



Retain or Replace: The True Costs of Unintended Faculty Departures and How to Minimize Them

BY DAVID J. BACHRACH, FACMPE/FACHE

Sears had a classic saying that it offered to new trainees: “If you don’t have time to do it right, how will you ever have time to do it over?” A variation on this theme applied today in academic medicine might be: “If you don’t have the time/resources to nurture your current valued faculty, how will you ever have the time/resources to recruit his or her replacement?”

In a perfect world our medical schools would be filled with just the right people all the time. When we create a new position, a suitable candidate will be immediately available to fill it. When a faculty member announces that they were leaving, the perfect replacement would slide into position as the departing colleague’s moving van pulls out—a new candidate so perfect that he or she would require no training or orientation and would slide into the slot “up to speed” and ready to assume a full complement of responsibilities.

It is no surprise that we do not live in a perfect world—we’re not even close. In fact, more often than not we operate at below-optimal staffing levels and often take far longer than most of us feel we should to recruit, relocate and orient new faculty. Some of this is unavoidable but the process can be improved upon. More important, some faculty turnover need not occur at all if we maintain an effective process of faculty communication. (At a future time we’ll explore the benefits that should be present in a well thought-out and executed recruiting process.)

Are You Communicating Effectively with Your Faculty?

There are several essential components inherent in an effective faculty communication process. When they are present, we have good to great outcomes. When they

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are absent, we suffer disruptions in our mission areas, loss of “customer” loyalty (not only patients but also medical student and resident candidates), increased costs, and diminished revenues. What is needed? Let us start with these five major elements:

1. Clearly articulated roles, goals and performance expectations conveyed in a well-written and understood position description. Includes objective and subjective measures of performance that are reported to the incumbent at appropriate intervals (at least annually) and discussed with their supervisor.
2. A well-defined and consistently applied performance evaluation process. The process includes incumbent self-evaluation and goal setting for the year(s) ahead followed by face-to-face discussion with a supervisor who confirms and/or adjusts the document to be consistent with the needs and expectations of the operating unit in which the individual resides.
3. Mechanisms for performance recognition that reward accomplishment of expected goals, as well as attainment of “stretch” goals that exceed minimum expectations. Longer-term recognition of performance comes in the form of academic advancement and, for those who seek it, increased responsibilities associated with advancement in the administrative ranks to section chief, chair, or dean.
4. An effective compensation review process that includes periodic examina-

tion of marketplace and competitive factors such that compensation (salary and benefits) are set at levels that will allow an organization to attract and retain the faculty they want and need to meet their multi-dimensional goals of teaching/research/patient care/administration. While it should go without saying, and it often doesn’t, this process should include equity reviews to affirm that any salary differences are due to time-in-grade and demonstrated performance rather than gender/race or other factors of diversity. Adjustments to achieve equity goals must often compete with meritorious performance rewards for attention but should, in fact, be made before merit adjustments.

5. While performance excellence may include noneconomic recognition, the harsh reality is that additional income (often in the form of incentive awards that do not become a part of the individual’s base compensation) is often the best near-term motivator of such performance. As modest or robust as such a mechanism may be, it should be objective, unambiguously measured, consistently applied and equitably awarded in a timely fashion based upon individual and/or (as predetermined) group performance.

While all these are essential to an effective process, I have found that the element that is often missing, or least well developed, is that which deals with a well defined, executed, and meaningful evaluation process.

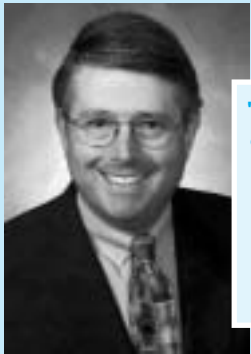
Are You Maintaining an Effective Evaluation System?

