American Handbook of Psychiatry

MEDICAL FACULTY, ORGANIZATIONAL PRESSURES, AND SUPPORT

Pamela J. Trent
H. Keith H. Brodie

MEDICAL FACULTY, ORGANIZATIONAL PRESSURES, AND SUPPORT

Pamela J. Trent and H. Keith H. Brodie

e-Book 2016 International Psychotherapy Institute

From *American Handbook of Psychiatry: Volume 7* edited by Silvano Arieti

Table of Contents

MEDICAL FACULTY, ORGANIZATIONAL PRESSURES, AND SUPPORT

Introduction

Organizational Pressures

A Focus on Psychiatry

Conclusion

Bibliography

MEDICAL FACULTY, ORGANIZATIONAL PRESSURES, AND SUPPORT

Pamela J. Trent and H. Keith H. Brodie

Introduction

Medical education in the United States has not faced such careful scrutiny since Abraham Flexner published his report in 1910. Whereas that report disclosed the need to organize medical education, present studies of the issues reflect the overwhelming complexity of that organization. The recent report, *The Organization and Governance of Academic Health Centers* makes this abundantly clear. Academic health centers (AHCs), direct descendants of post-Flexnerian efforts to improve medical schooling, are now complex and diverse institutions "consisting of a medical school, at least one other health school, and a teaching hospital (owned or affiliated)." Note the historical factors leading to this complexity, as delineated in the report:

1. There has been an overwhelming increase in the operating and capital budgets for programs, staff, students, and faculty.

2. There has been a tremendous growth of new medical knowledge in the past forty years.

3. There has been a large and steady increase in federal support for health care, medical education, and medical research since

1945, adding to the administrative complexity.

4. Since the 1960s, there has been pressure to provide more and better health care to all members of society.

5. There has been a major increase in external regulation from all levels of government.

6. There has been increasing competition from non-physician professionals who seek to improve their status, capabilities, and credibility in health-care delivery.

Note also the diverse modes for organizing and governing AHCs:

1. Some are public, others private.

2. Most are subdivisions of a "parent" university, but a large minority are autonomous.

3. Of those that are part of a "parent" university, some are on the same campus, some are on a different campus in the same city, and some are in a different city.

4. Some include a university-owned hospital while others make arrangements with affiliated hospitals.

5. The number of health schools on a campus may range from one to seven.

6. The majority have a position identified as chief administrative officer, often with the title of vice president for health affairs.

Finally, observe the various factors that induce complexity at the policy-making level:

1. The several interacting components in AHCs incorporate different modes of government.

2. The three distinct missions of the AHC—education, research, service—frequently conflict, leading to frustration and ambiguity.

3. Because AHCs must respond to diverse client groups with often contradictory expectations, it has been impossible to develop performance measures for institutional activities.

4. AHCs are part of and vulnerable to a powerful, dynamic environment vis-a-vis changing technology, consumer demands, and governmental regulation.

5. AHCs accommodate professionals with wide-ranging skills, interests, and roles, who often experience conflict between professional values and organizational expectations.

6. The power and influence in AHCs are issue-specific.

Clearly, the *Organization and Governance of Academic Health Centers* report is enlightening. The complexity of the medical education enterprise challenges the notion that the people who work in these organizations can understand their unique role, the position of their administrative component,

and their relative security in the organization. Although research on academic health centers is still forthcoming, we do know from classical research and theory-that high complexity in organizations leads to employee confusion about lines of authority, alienation from the task (or inability to make a meaningful commitment to the work), fragmentation of efforts, and overall insecurity. In short, the person gets lost in the organizational labyrinth.

This chapter is concerned with medical faculty as teachers in academic health organizations. It focuses on the teacher for three reasons. First, there is much thought and writing, especially in psychiatry, about medical education issues (for example, students, learning styles, teaching methods, and evaluation). But there is an obvious dearth of discussion and data regarding the needs of teachers in medical education. Second, teachers make choices that affect students' lives. These choices, never based purely on intellectual consideration or quantitative data, include implicit values, philosophies, personal meanings, and assumptions about life. Teachers need to heighten their awareness of these implicit underpinnings. Third, the teacher-student relationship is a model for the doctor-patient relationship, a relationship that should be based on trust and acknowledgment of a personal commitment. It is difficult for the teacher to make a commitment if his or her own needs are not addressed. This chapter delineates the pressures affecting medical faculty in general, it describes strategies used by faculty for coping with the pressures, and it then focuses on the particular needs of psychiatry faculty with a

recommendation for addressing those needs.

