Evolution of Faculty Affairs and Faculty Development Offices in U.S. Medical Schools: A 10-Year Follow-up Survey

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Abstract

Purpose
To determine how U.S. MD-granting medical schools manage, fund, and evaluate faculty affairs/development functions and to determine the evolution of these offices between 2000 and 2010.

Method
In December 2010, the authors invited faculty affairs designees at 131 U.S. MD-granting medical schools to complete a questionnaire developed by the Association of American Medical Colleges Group on Faculty Affairs, based on a 2000 survey. Schools were asked about core functions, budget, staffing, and performance metrics. The authors analyzed the data using descriptive statistics.

Results
A total of 111 schools (85%) responded. Fifty percent of the offices were established since 2000. Seventy-eight percent reported their top core function as administrative support for appointments, promotions, and tenure, as in 2000. Faculty policies, appointments, databases, governance support, grievance proceedings, management issues, and annual trend analyses continued as major functions. All 11 core functions identified in 2000 remain predominantly provided by central offices of faculty affairs, except support of major leadership searches. Web site communication emerged as a new core function. Similar to 2000, several other offices were responsible for some faculty development functions. Office size and budget correlated positively with size of the faculty and age of the office ($P < .05$ for all). Thirty-five schools (31.5%) reported formally evaluating their faculty affairs office.

Conclusions
The number of faculty affairs offices and their responsibilities have substantially increased since 2000. Most major core functions have not changed. These offices are now an established part of the central administration of most medical schools.

Faculty in medical schools are responsible for accomplishing the critical elements of the institution's tripartite mission: education, research, and patient care. They are academic medicine's most valuable resource as well as a major cost.[1–3] Surprisingly, offices that manage crucial faculty-related issues are relative newcomers to U.S. medical school administration[4] and are rarely found as independent entities in other health sciences schools. Historically, most efforts and resources in faculty recruitment, development, and retention have been directed from the departmental level. Over the past decade, medical school administrators have increasingly recognized the necessity for providing services and support through a central administrative office located within the medical school.[1–5] However, we know relatively little about how the composition, roles, and functions of faculty affairs offices have evolved in U.S. MD-granting medical schools.[4]

In 1990, medical school administrators established an informal network of colleagues who were responsible for a broad array of faculty issues administered by various offices, for the purposes of collaborative support and professional development to better meet faculty needs. The Association of American Medical Colleges (AAMC) sponsored a professional development conference every 18 months to facilitate discussion on emerging issues and challenges for faculty, and to develop and share effective policies and strategies. In 2000, the AAMC conducted the first comprehensive study of U.S. MD-granting medical schools (N = 125), to determine the status of offices of faculty affairs and faculty development.[4] In 2006, the Group on Faculty Affairs (GFA) became a fully endorsed group of the AAMC, supported by the AAMC Board of Directors and the Council of Deans. Its mission is to

> build and sustain faculty vitality in medical schools and teaching hospitals. The GFA does this by supporting faculty affairs deans and administrators in their development and implementation of institutional policies and professional development activities that advance the academic missions of teaching, research and clinical care.[6]

Membership in the GFA in 2012 included representatives from all U.S. MD-granting medical schools and totaled 530.[7] The GFA is led by a steering committee elected by the membership and has three subcommittees with specific functions: membership and nominations; professional development and programs; and research and project development. The group has developed formal policies, maintains a robust Web presence within the AAMC Web site, and hosts an annual professional development conference.

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This report presents the findings of our 10-year follow-up survey study to establish similarities and evolution among faculty affairs and development functions since the first survey study was performed in 2000.[4] We aimed to (1) collect data describing how MD-granting medical schools in the United States administer faculty affairs and faculty development responsibilities, functions, and their organization, (2) update the current status of offices of faculty affairs and development since the initial 2000 study, (3) report on new and projected roles, responsibilities, and expectations for offices of faculty affairs and development, and (4) assess ongoing measures of success and effectiveness for offices of faculty affairs and development, based on the outcomes-logic model.[8,9] We believe the findings will assist existing and new medical schools in the United States and elsewhere to determine the functions, optimal size, roles, responsibilities, and resources for their faculty affairs offices.