Faculty turnover occurs, in part, when faculty do not know where they stand. Do your faculty know what you *think* of them? Do

they know what you *expect* of them? Do they know *how they are doing*? Is their view of themselves *consistent* with your view of them? If the answers to these questions leave the faculty member in doubt, then whatever mechanism you presently have in place would appear not to be working. Here are some thoughts that may lead to a remedy.

The Role of the Chair in This Process

Chairs—as well as deans, in their relationship to chairs—have three priority functions, all essential and all of equal value. If each of them is done well the chair is likely to be judged a success; with one or more done poorly, it will be difficult for the chair to succeed in his or her role. The time that must be committed to these activities will vary according to the size and complexity of the department, but a large department may require that 50 to 60% of the chair's time if he or she is to be successful—this is not a part-time job. The first of the three applies most directly to faculty retention.



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- ❖ Recruit, nurture, cultivate, encourage, foster, mentor, promote (and, when necessary, discipline and even dismiss) the faculty.
- ❖ Establish and communicate the vision of the department, consistent with the vision of the medical school, and translate this vision into individual and col-

lective faculty activities, measures of performance, outcomes, and deliverables.

- ❖ Effectively steward resources: Garner, allocate/re-allocate, properly conserve, and apply to their highest-and-best use the resources entrusted to them consistent with the objective of fulfilling the mission of the organization (why does it exist?), advancing the organization toward its vision (where is it going?), and operating within its principles (by what rules does it operate?).

Retention is the Goal

Are you able to keep the faculty you want? When you lose faculty to another institution, is it because of legitimate reasons such as a spousal move or promotion? If you are losing faculty due to disenchantment or disillusionment then there is an opportunity, as well as a need, to fix the problem.

The cost of replacing faculty is considerable. In recent publications on the subject J. Deane Waldman, MD, examines the elements of cost for different categories of employee within an academic health center.¹ When the components of recruiting, lost productivity during training of the new employee, lost efficiencies of others in the unit, and lost revenues are factored in, this cost may amount to as much as 5% of the operating budget of the academic medical center (AMC). In an organization with 5100 employees (including 625 physicians) and a \$500 million annual budget, that amounts to \$25 million. It is not difficult to imagine that a far smaller investment in systems and processes, coupled with a modest investment in a competitive compensation strategy, could be easily accommodated within the scope of this figure.

Turnover problems are not just an issue with the members of the faculty. Turnover among academic leaders is also significant. The somewhat legendary average length of service for the typical medical school dean

of less than five years is of great concern. A 2002 publication by the Association of Professors of Medicine (APM) reports chair of Internal Medicine turnover since 1971 also at a high level.² That article reports that in December 2001, 23 medical schools (18.5%) were searching for deans and 29 (23%) were searching for chairs of Internal Medicine. While the number of medical schools has increased during this 30 year period (from 96 to 126), Internal Medicine chair turnover (including both interim and "full" chairs) has never been lower than 6% in any given year and has been higher than 20% during six of these years.

Where Do We Go from Here?

While some will elect to maintain a "business as usual" approach, and thus are likely to continue to be faced with costly faculty turnover, others will venture forth with a commitment to an effective evaluation tool that is consistently applied in a timely fashion across the faculty. This may best be done by the dean committing to the process by applying it to the chairs whom he or she is responsible for evaluating. While this requires a considerable amount of time to implement, once in place the benefits received year after year far outweigh the typical annual time commitment. Further, the most effective programs will not be "stand-alone" but rather will be an integral part of an enhanced communication program that goes beyond evaluation to include other factors that lead to an improved sense of community within the institution. All such programs lead to a stronger, more resilient, and thus more effective organization. ❖

Notes

1. Waldman JD et al. The shocking cost of turnover in health care. *Health Care Management Review* 2004;29(1):2-7 and Waldman JD et al. Measuring retention rather than turnover: a different and complementary HR calculus. *Human Resources Planning* 2004;27(3).
2. Turnover among APM members since 1971. *American Journal of Medicine* 2002;113:706-710.