these lines. Thus, many professionals lack critical skills in accurate self-assessment, understanding organizational cultures, adapting to change while maintaining focus, managing conflicts, building and participating in high-functioning teams, and communicating with people across differences. These faculty in turn are unable to fulfill their responsibilities as teachers and role models of these skills.
- (b) While the traditional faculty path has assumed total immersion in the job, an increasing percentage of the incoming “intellectual capital” are women with substantial responsibilities at home. More young men as well are seeking opportunities that permit robust personal lives and ways to integrate family with professional life.

The Intersection of Gender and Generational Differences

Academic health centers are clearly dependent on the current trainees and junior faculty as their next high producers, mentors, and leaders. All of these individuals are, by definition, from a different generation and now over 60% of college graduates are women. Even three decades after women began entering the professions in force, despite their intellectual capital being equivalent to men's, they remain much less likely than men are to realize their professional potentials [10]. How can necessary improvements in biomedical research, medical education, and clinical care reach fruition if over half of the scientific and clinical intellectual capital remains underutilized?

Diversity is a necessary ingredient of an outstanding institution. Diverse teams outperform homogenous ones and in natural systems, as diversity increases, so does stability and resilience [10]. Yet, the paucity of women in board rooms, on key committees, and in leadership positions means that few men have experienced the improved collaborations, dynamics, and productivity that often results when a group is close to half men and half women [12].

The causes of gender disparities are multifactorial and remain controversial [13]. This chapter focuses on only two areas, both of which also affect many young men as well—the need for more effective mentoring and more flexible personnel policies.

While women faculty are as likely as men to report access to a mentoring relationship, most studies show that women gain less benefit from these relationships in terms of career planning and less encouragement to participate in professional activities outside the institution and that women are more likely than men to report

that their mentor takes credit for their work and that their mentor is a negative role model [14]. Successful men who from boyhood have had role models reflecting their aspirations often take this advantage for granted and discount the extra challenges women face in building developmental relationships.

Some men are not as forthcoming or comfortable with women as with men mentees, which can impede the value of mentoring that women receive. Some men seem more comfortable in paternalistic relationships with women (i.e., father–daughter) than as equals. Then at the critical point when their women proteges begin spreading their wings and seeking more independence, it is not unusual for senior men to withdraw their support, as if put off by the protégé’s growing power.

Being under-mentored seems to translate into a virtual “personal glass ceiling”—that is, women underestimating their own abilities and internalizing as personal deficits the cultural difficulties they face. These and other factors (e.g., being comparatively underpaid) reinforce each other, resulting in many women losing their ambitions and confidence and hence becoming less likely to successfully compete for raises, publications, and grants. Thus, senior faculty who make the extra effort to help women see their own leadership potential and connect them to resources and role models will likely have the satisfaction of witnessing a great impact on their development.

Lack of career guidance is not just a problem for women; virtually, all studies find that large percentages of faculty and residents of both sexes are not obtaining effective mentoring [15]. For example, one study found that only 42% were satisfied with the mentoring they received during residency, and 25% reported discomfort in discussing important issues with their mentor [16].

Many senior faculty are having difficulty adapting to their young proteges’ different needs and realities [17]. It should go without saying the younger generations have had different life experiences and formative influences than their parents, but Baby Boomers tend to behave as if they were THE Generation and to forget how different the world is now from how it was in their youth.

One important difference is that Boomers have tended to define themselves through their jobs. Their children, Generation X, is the first one in which both parents were likely to work outside the home and in which parental divorce became prevalent. Corporate downsizing also took its toll during their youth. In part, because of these trends, Generation Xers are seeking a greater sense of family and have less faith in organizations than their Boomer parents did. They see the toll that such complete dedication has taken on their parents and mentors

Thus, among Generation Xers (most junior faculty and residents) and the Millennials (now emerging from medical and graduate schools), men as well as women are seeking more temporal flexibility than the typical faculty appointment allows. While committed to the profession, they are rejecting the pursuit of excellence through human sacrifice [18]. There is a gap between the model of success embodied by the career trajectories of men whose idea of balance is making it home in time for dinner to be served and what the younger generations are seeking (few of whom have nonworking partners). Current faculty who are successful by their

discipline's and school's measures may not necessarily look like positive role models to Generation Xers and the Millennials.