Method

Members of the AAMC GFA's Subcommittee on Research and Project Development (R.E.S., V.R., E.M., K.G.N., and W.C.W.) conducted a cross-sectional, follow-up survey using the AAMC database listing. In December 2010, we sent an e-mail invitation to complete the survey to all 131 U.S. MD-granting medical schools existing at the time of the survey. We retained most of the elements of the original 2000 survey instrument,[4] although we revised items that had proven to be confusing (e.g., size, personnel, budget) and eliminated obsolete items as recommended by the original principal investigator (P.S.M.). We updated the questionnaire to include additional items on new functions and performance metrics. At each institution, the most senior faculty affairs administrator, as designated by each school's dean, completed the survey. Respondents completed the questionnaire online, and the AAMC administered the survey.

The Michigan State University institutional review board reviewed, approved, and granted administrative exemption status to the project. The AAMC granted licensing agreements to the institutions of investigators who analyzed the data. Schools agreeing to release budgetary information signed a separate consent with the understanding that only aggregate data would be reported without reference to individual institutions.

Questionnaire

The online questionnaire consisted of 126 questions divided in four parts. Part 1 contained 72 items about office activities and functions. These were primarily "select all that apply" and rank-type questions. Part 2 included 7 items about office budget, staffing, and length of time the office had existed. Respondents were asked to select the best possible answer from a list and had the opportunity to provide unique descriptors in narrative fashion. Part 3 included 46 items about performance evaluation; these were also "select all that apply" and rank-type questions. Part 4 was a single, open-ended question allowing the respondent to make additional comments. Within these four sections, we asked about school characteristics including faculty size, school ownership (public or private), and geographic location. We classified respondents' offices as "new" (10 years old or less) or "established" (more than 10 years old) based on years since creation, and as "large" (3 or more full-time equivalents [FTEs]) or "small" (fewer than 3 FTEs). One of the schools reported an FTE number that we considered unrealistic, and we deleted that FTE information from the analysis.

Analysis

We calculated frequency distributions and proportions for all variables and obtained means and their corresponding standard deviations for continuous variables. We conducted statistical analyses consisting of chi-square tests, and either *t* tests or analyses of variance for categorical and continuous variables, respectively, using the usual type I error of .05 for statistical significance. We performed all analyses using Stata version 11 (StataCorp, College Station, Texas).

We chose to analyze these data using two methods: "row" and "column" percentages. We used the column method to demonstrate "what" proportion of schools performed these activities, as illustrated in Tables 1, 4, and 5. We included the column percentages, the conventional approach, to demonstrate the actual proportion of responding schools in the 2010 survey conducting these functions. The row method allows comparisons with the 2000 survey by indicating "where" activities occurred across the college and university. As such, the denominator of these percentages is calculated based on the number of multiple responses to a specific question and not on the number of schools that answered the question. We chose this approach because the intention with the 2000 survey was to determine where those functions were taking place among medical schools performing them, as in Tables 2 and 3. The original 2000 survey dataset is not available for reanalysis. Therefore, we based our comparisons only on the data presented in the published article.[4]

Results

Characteristics of faculty affairs offices

Of the 131 schools contacted, 120 respondents initiated the process to answer the survey, and 111 respondents finished most sections. The final sample that we used comprises these 111 schools. The 84.7% response rate compared favorably to the response rate of 60.8% (76/125 schools) in the 2000 survey. The responding schools included the majority of U.S. MD-granting medical schools relative to geographic regions, and the proportion of public (67; 60.4%) compared with private (44; 39.6%) schools mirrored national demographics.

Similar to the 2000 study, the titles of the offices that handle the functions of faculty affairs and development varied, including "office of faculty affairs," "faculty affairs and development," "academic affairs," and "faculty administrative services." The predominant title (89; 80.2%) included the words "faculty affairs." Only six schools (5.4%) reported "faculty development" as the sole title of the central office managing the core functions. Most respondents (94; 84.7%) were senior-level administrators; the majority held titles of associate dean or higher and held degrees of MD, PhD, or JD. We found no significant differences ($P > .05$) in the titles of senior administrators between new and established offices. Forty-two respondents (37.8%) reported that their office had a faculty advisory group or council.

Respondents reported an average number of staff (professional and support) of the central office of 3.5 FTEs (SD 3.1) with a range from 0.2 to 18 FTEs, and an average budget support of $670K, with a median of $270K. The overall size of the budget and staffing correlated positively ($P < .05$) with the size of the faculty in the 90 schools (81.1%) that completed the questions on budget and authorized the use of this information for research. We found no differences in the staff size or budget support between public and private schools.