Organizational Pressures

Factors impinging on the teaching function of faculty members are external and internal to the organization. External factors considered here to be especially deleterious include economic conditions, knowledge explosion, and legal influences. Internal factors include administrative responsibilities, tenure and promotion considerations, and performance evaluation.

External Factors

Economic Conditions

Spiraling inflation, rising costs for medical care and medical education, and limited research and training funds have caused internal stress on AHCs, which saw an increasing support base annually during the 1950s and 1960s. In a climate of diminishing resources, individual faculty members must develop various fiscal responses.

Decreasing research and training funds require that clinical faculty devote more time to patient care, generating money from their clinical practice to support their own salaries and other departmental expenses. The transfer of these monies is organized in a variety of ways. In some

institutions, the funds from individual practice are given directly to the medical school that, in turn, pays the clinician's salary and overhead costs. Other clinical departments are organized as partnerships, and still others allow physicians to function in solo fashion with or without constraints on total income. Regardless of how the financial arrangements are organized, some faculty receive negligible financial support from their university and many are even required to pay for their own office space, secretarial assistance, and supplies.

Faculty members who must depend solely on research and training funds suffer from equally burdensome financial problems. Federal and private grants and contracts have become limited;' this results in a highly competitive market made even more competitive by fluctuating funding priorities. What was considered highly fundable in 1980 may be a low priority in 1984. This puts faculty in a precarious position as they spend time and energy developing grants, bidding on contracts, reporting about ongoing projects, and trying to predict what will be attractive to funding agencies when the priorities change. It encourages "project-hopping" rather than research built on a logical and sequential approach that is conducive to the development of a research product and career of excellence.

The financial burden on individual faculty members is augmented by the need to contain costs in an uncontrolled economy. This means restricting

research and teaching, limiting growth, decreasing certain activities, and adjusting to strict allocation of resources. The situation encourages competition for scarce resources in a profession that is already highly competitive. Pressures from economic conditions are most deleterious because they chip away at the faculty's fundamental need for security (that is, a steady income and predictable job) and for commitment to a sustained effort.

Knowledge Explosion

Rapid increase in knowledge has encouraged specialization and a competency-based approach to education, placing additional pressure on faculty members.

Specialization, although necessary for organizing profuse knowledge and providing skilled care, tends to fragment the medical profession and encourages "empire building nationally, regionally, and locally." For instance, specialization perpetrates a keen competition among faculty in the same institution for available time in an overcrowded curriculum. As a result, specialization builds barriers to communication among faculty who could otherwise share theories, interests, and frustrations. In similar fashion, specialization affects communication between teacher and student. Tosteson comments about this:

> It is my impression that the opportunities for developing meaningful fruitful relations between students and faculty have decreased in our medical schools during the past decade even though the faculty-to-student ratio has increased. One factor leading to this situation is the growing specialization of medical education. An expert appears briefly to present his knowledge and disappears, rarely to be seen again by the students. Such brief encounters do not allow the students to know the faculty as persons, [p. 693]

Because of the overwhelming amount of knowledge and scientific information a student must learn and apply through medical training, the competency-based educational model has become popular for its ability to specify learning objectives and evaluate performance. Indeed, federal training grant proposals are given higher priority scores if they use the standards of this model. The model requires a defined competence of all students; makes explicit the knowledge, skill, and attitude objectives; evaluates achievement according to a criterion rather than a norm; and allows students to repeat certain training until they achieve competence in that area. Preliminary studies indicate its effectiveness in medical training, and the benefits are self-evident: It provides a guide for teachers and students, organizes content, and minimizes competition since all students are encouraged to succeed.