Many of the younger generations of physicians and scientists measure success both by specific contributions to society and by their ability to maintain personal and professional balance. They do not want to disappoint their mentors, but they are explicitly creating and pursuing their own vision of this balance [19]. But instead of respect, too often young physicians encounter labels like “slacker” and value judgments about their commitment to the profession. As one resident asked, “Why are the older faculty so defensive and self-righteous—as if the way things were for them was the best of all possible worlds? If they really cared about us, they’d be trying to make life easier instead of hanging on to the past. Or maybe this is really about protecting their own privileges or justifying their own mistakes and sacrifices.”

Promising Directions for Enhancing Faculty Resilience

Organizational, departmental, and faculty resilience depend on a supportive ecology such that individuals cooperate in achieving both institutional missions and in enabling each other to meet professional goals and potentials. In recent years, a “quarterly statement” orientation has replaced the longer-term perspective necessary to develop people and critical to building an organization’s leadership “bench strength” and to succession planning. While there is an inherent polarity between short- and long-term perspectives [20], when a department resembles a giant adding machine more than a community of learners, than successful can it be educating the next generation of scholars?

Academic health center leaders can better manage this difficult polarity with more attention to the following:

More Flexible Faculty Structures

Recruiting and retaining valuable faculty increasingly depends upon creating an environment in which individuals can build satisfying careers without having to choose between personal and professional success. But the continuing tyranny of the assumptions that it’s “either advancement or family” and that faculty should not need time away from work especially during their twenties and thirties interfere with creative exploration of less-than-full-time alternatives.

Part-time pathways that can expand and contract as personal issues emerge are vital to making academe competitive with other medical career paths [21]. For example, part-time practice has been shown to be satisfying not only for physicians, but also for their patients [22]. In addition to nonpunitive less-than-full-time alternatives, other adaptive structures include opportunities to alternate high-involvement phases with lower involvement, unpaid leave for personal

reasons without loss of benefits, and more off- and on-ramps for faculty as their responsibilities shift [23]. Other humane adaptations include post-service “catch up” time, mini-sabbaticals, bridge funding, and more backup for clinical services so one person’s absence does not so negatively cascade onto others’ backs.

While such options may incur some up-front costs, they are less expensive than re-recruiting and onboarding replacements. Offering temporal flexibility also translates into a competitive advantage, building commitment and loyalty in individuals who have many decades of professional life ahead of them. Moreover, in a field as demanding as medicine, why not try to support Gen-Xers’ and the Millennials’ intentions to integrate their personal and professional lives so that they achieve their potential?

Updated Approaches to Mentoring and Career Development

Burdened by increasing demands on them, faculty face many challenges in “being there” for the trainees and junior members of the academy looking to them for support and guidance. Mentoring represents the most tangible bridge to continuing traditions of excellence, but given how work-related demands have escalated and how informal time at the bedside has decreased, updated approaches to mentoring are necessary.

Mentoring entails effectively and comfortably communicating about many delicate issues, including beliefs about professionalism, and across many differences including gender and ethnicity. Patience is required, especially in establishing trust with someone very different from oneself. While administering oxytocin to strangers has been found to facilitate trust, obviously no such shortcuts are available, and in any case nothing can substitute for listening with positive attention and asking open questions that encourage the other to explore their thoughts and feelings.

Faculty can be assisted to improve their competencies of active listening, avoiding assumptions, and combining an optimal balance of support and challenge, thereby maximizing their impact in the limited time available for this activity. Offering more learner-centered mentoring, they will avoid such common mistakes as undervaluing the younger generations’ perspectives and automatically communicating their version of “reality.” Fruitful opening questions are “What is most important to you right now?”, “How do you most like to spend your time?”, and “How would you define success in this situation?” If the answer to the first question is “finding competent child care,” then begin with that.

Although some faculty seem irrevocably lost to a “hardening of the categories,” most have something important to offer as mentors and with coaching can become more effective at and also get more out of this essential activity, extending their own legacies. Like senior citizens holding the paper further away so their eyes can better focus, mentors sometimes need to loosen their grip on how their proteges “ought to act.” For example, rather than relying primarily on their greater expertise or beginning sentences with “When I was a resident,” senior

faculty need to remember and acknowledge how much higher the bar is now set in terms of the time pressures and the complexity of virtually every patient care decision.

Too often, mentoring is treated as an activity that faculty, who are so inclined, engage in during their “free time”; and there are no consequences for being a negative role model and mentor. But mentoring is a professional responsibility that medical schools should support and recognize as a core academic responsibility. Many senior individuals could use supportive coaching in acquiring the competencies entailed in mentoring “across differences,” and this should be available.