Evolution and expansion of faculty affairs functions

Table 1 describes the distribution of the main faculty affairs functions handled by centralized faculty affairs, academic affairs, or administrative affairs offices of U.S. medical schools in 2010. Based on the number of schools reporting, the top eight functions in 2010 were Web site information and resources (93; 83.8%), administrative support for appointments, promotions, and tenure committees (87; 78.4%), faculty policies (87; 78.4%), annual or periodic trend analyses (81; 73.0%), databases for faculty appointment information (77; 69.4%), faculty management issues (77; 69.4%), faculty governance/administration (71; 64.0%), and grievance proceedings (68; 61.3%). Web resources for faculty affairs and/or faculty development information notably emerged as a major new function not reported in 2000 (93; 83.8%). Respondents reported no differences in the core functions of offices in public versus private schools. Furthermore, the core functions were the same regardless of office size.

Table 2 compares the location of the core functions reported in 2000 with that reported in 2010. In 2010, the central offices of faculty affairs (based on top proportion reported as compared with other medical school, university, or department offices) remained the predominant offices that handled all core functions as reported in 2000, except for administrative support for searches (e.g., chairs, center directors, and deans). Respondents reported "another medical school office" as predominant for this function. Annual or periodic trend analyses (e.g., retention, recruitment, and gender issues) increased from 2000 to 2010 (48; 45.8% versus 81; 56.3%). Web site information and resources (93; 83.8%) is a major new function. Several statistically significant differences ($P < .05$) between 2000 and 2010 emerged in three functions: faculty policies (69; 67.0% versus 87; 52.7%), databases for faculty appointment information (64; 70.3% versus 77; 57.5%), and contracts and letters of appointment (67; 60.9% versus 65; 41.4%).

Evolution of faculty development functions and their location within the school or university

Table 3 compares how distribution of responsibility evolved for seven typical faculty development functions among different offices between 2000 and 2010. Centralized offices limited to "faculty development" continued to be few in number, and none were the predominant office for the faculty development functions. "Faculty affairs" offices were the predominant office handling three functions: teaching, research, and clinical skills development; orientation programs for new faculty; and programs for women and minorities. Overall, the results show apparent increases in faculty development functions occurring at multiple levels of the academic health science enterprise. This may reflect a trend for other offices within the college/university to assume specialized faculty development roles. Respondents in 2010 indicated an increase in university-level offices responsible for developing programs for women and minorities, a decrease in departmental responsibility for all faculty development functions, and small increases in other school offices responsible for mentoring programs and administering fellowships for junior faculty. Centralized faculty affairs offices and departments now appear to share responsibility for career planning and mentoring programs.

Differences between new (≤ 10 years) and established (> 10 years) offices

Fifty percent (52/103) of the respondent offices were new, established within the past 10 years (less than 1 year, 6.8% [7/103]; 1–4 years, 15.5% [16/103]; 5–9 years, 28.1% [29/103]). The other fifty percent (51/103) of the respondent offices were established over 10 years ago. The overall size of the budget and staffing correlated positively ($P < .05$) with the age of the offices in the 90 schools that completed the questions on budget.

We observed little difference in the core functions of new offices as compared with established offices. Respondents described faculty development as an important responsibility of their office regardless of whether the office was new (87.5% [49/56]) or established (70.9% [39/55]). However, compared with new offices, a significantly higher proportion ($P < .05$) of established offices reported handling functions such as compensation guidelines, salary equity analysis, letters of offer/appointment, governance/

Table 1

Distribution of 12 Functions Handled by Centralized Offices of Faculty Affairs, Academic Affairs, or Administrative Affairs in 111 U.S. Medical Schools, 2010*

Function	No. (%)
Web site information and resources	93 (83.8)
Administrative support for appointments, promotions, and tenure committees	87 (78.4)
Faculty policies	87 (78.4)
Annual or periodic trend analyses (e.g., retention, recruitment, gender issues)	81 (73.0)
Databases for faculty appointment information	77 (69.4)
Faculty management issues (e.g., faculty counseling, ombudsperson)	77 (69.4)
Faculty governance/administration (e.g., committee maintenance: minutes, scheduling)	71 (64.0)
Grievance proceedings (particularly with respect to contracts)	68 (61.3)
Contracts and letters of appointment	65 (58.6)
Faculty handbooks	64 (57.7)
Bylaws	60 (54.1)
Administrative support for searches (e.g., chairs, center directors, deans)	45 (40.5)

*Based on data from the Association of American Medical Colleges Group on Faculty Affairs' cross-sectional survey of all U.S. MD-granting medical schools existing at the time.