However, there are subtle pressures inherent in the competency-based system. The amount of time and energy that must be devoted to developing a competency-based teaching “module” or program is substantial and might unduly strain an already overworked teacher who conceivably receives few

rewards for teaching. A cost-benefit analysis of the model should test this observation. In addition, competency-based proponents encourage teachers to think that every iota of student learning can and should be measured. This restricts evaluation of learning to a very objective, technical meaning, one that may ignore the teacher's subjective ability to observe subtle changes in students. Psychiatrists, for instance, realize that psychiatric education is largely an artful, intuitive activity that often defies precise measurement. Finally, since competency-based teaching is systematic and structured, teachers may think that students can travel through the learning experience with minimal guidance. Where this encourages self-directed learning it is a noble outcome; where it encourages the teacher to become personally removed from the educational process, acting as a barrier to communication, it becomes counterproductive for both teachers and students.

Legal Influences

The physician's image as expert, or unquestionable authority, has been challenged extensively in litigation regarding malpractice suits, students rights' to due process, and privacy rights of students and parents. The potential for litigation forces the physician to be constantly aware of his or her actions, adding pressures unanticipated ten years ago. In terms of malpractice suits, Rogers states succinctly:

> The threat of lawsuits adds to the pressures that constrain and sometimes

> paralyze the physician's ability to act quickly and effectively in treatment. And the physician's response is typically and predictably one of caution, demonstrated always in more conservative decisions, more protracted tests and consultation, and more guardedness in sharing information with the patient, [p. 41]

Psychiatry, for instance, faces a skeptical public's demand for evaluation of treatment modalities and clarification of patients' right to treatment and right to refuse treatment. This forces psychiatrists into more conservative postures. Further pressure ensues when the guarded conservative approach to patient care conflicts with the need to contain costs, forcing the physician to arbitrate between these conflicting needs. The clinical teacher is required then to be duly conscious of what patients and procedures can be used for medical educating and of the patients' rights to informed consent in patient care, teaching, and research.

Due process, a legal concept expressed in the fifth and fourteenth amendments to the Constitution of the United States, provides that neither the federal nor state government shall "deprive any person of life, liberty or property, without due process of law." This is a significant issue in medical education where students serve in a professional capacity, and faculty must evaluate students' professional as well as personal judgment, ethical integrity, clinical skills, and relation to and management of patient welfare. Because evaluation must often be based on subjective interpretations, students have become increasingly concerned and vocal about right to due process.

Litigation has forced interpretation of the law. Pursuant to litigation and in accordance with interpretation, the Liaison Committee on Medical Education, sponsored by the Association of American Medical Association, developed a policy as follows:

> III. *Educational Program.* A medical school should develop and publicize to its faculty and students a clear definition of its procedures for the evaluation, advancement, and graduation of students. Principles of fairness and "due process" must apply when considering actions of the faculty or administration which will adversely affect the student to deprive him/her of valuable rights. [p. 3]

In addition to due process, the Privacy Rights of Parents and Students Act of 1976 allows parents and students direct access to students' educational records. Students are able to review professors' comments and evaluations. This law protects students from derogatory evaluation, but if taken to an extreme it allows students to challenge the professor's perception about what constitutes quality patient care. On the one hand, this law together with due process pressures the faculty to be very circumspect in evaluating student performance. On the other hand, it pressures them to be less than honest in cases where they may realistically fear litigation.

A short anecdote told by a psychiatry colleague puts this dilemma into a personal perspective. In a psychiatry curriculum committee meeting, a faculty member explained that a student requested a change in the rhetoric of an evaluation. The student challenged the psychiatry educator's use of the term

"passive" in describing the student's lack of involvement in learning. The teacher changed the term, agreeing that use of psychiatric terms was inappropriate in student evaluation, and suggested to colleagues that they take greater care in describing student performance. (It is easy to phrase student evaluations with the same language used in patient summaries.) The colleagues agreed about the language but some were aghast over the student's ability to review the file and request a change. They felt threatened by this, for it undermined their perception that they were autonomous and that as medical faculty they could command an almost unquestioning respect regarding their professional judgment.

Internal Factors

Academic health centers have grown so rapidly that faculty members must adjust to increased administrative responsibilities, tougher guidelines for promotion and tenure, and systematic performance evaluation.