The goal is building a supportive ecology in which collegial relationships develop as naturally as possible for all participants. In addition to one-on-one mentoring programs, an emerging model is collaborative and peer mentoring programs, for instance, facilitated group-mentoring that provides a framework for professional development, emotional support, and career planning [24, 25]. “Mentoring teams” can similarly be established so that junior faculty and trainees can access advice about an array of issues that a single mentor cannot adequately address [26]. This updating of mentoring practices also responds to medicine’s need for new models of mutuality and “facilitative” leadership based on shared authority.

A well-staffed faculty development office should work with chairs in providing such opportunities. Such offices can also do more to help new faculty build their community and acclimate to the institution. However, few academic health centers currently offer comprehensive faculty development services or widely available leadership development programs [27].

Given that academic medicine is dependent on the current trainees as the next generation of faculty and leaders, academic health centers should also be actively encouraging trainees’ interests in faculty roles. Residency programs should also offer trainees targeted assistance and coaching in seeking and negotiating the best possible first job; even if they do not stay within that academic health center or in academics, the trainees will appreciate and remember this assistance and support, which will build loyalty and help to recruit others. Residency and fellowship programs should also be offering trainees seminars on the whole range of career development skills, e.g., goal-setting, managing key relationships, and relationship-centered delegation.

Supporting and Evaluating Department Heads

Since department heads hold the keys to faculty vitality, faculty development needs to be high on their list of priorities. With the rising competition for funding and accelerating complexities in all knowledge and skill domains, it has never been a more challenging time to build a faculty career. Even though virtually all faculty are experiencing the same types of difficulties, each one feels alone with the steep

challenges. So chairs should do whatever they can to create a sense of “academic community,” including meeting with faculty regularly to provide constructive feedback and guidance regarding academic progress and professional development, and offering faculty opportunities for input into the department’s governance. When people feel cared about and listened to, they are better able to rise to complex challenges and expectations.

Departmental leaders should be held accountable for their competencies as role models and as mentors, particularly in their ability to mentor “across differences.” If junior faculty are given the opportunity to evaluate their chairs and mentors on such indicators as “provides timely feedback that both challenges and supports me,” “advocates effectively for my development,” and “inspires me as a role model,” this will build a database that can be used for both summative and formative purposes.

During chairs’ annual performance reviews, deans should also include assessment of the chair’s progress in nurturing the careers of women and minority faculty. Linking effectiveness in these areas to a consequence of value, such as approval of new positions or access to faculty development resources, would add weight to this evaluation. Certainly department heads cannot mentor everyone, but they can create structures and options that assist all their faculty in obtaining the mentoring they need.

To accomplish these improvements, department chairs require support from their dean’s offices. Excellent faculty affairs administrators build partnerships with chairs in becoming better developers of their human resources. They offer onboarding and educational sessions as needed and connect chairs who are struggling to coaches who can help them develop their “people” skills. A staple of leadership development in the corporate world, one-on-one executive coaching has been shown to increase the capabilities of motivated professionals particularly in the areas of accomplishing objectives and improving relationships [28].

Questions

To be sure, if these goals were easy to achieve, we would be further along. Many thorny questions arise as we consider how to boost faculty and departmental resilience. For instance:

1. How can academic health centers better support and assist faculty to take early responsibility for their own development and to see beyond their immediate career goals and departments such that they better understand their organizations and the “bigger picture” affecting them?
2. Even though faculty and leadership development programs likely protect investments and save resources in the long-run, how can strapped organizations come up with necessary start-up funding for such programs?

3. Where is the line between dedication to one's own family and health and insufficient dedication to one's profession and peers? How can we create safe forum in which to discuss such professionalism issues?
4. What academic health centers are making the most progress in aligning their performance evaluation criteria with their highest professional values and their educational missions (and not just their financial and research missions)? How can academic health centers better deal with administrators who use-up and demoralize faculty rather than develop them?

Conclusion

Assuring faculty resilience means addressing the developmental needs of current faculty and building bridges to the next generation. This work increasingly entails skillfully and courageously mentoring across many differences and creating alternatives to the traditional full-time model of continuous engagement. Unless academic medicine improves mentoring and expands its models, it will lose access to a great deal of intellectual capital. Neither academic medicine nor society can afford this loss.

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