Table 2

Twelve Functions Handled Predominantly by Centralized Offices of Faculty Affairs, Academic Affairs, or Administrative Affairs in U.S. Medical Schools, 2000–2010*†

	2000	2010			
Function	Primary office: no. (%)	Primary office: no. (%)	Other medical school office: no. (%)	University office: no. (%)	Department office: no. (%)
Administrative support for appointments, promotions, and tenure committees	68 (76.6)	87 (66.4)	26 (19.8)	7 (5.3)	11 (8.4)
Faculty policies‡	69 (67.0)	87 (52.7)	33 (20.0)	34 (20.6)	11 (6.7)
Databases for faculty appointment information‡	64 (70.3)	77 (57.5)	32 (23.9)	18 (13.4)	6 (4.5)
Contracts and letters of appointment‡	67 (60.9)	65 (41.4)	53 (33.8)	11 (7.0)	28 (17.8)
Faculty handbooks	48 (54.6)	64 (48.9)	24 (18.3)	38 (29.0)	2 (1.5)
Bylaws	48 (52.1)	60 (44.1)	43 (31.6)	30 (22.1)	2 (1.5)
Administrative support for searches (e.g., chairs, center directors, deans)	51 (53.7)	45 (47.9)	63 (67.0)	11 (11.7)	17 (18.1)
Faculty governance/administration (e.g., committee maintenance: minutes, scheduling)	54 (50.0)	71 (54.2)	41 (31.3)	13 (9.9)	6 (4.6)
Grievance proceedings (particularly with respect to contracts)	54 (46.8)	68 (42.2)	40 (24.8)	45 (28.0)	8 (5.0)
Faculty management issues (e.g., faculty counseling, ombudsperson)	48 (44.9)	77 (47.2)	39 (23.9)	25 (15.3)	22 (13.5)
Annual or periodic trend analyses (e.g., retention, recruitment, gender issues)	48 (45.8)	81 (56.3)	37 (25.7)	23 (16.0)	3 (2.1)
Web site information and resources	ND§	93 (83.8)	29 (20.9)	13 (9.4)	0 (0.0)

*Based on data from the Association of American Medical Colleges Group on Faculty Affair's 2000 and follow-up 2010 cross-sectional surveys of all U.S. MD-granting medical schools existing at the time.
†Each row percentage was calculated based on the number of multiple responses to a specific question, not on the number of schools that answered the questions. Therefore, the denominators varied for individual functions because some respondents indicated that several offices dealt with the particular function, or no office dealt with the particular function, or the respondent did not know where the functions were located.
‡Statistically significant difference ($P \leq .05$) between the 2000 and 2010 surveys' row percentages of primary offices.
§Item not included in the 2000 survey.

administration, and faculty appointment information (see Table 4).

Performance indicators for faculty affairs offices

Of the 111 survey respondents, 107 answered questions on indicators of success. About one-third of respondents (37; 34.6%) in 2010 reported that their office collected some performance data for the medical school or for their own office. The major outcome metrics included increased number of women and minorities reaching associate professor level (37; 34.6%), women and minorities at all ranks (36; 33.6%), increased faculty retention (34; 31.8%), improved standing on United States Medical Licensing Examination Step 1 (33; 30.8%) or on external peer-reviewed grants (30; 28.0%) (see Table 5).

Fewer offices reported that they collected additional process data to evaluate the functioning of their own office, such as customer satisfaction (24; 22.4%) or number of complaints or compliments received (12; 11.2%). Relatively few offices reported that they *used* some of these indicators to evaluate the success of the central faculty affairs and/or faculty development office. Of the offices that did, customer satisfaction (23; 21.5%) was the major indicator used to evaluate success.

Replying to the open-ended question, 20 respondents (18.0%) noted the potential value of the survey results to assist in restructuring or expanding their offices. One reported that their office had undergone an internal and external review resulting in a restructuring of the office and leadership; the restructured office will be evaluated periodically by a faculty committee. Three reported that although their offices are not formally evaluated, the dean's office evaluates the individual(s) in leadership within the office at least annually. Three new schools in particular are seeking data as they create policies and infrastructure for faculty.