Administrative Responsibilities

Although health education became more organized after the Flexner report, the schools retained a simple administrative network. They were usually "administered by part-time deans with assistance of a small clerical staff, and department heads devoted the majority of their time to their own professional activities rather than departmental administration." The past

twenty years have seen a notable difference with administrative decision making branching out to include university and hospital boards, a university president, health center chief administrative officer, deans of medicine and other health schools, department chairmen, division and section heads, professional and nonprofessional support staff, students, and alumni.

This administrative complexity requires faculty members to become more involved with supervision of support staff and institutional service. They must devote time to work on committees for admissions, curriculum, recruitment, student affairs, governance, and human subjects research. The increased administrative responsibility is a burden to faculty because they often lack administrative skills. There is no defined reward for this work, and it absorbs time that would otherwise be given to patient care, teaching, and research.

Faculty must also adjust to the increasing administrative pressures placed on their department chairmen. In the past, chairmen could spend time interacting personally and professionally with each faculty member, knowing firsthand their concerns and aspirations. Now the increased size of departments, managerial duties, and fiscal responsibilities tend to insulate chairmen from faculty. This is frustrating for both, leaving a gap that may needlessly strain relationships and is difficult to fill.

Promotions, Tenure, and University Expectations

Financial constraints, probability of decreased growth rate, high cost of a large tenured faculty, difficulty of maintaining research productivity in the present market, and pressure to train more primary-care physicians rather than specialists have led to redefinition of university expectations and revision of promotion and tenure guidelines. Although there are advantages to reassessing the tenure and promotion systems, the major disadvantage is that this generation of faculty members must live with indecision regarding their security in medical academia. Some institutions have frozen tenure, others have changed the time line for consideration, still others give faculty non-tenured appointments, using clinical and research professoriates. With very little knowledge about the long-term outcomes of these actions, it is difficult for faculty to choose the "right" career path. Choosing becomes even more difficult when university expectations remain uncertain and faculty performance criteria are vague.

Performance Evaluation

Over the past twenty years, there has been an increased need to document and evaluate faculty performance for promotion and tenure decisions, in fairness to faculty and in compliance with their rights by law. Although elaborate evaluation systems have been proposed in higher education generally, it is difficult to implement such systems in medical

education because of the patient-care milieu and unique institutional constraints. Nevertheless, faculty evaluation has been a longstanding concern among administrators, students, and faculty in the medical professions, and several issues emerge.

First, in terms of patient care, it is difficult to evaluate clinical competence because reaching a consensus regarding the definition of competence is almost impossible. “There are degrees of competence expected and necessary at different points in a physician’s career and according to the specialty pursued, and the nature of the practice.” The lack of definitive criteria and measuring instruments necessitates further research into reliable and valid assessment in this area.

Second, differences among specialties and subspecialties make it difficult to evaluate the quality of a faculty member’s research and publication contributions. At most institutions, research publications are counted rather than critically appraised. Furthermore, critical appraisal would require adjusting the evaluation criteria to reflect decreasing research funds, varying journal review procedures, different publication standards, and professional politics. It would also require objective peer evaluation and review, which are costly and time-consuming.

Third, as with research, institutional service is measured by counting

the number of committees to which the faculty member is appointed. Quantity rather than quality becomes the explicit criterion. Where quality of contribution is considered, it is usually assessed through informal communication channels and remains an implicit criterion.

Fourth, although much research has been done on the evaluation of teaching, the concept of teacher effectiveness remains almost as vaguely defined as physician clinical competence. Ordinarily, lists of teaching characteristics, which vary from institution to institution, are developed into rating scales and used for evaluating teaching performance. Ideally, the teacher should be evaluated by a variety of persons including administrators, peers, and students. But, too often, only student evaluations of instruction are used, and consequently the student ratings often reflect biases such as: students' general disposition toward instructors and instruction; teaching conditions including class size, elective versus required status of course, and subject matter; student preference for highly structured or less structured teaching styles; and student expectations and achievement. Clearly, there is a need for further research in the development of teacher evaluation measures and methods.

Because of the relatively unsophisticated state of the art in performance evaluation, medical faculty must live with a certain amount of ambiguity. Although current evaluation efforts attempt to explicate the basis of

performance decisions, their lack of sophistication pressures the faculty for the following reasons:

1. Faculty members rarely have direct input into developing criteria that will be used to assess their individual performance.

