Editorial

Balancing the Three-Legged Stool: Which Faculty Are Most Important in Our Academic Medical Centers?

Although vehemently professing an even-handed devotion to the "3-legged stool" of research, teaching, and patient care on which they allegedly base their mission, most academic medical centers undervalue the last 2 "legs" and place a much higher priority on the first. In too many of our medical schools, the princes of the faculty are not the worker bees (usually junior and often female) who staff the clinics or even the experienced clinicians who contribute income to their departments in exchange for the privilege of admitting patients to the center's hospital beds and agreeing to teach its house officers for 6 weeks or more a year. The royalty are those who win the uniquely prestigious research dollars from the National Institutes of Health and other peer-reviewed granting agencies—laboratories supported by these grants are vitally important credentials for academic advancement and access to governance and policy-making positions at academic centers. This is the reason for the meticulous parsing of academic faculty appointment titles: "Clinical Professor" versus "Professor of Clinical" versus "Professor" without modification. Then we have an even finer slicing of the pie: some only hold their faculty titles "at" a particular geographic subsection of the complex institution. (I've often wondered if when they make a guest appearance at another building on the campus to lecture or teach, the titles of such hapless faculty magically disappear and are only restored when they return to their home base. Decisions as to which modified title to award to a particular investigator are hotly debated and fiercely scrutinized by the faculty who lead individual departments—the most influential of whom hold the most prestigious "unmodified" titles.)

Does a young investigator under consideration for a critically important promotion bring in millions of dollars to her department from pharmaceutical companies to support well-run clinical trials, millions of dollars that supply salaries for young trainees and other activities the department needs to maintain its educational mission and its commitment to patient care? No matter that she is able to construct a trial based on sound statistical methods, coordinate data from multiple (and inevitably heterogeneous) centers around the world, and produce a summary of those data that survives careful peer review and is published in an indexed journal. She simply isn't perceived to be performing as prestigious a function as the potential Nobel laureate who is generating novel information about important questions regarding how disease works to disrupt health. It's "pharma money" after all that funds her work, funding presumably skewed by the self-interest of the pharmaceutical companies that supply it. One outraged young head of a clinic rose to her feet after her dean leveled biting criticism at her acceptance of free medications for patients. She protested that it was life-saving for many of her clients who otherwise could not afford the treatments they needed: "If I couldn't reach into my cabinet to give my patients these medicines, they would simply go without!"

The disastrous reports from Britain about a new drug trial that had gone horribly wrong[1] emphasized once more for me the enormous responsibility clinical investigators shoulder when they agree to formulate a new product and accept the consequences of testing its efficacy and safety. As for patient care, when an individual endures the grip of a serious illness, the knowledge, empathy, and steadying support of a seasoned clinician are critically important. Without each of these, that person may not survive.

Decades ago, when our knowledge of medicine was much less than the mass of information that now exists, the great leaders of academic institutions, like Robert Loeb of Columbia University and William Osler of Johns Hopkins University, contributed fundamentally important, original new

knowledge to their disciplines. But they also spent time actually caring for patients and had developed spectacular competence in teaching students how to care for the sick. One day Dr. Loeb led rounds to the bedside of a patient dying of cancer, where the case was explained to the attendant group of students and young house officers. As Loeb turned away from the bed after the teaching exercise, he overheard the third-year medical student assigned to the case say to the patient: "Don't worry, Mr. B, everything's going to be fine." Loeb stopped his rounds and called the hapless student aside, telling him: "You're dismissed from medical school. Get your things and leave the premises now. But don't worry. Everything's going to be fine." Loeb let the student's shock and dismay crescendo for a few minutes, and then explained that what he had experienced was what the dying man had felt when he was told "everything was going to be fine." As harsh as the lesson seemed, the student understood how he had trivialized the patient's suffering, and he would never forget what he learned about the terror and isolation faced by a sick person who knows that he is doomed. As a man dying of bladder cancer, who was anticipating surgery to relieve an intestinal obstruction from his metastases, said to me: "I will survive this operation. But after this, I face the abyss."

The teaching abilities of men like Osler and Loeb and their expertise in caring for sick patients were as refined and accomplished as their research, and they were valued for all of these skills. Medical knowledge is more complex today; it is so vast a discipline that mastering even a tiny area demands undiluted concentration on a single subset of the whole. Some of the scholars we appropriately regard as uniquely gifted and valuable will unlock the secrets that will save millions of lives. The unbounded esteem in which we hold our full-time faculty who have generated novel and vitally important information is entirely justified. Yet each group of physicians who function within a medical center makes equally important contributions; each simply brings a different—but equally essential—gift to the table. Some are masters at diagnosis and constructing the therapeutic plans that improve and prolong lives, and are brilliantly effective at teaching younger, less experienced doctors to do the same. Others assemble teams and generate funds that not only push forward the development and testing of new drugs and interventions that will cure illnesses, but also support the education and training of young investigators who otherwise would have no way to take their eventual place on the medical school faculty. Still others reach out to the indigent and disadvantaged in clinics that serve the communities in which their academic centers are embedded, offering state-of-the-art care to the poorest and most neglected segments of our population. All of these functions are vital and complimentary.

It's time we listened to our own mission statement and gave appropriate (read equal) credit to the diverse and accomplished players in the life of our medical schools and their associated research enterprises. After all, the function of a medical school is not only to generate knowledge that will improve public health but to extend expert care to the sick. Research is indeed one essential leg of the stool. But patient care and the training of those who will eventually take our place is an equally essential part of our mission. Our meticulous and discriminatory parsing of faculty titles, however, militates against that view.

Marianne J. Legato, MD, FACP
Editor-in-Chief

REFERENCE

1. Rosenthal E. British rethinking rules after ill-fated drug trial. *New York Times*. April 8, 2006: A1, A6.