Discussion and Conclusions

We have described the current state of faculty affairs and faculty development offices in U.S. MD-granting medical schools and detailed the organization, funding, and evaluation of these offices, as based on the findings of a survey we conducted in 2010. By comparing responses from senior faculty affairs administrators with responses to a similar survey conducted in 2000,[4] we are able to describe the evolution of these offices over time. Respondents apparently perceived the study as valuable, given the high response rate—85% of all schools provided usable data. The sample reflects the public/private proportion of U.S. medical schools. The findings should be generalizable to the majority of medical schools in the United States. Deans and other GFA leaders showed considerable interest during a preliminary report of these findings presented at a plenary session of the AAMC 2011 Annual Meeting.[10]

Table 3

Distribution of Responsibility for Faculty Development Functions among Various University or School Offices or Departments in U.S. Medical Schools, 2000–2010*

Function	Faculty development office†		Faculty affairs office†		Other medical school office†		University office†		Department†	
	2000: no. (%)	2010: no. (%)	2000: no. (%)	2010: no. (%)	2000: no. (%)	2010: no. (%)	2000: no. (%)	2010: no. (%)	2000: no. (%)	2010: no. (%)
Mentoring programs	15 (19.7)	18 (11.3)	29 (38.2)	50 (31.3)	10 (13.2)	30 (18.8)	7 (9.2)	12 (7.5)	34 (44.7)	53 (33.1)
Programs for women and minorities	13 (17.1)	10 (6.1)	42 (55.3)	41 (57.5)	28 (36.8)	49 (29.3)	14 (18.4)	62 (37.8)	17 (22.4)	2 (1.2)
Orientation programs for new faculty	11 (14.5)	20 (12.5)	42 (55.3)	69 (57.5)	14 (18.4)	21 (13.1)	20 (26.3)	25 (15.6)	24 (31.6)	25 (15.6)
Career planning	10 (13.2)	16 (10.4)	30 (39.5)	52 (33.8)	11 (14.5)	23 (14.9)	7 (9.2)	8 (5.2)	49 (64.5)	55 (35.7)
Scientific ethics	8 (10.5)	15 (9.6)	18 (23.7)	48 (28.7)	45 (59.2)	52 (33.1)	27 (35.5)	18 (11.5)	29 (38.2)	24 (15.7)
Fellowships for junior faculty	6 (7.9)	12 (9.7)	17 (22.4)	25 (20.2)	21 (27.6)	42 (33.9)	17 (22.4)	14 (11.3)	39 (51.3)	31 (25.0)
Teaching, research, and clinical skills development programs	(6.6–21.1)‡	19 (10.9)	(15.8–32.9)‡	63 (36.2)	(38.2–44.7)‡	52 (29.9)	(15.8–19.7)‡	14 (8.1)	(21.1–55.3)‡	26 (14.9)

*Based on data from the Association of American Medical Colleges Group on Faculty Affairs' 2000 and follow-up 2010 cross-sectional surveys of all U.S. MD-granting medical schools existing at the time.

†Each row percentage was calculated based on the number of multiple responses to a specific question, not on the number of schools that answered the questions. Therefore, the denominators varied for individual functions because some respondents indicated that several offices dealt with the particular function, or no office dealt with the particular function, or the respondent did not know where the functions were located.

‡Faculty development in teaching, research, and clinical skills was separated into three questions in the 2000 survey, so the range of data for the three questions is reported for comparison with the 2010 survey, which combined these three faculty development topics.

Over the past 10 years, faculty affairs offices have increased in number, size, and complexity, which may have been partly stimulated by the formation of the official AAMC GFA in 2006. The financial investment that medical schools make in these offices correlates with size of the medical school faculty and age of the office. Regardless of age of the office, leadership of these offices is at the decanal level (dean title). The average number of staff (professional and support) is 3.5 FTEs. This number underrepresents the professional staff, because medical school administrative leadership positions are often part-time (< 1 FTE). These individuals may also hold leadership roles such as department chair, division chief, or director of major programs. The actual number of faculty-level professionals (MDs/PhDs) working in faculty affairs and development is likely greater than it appears by looking at the total FTEs of an office.