2. By and large, faculty are not trained to be administrators and teachers, but are nevertheless being evaluated in those functions.

3. Faculty are uncertain about how evaluation results are used in making promotion and tenure decisions.

4. Performance evaluation is used primarily to make judgments (for example, contract renewal, tenure, and promotion) rather than to facilitate professional growth and development.

5. Evaluators, be they students, administrators, peers, or outside observers, always hold implicit values and biases which they are not required to clarify in their ratings of faculty.

6. Evaluation is always threatening, especially when conducted in a competitive rather than trusting atmosphere. No one would deny the competitiveness inherent in medical training and the discomforting challenge of being observed and rated.

These organizational factors indicate the substantial pressures on faculty members in academic health centers—their financial insecurity, uncertain job futures, increased responsibilities, and confusion over

institutional expectations and reward. What emerges is a picture of faculty members in need of support.

Coping Strategies

While physicians are trained to be confident and responsible, they now face severe limits and a certain helplessness vis-a-vis the complex organization. Rogers describes the sense of helplessness as a "fear of impotence in effecting change or control," and points out physicians' unconstructive as well as adaptive responses to the current situation.

The unconstructive responses, similar to those used by larger groups of people experiencing greater helplessness, depend on psychological denial and escape. One such strategy is the compulsion to identify with symbols of power, which can obscure a person's real limits in decision making and control. Another strategy, most obvious in the medical profession, is simply overwork. Seriousness and dedication turn into compulsion. Faculty members refuse to accept the limits of responsibility, time, and energy. A third strategy is to surround oneself with technology, becoming insulated from interpersonal interactions that require openness and vulnerability. Although distancing is important in patient care, it is often extended to other human interactions, even those that should be "intimate." Finally, another strategy, which some claim is a conspicuous illness of our age generally, is the inability

to make a commitment to one's work, family, and community. As Dyer states: "Serious indeed is the erosion of public confidence that medicine has suffered, but equally grave is the loss of self-confidence of many physicians who often practice within the confines of what is expected of them rather than what they are committed to."

Adaptive responses rely on understanding the valuable components of unconstructive strategies and recognizing where overreaction begins. A constructive response requires acknowledging the real limits of time, training, disposition, and situation. It also means "differentiating real helplessness and professional limits from obsessive and worrisome forms of imagined helplessness."

As teachers, faculty members build the future of the medical profession in their daily interaction with the next generation of physicians. They make choices which affect students' lives, and their relationships with students are models for students' relationships with patients. If indeed the stresses are producing, as Miller describes, "a new breed of ambitious specialized professionals who are, by preference, by training, and by the requirements of the tenure and promotion system, more interested in the prestige of research and publication than in the humbler rewards of excellent teaching," then we must be concerned with how the teachers' choices affect students. And if teachers take "easy" options, ignoring ethical obligations to students while

engaging in “the genteel art of cutting rival scholarship, of rejecting articles without reading them, of extorting free books from publishers, and the like,” then we must be concerned with what is being modeled in the teacher-student relationship. But most important, organizations must be sensitive to the needs of the faculty, the pressures they face, and the support they have for coping with stress.

A Focus on Psychiatry

Recommending ways for addressing faculty needs and establishing support systems in medical education is too ambitious a project for this chapter. Surely there are no simple answers to the complex issues. It seems more sensible therefore to choose to focus on psychiatry education with its unique problems and to suggest one possible method for faculty support. Perhaps then, as Herbert Pardes, Director of the National Institutes of Mental Health, suggested: “The close attention that psychiatry gives to the details of its professional education can serve as a model for the rest of medicine.” In addition to coping with pressures that are part of the academic health organization, psychiatry faculty face unique issues. First, limited financial support is not new to psychiatry. Over the past ten years, research and training funds from the Department of Health, Education and Welfare have not kept pace with inflation and the increase in number of medical schools. Furthermore, psychiatry is the lowest paid clinical specialty in medicine

because of discriminatory third-party coverage, the amount of physician time spent in patient care, and the lack of profitable technologies. Second, psychiatry suffers from a poor image both inside the profession (with an unclear status as a medical field) and outside the profession (from a skeptical public). Third, psychiatrists must adjust to working with a variety of mental health professionals such as social workers, psychiatric nurses, and clinical psychologists, and must also compete for patients with these professionals. Finally, psychiatry is experiencing dwindling residency enrollments: there has been a 28 percent decline in interest among medical school candidates; a drop in medical students entering psychiatry (from 11 percent in 1970 to 3.6 percent in 1978), and an increase in the resident dropout rate (from 7.1 percent in 1978 to 12.2 percent in 1979).

To improve psychiatry's image and offset the dwindling enrollments, some have suggested that the profession pay special attention to improving its educational practices. Indeed, psychiatry is perhaps the most conscientious of all medical professions in this regard, with conferences devoted to teaching, innovative education efforts encouraged by the Psychiatry Education Branch of The National Institutes of Mental Health, and the development of education evaluation methods. Quite notable, in fact, was the report of the 1975 Conference on Education of Psychiatrists which, among other things, outlined specific responsibilities of psychiatric teachers (see table 34-1). The responsibilities reflect psychiatry's focus on and immense concern with

teaching. However, what remains to be addressed by the profession is the type of support teachers need to meet these responsibilities amid the pressures of complex organizations.

There is much to be learned about psychiatry faculty from research on professionals in academic organizations in general and from reactions of people in various types of corporate structure. But there is no substantial literature regarding pressures, coping mechanisms, and support systems for medical faculty and psychiatry faculty in particular. These issues obviously need to be addressed through rigorous research that can lead to appropriate organizational change and support.

Table 34-1 Teaching Responsibilities in Psychiatry Education

1. Serving as role models, demonstrating through their own example how a mature clinician should approach the diagnosis and care of patients

2. Supervising and guiding residents as they develop their own skills by providing advice, support, information, and extensive evaluative feedback

3. Conveying essential information concerning the intellectual and theoretical foundations of psychiatry through both clinical and didactic teaching

4. Serving as sensors to developments in the immediate and larger

social milieu, the profession, and the relevant sciences; communicating these to residents; and shaping the educational program to keep pace not only with the present but the future

5. Continually expanding their own state of knowledge and skill so that what is preached is practiced as well

6. Acting as compassionate, perceptive guides to professional development (with special skills honed by professional training) who can be responsive to the individual needs of residents at a time of great stress and growth

7. Understanding and respecting residents sufficiently to include them in major decisions that affect their education and professional well-being and shaping the residency program, to the extent possible, to achieve a reasonable balance between the fulfillment of resident needs, professional responsibility, and the demands of the service setting

8. Serving as the legally and professionally responsible representatives of patients' best interests and exerting leadership to assure that residents, as well as faculty members, practice with those interests foremost

9. Participating in administrative decisions that affect the educational milieu; the curriculum; faculty; residents and other students in the training settings; the use of time, space, and personnel; the dominant philosophy and approaches to education; and the accommodation among departmental research, education, and service activities

10. Helping to articulate educational objectives, assess whether and how well they are being met by teachers and students, and introducing those changes needed to aid in their realization

Source: Rosenfeld, A. H. Psychiatric Education: Prologue to the ig8o's. Washington, D.C.: American Psychiatric Association, 1976, pp. 195-196.

In the meantime, based on our experience and sense of what is true, it is clear that faculty need support. And we must be willing to explore, develop, and assess alternative faculty support structures that are built into each faculty member's immediate milieu. One alternative is available: In order to facilitate the matching of individual faculty expectations with institutional goals, to help faculty clarify their personal values and professional commitments, to provide faculty with opportunities for developing teaching, research, and administrative skills that are not taught in medical training, and to enhance physicians' current capabilities, we suggest maximizing the relationship between individual faculty and faculty administrators such as section chiefs, division heads, and chairmen. Such a relationship could be characterized as an advisory system that could be established in the context of present departmental structures or in matrix-management arrangements. Matrix management, a preference in some academic health centers, defines horizontal and vertical lines of authority in which "functional managers" are responsible for merit review and "project managers" supervise productivity in patient care, teaching, research, and administration.

We suggest that advisory systems, based on relationships between functional managers (for example, section chiefs, division heads, chairmen) and faculty members, be implemented and studied as supportive means for faculty guidance, development, and accountability. Guidance would acknowledge personal as well as professional concerns by: (1) clarifying rights and responsibilities of faculty members; (2) providing appropriate counsel and support; (3) defining organizational opportunities as well as organizational constraints; and (4) helping faculty to prioritize their personal and professional goals. A commitment to faculty development would assure that: (1) performance evaluation be used as a developmental tool; (2) opportunities for faculty enrichment are studied thoroughly; and (3) individual faculty members are made aware of different types of rewards for varying contributions to the institution. Accountability would be formulated through a written contractual arrangement that would delineate: (1) organizational expectations regarding productivity and salary support; (2) the means for documenting faculty performance; (3) long-and short-term goals of faculty members; (4) developmental time lines for promotion and tenure; and (5) methods for negotiating and altering the contract.

The very nature of the advisory relationship requires a fiduciary commitment; that is, that it be founded in trust and confidentiality. Not a new concept, the fiduciary standard has its roots in the historical beginnings of the medical profession and is intimately connected to the ethics of professional

responsibility. As Dyer explains:

> The fiduciary tradition in medical ethics is at least as old as the Oath of Hippocrates and the cults of Aesculapius, and it has endured not as a code but as a symbol of the ideals most deeply cherished by the medical profession. While not encompassing in terms of behavioral guidelines, it has yet to be replaced by anything more morally inspiring, [p. 989]

If we espouse the importance of the fiduciary commitment in patient care and teaching, then we must acknowledge its importance in the advising and care of faculty. Above all that is expected of our teachers, and all they are able to produce, they are first and foremost people who, like other people, need support and guidance.

Conclusion

This chapter has focused on the complexity of academic health centers, describing the resultant pressures incurred by faculty. While the complexity affects medical education in general, faculty are singled out because teachers are medical education's greatest resource, and their needs, coping strategies, and support systems are sorely understudied. Moreover, teachers affect students' lives in immeasurable ways, and their relationships with students are echoed in the students' relationships with patients.

There are no easy answers, and no one answer, for meeting faculty needs in medical education. Developing and exploring the feasibility of

alternative support systems, one of which could be an advisory system for faculty, is one way to meet this challenge. Because of psychiatry's unique knowledge and skills regarding human behavior, it appears to be a fertile field in which to cultivate research and development in this significantly important area.

Bibliography

Baldridge, J. V. "Environmental Pressure, Professional Autonomy, and Coping Strategies in Academic Organizations," *Research and Development Memorandum No. 78.* Stanford: Stanford Center for Research and Development in Teaching, 1971.

Bergquist, W. H., and Phillips, S. R. *A Handbook for Faculty Development.* Washington, D.C.: Council for the Advancement of Small Colleges, 1975.

Costin, F., Greenough, W. T., and Menges, R. "Student Rating of College Teaching: Reliability, Validity, and Usefulness," *Review of Educational Research,* 41 (1971): 511-535.

Council on Medical Education. Report of The Council. *Future Directions for Medical Education.* Washington, D.C.: American Medical Association, 1979.

Daniels, R. S. "Premedical Education in The Medical School Admission Process: Factors Influencing Psychiatry as a Specialty Choice." Paper presented at National Conference on Psychiatric Manpower and Recruitment, San Antonio, March 1980.

Dyer, A. R. "Medical Ethics, The Art and Science of Medicine," *Connecticut Medicine,* 40 (1976): 467-470.

----. "Reflections on The Doctor-Patient Relationship," in Brady J. P., and Brodie, H. K. H., eds., *Controversy in Psychiatry,* Philadelphia: W.B. Saunders, 1978, pp. 983-996.

Eaton, J. S. JR. "The Psychiatrist and Psychiatric Education," in Kaplan, H. I., Freedman, A. M., and

Sadock, B. J., eds., *Comprehensive Textbook of Psychiatry,* vol. 3. New York: Williams & Wilkins, 1980, pp. 2926-2950.

Flexner, A. *Medical Education in The United States and Canada.* A Report to The Carnegie Foundation for The Advancement of Teaching. Bulletin no. 4. Boston: Updyke, 1910.

Gaff, J. G. *Toward Faculty Renewal.* San Francisco: Jossey-Bass, 1975.

Goodman, R. A. "Organization and Manpower Utilization in Research and Development," *IEEE Transactions on Engineering Management,* EM-15/4 (1968): 193-204.

Grasha, A. F. *Assessing and Developing Faculty Performance: Principles and Models.* Cincinnati: Communication and Education Associates, 1977.

Hales, D. "Recruiting Psychiatrists Seen As Crucial Issue," *Newspaper of The American Psychiatric Association,* 4 April 1980, p. 1.

Hastings, D. A., and Crispell, K. R. "Policy-Making and Governance in Academic Health Centers *Journal of Medical Education,* 55 (1980): 325-332.

Hildebrand, M., Wilson, R. C., and Dienst, E. R. *Evaluating University Teaching.* Berkeley: Center for Research and Development in Higher Education, University of California, 1971.

Holley, W. H., and Feild, H. S. "The Law and Performance Evaluation in Education: A Review of Court Cases and Implications for Use," *Journal of Law and Education,* 6 (1977): 427-448.

Kanter, R. M. *Men and Women of The Corporation.* New York: Basic Books, 1977.

Katz, D., and Kahn, R. L. *The Social Psychology of Organizations.* New York: John Wiley, 1966.

Kulick, J. A., and Mckeachie, W. J. "The Evaluation of Teachers in Higher Education," in Kerlinger, F. N., ed., *Review of Research in Education.* Itasca, Illinois: F.E. Peacock, 1975, pp. 210-240.

Liaison Committee on Medical Education. *Accreditation of Schools of Medicine: Policy Documents*

and Guidelines. Washington, D.C.: Association of American Medical Colleges, 31 March 1976.

Miller, J. W. "Punctiliousness or Pettifoggery?: A Case for Commitment to Ethics in Academe," *American Association of Higher Education Bulletin,* 31 (1979): 3-4.

Moore, J. T., and Bobula, J. A. "A Conceptual Framework for Teaching Geriatrics in a Family Medicine Program," *Journal of Medical Education,* 55 (1980): 339-344.

Muslin, H. L. et al. *Evaluative Methods in Psychiatric Education.* Washington, D.C.: American Psychiatric Association, 1974.

Organization and Governance Project of the Association of Academic Health Centers. Report of the Project. *The Organization and Governance of Academic Health Centers: Presentation of Findings.* Washington, D.C., 1980.

Rogers, W. R. "Helplessness and Agency in The Healing Process," in Rogers, W. R., and Barnard, D., eds., *Nourishing The Humanistic in Medicine: Interactions With The Social Sciences.* Pittsburgh: University of Pittsburgh Press, 1979, pp. 25-51.

Rosenfeld, A. H. *Psychiatric Education: Prologue to the 1980's.* Report of the 1975 Conference on Psychiatric Education. Washington, D.C.: American Psychiatric Association, 1976.

Schein, E. H. *Organizational Psychology,* 2nd ed. Englewood Cliffs, N.J.: Prentice-Hall, 1970.

Seldin, P. *Successful Faculty Evaluation Program: A Practical Guide to Improve Faculty Performance and Promotion/Tenure Decisions.* Crugers, N.Y.: Coventry Press, 1980.

Stillman, P. L., and Sabers, D. L. "Using A Competency-Based Program to Assess Interviewing Skills of Pediatric House Staff," *Journal of Medical Education,* 53 (1978): 493-496.

Tosteson, D. C. "Learning in Medicine," *The New England Journal of Medicine,* 301 (1980): 690-697.

Trent, P. J., and Brodie, H. K. H. "Psychiatric Research: A Process View," in Kaplan, H. I., Freedman, A. M., and Sadock, B. J., eds., *Comprehensive Textbook of Psychiatry,* vol. 3. New York:

Williams & Wilkins, 1980, pp. 3298-3305.

U.S. Department of Health, Education and Welfare, Office of the Secretary. Rules and Regulations. "Privacy Rights of Parents and Students: Final Rule on Education Records," *Federal Register*, 41 (17 June 1976): 24670-24675.