Core areas of responsibility of faculty affairs offices include administrative support for appointments, promotions, and tenure; faculty contracts and letters of appointment; faculty governance; bylaws; faculty policies; faculty handbooks; grievance proceedings; faculty management issues; and faculty databases and periodic trend analysis. Our survey indicates that all of the 11 core functions of these offices that were identified in 2000[4] have been either retained or expanded over the past 10 years. "Web site information and resources" has been added as a 12th core function. The only function not predominantly handled by centralized offices of faculty affairs in 2010 was the administrative support for department chair, center director, and dean searches; this may be because dean's offices may increasingly use search firms and search process specialists for this purpose. Trend analysis is an expanded function in 2010 compared with 2000. Three functions that decreased in comparison with 2000 noted in Table 2 (faculty policies, databases on appointments, and contracts/letters of appointment) remain as functions provided by central offices of faculty affairs by the majority of schools (see Table 1). These differences between 2000 and 2010 may reflect differences in the number of respondents and response rates between the two surveys, or the evolution of administrative functions in the college and university.

The core functions that have remained consistent over a 10-year span fall into three categories: academic processes, talent management, and accountability and reporting. First, and perhaps most important, is developing the infrastructure and support for the *academic processes* and databases required for appointments, promotions, and tenure; faculty governance committees; and bylaws. To ensure the smooth functioning of medical schools, medical school administrators must manage these activities and processes efficiently and effectively.

The next set of functions remaining essential over time involves *talent management.*[1] This includes faculty

Table 4

Differences Between New and Established Faculty Affairs Offices and Functions Handled in 111 U.S. Medical Schools, 2010*

Functions	New offices: no. (%)‡	Established offices: no. (%)‡	*P* value
Core functions†			
Administrative support for letters of offer/appointment (n = 63)	23 (36.5)	40 (63.5)	.001
Faculty governance/administration (n = 68)	29 (42.7)	39 (57.4)	.037
Databases for faculty appointment information (n = 74)	32 (43.2)	42 (56.8)	.028
Other functions			
Compensation guidelines (n = 30)	8 (26.7)	22 (73.3)	.002
Salary equity analysis (n = 41)	13 (31.7)	28 (68.3)	.003

*Based on data from the Association of American Medical Colleges Group on Faculty Affairs' cross-sectional survey of all U.S. MD-granting medical schools existing at the time.
†For a complete list of the core functions, see Table 1.
‡New is defined as 10 years or less since creation, and established as more than 10 years.
§Data for new and established offices were compared using the chi-square test. Only the functions in Table 1 and newer functions that were significantly different between new and established offices are shown.

development, oversight of processes, and faculty management issues such as annual evaluation, faculty counseling, grievance procedures, and conflict management. Talent management also encompasses most faculty development functions such as skill development, programs for women and minorities, and career planning, as well as resources such as fellowships.

Several functions reported by more mature offices were less commonly covered by newer offices: compensation guidelines, salary equity analyses, letters of offer and appointment, governance and administration, and faculty databases. As new offices are established, they appear to focus on the core functions that have persisted over time. As the offices evolve, they may assume expanded roles. Data collection and trend analysis are essential for strategic planning and development and may assume increased emphasis in the future, especially in times of limited resources.

The responsibility for faculty development and mentoring is now widely distributed.

Table 5

Top-Ranking Performance Indicators Collected and/or Used by Offices of Faculty Affairs and Medical Schools in the US, 2010*

Indicator	Offices or schools that *collect* data: no. (%)†	Offices or schools that *use* data: no. (%)†
Increased number of women and minorities reaching associate professor level	37 (34.6)	11 (10.3)
Increased number of women and minorities at all ranks	36 (33.6)	12 (11.2)
Increased faculty retention	34 (31.8)	9 (8.4)
Improved standing on USMLE Step 1	33 (30.8)	1 (0.9)
External peer-reviewed grants	30 (28.0)	2 (1.9)
Customer satisfaction	24 (22.4)	23 (21.5)
Number of complaints or compliments received	12 (11.2)	11 (10.3)
Number of mentoring pairs	12 (11.2)	4 (3.7)

*Based on data from the Association of American Medical Colleges Group on Faculty Affairs' cross-sectional survey of all U.S. MD-granting medical schools existing at the time. USMLE indicates United States Medical Licensing Examination.
†N = 107 because 4 of the 111 respondents who completed surveys did not respond to the questions on indicators of success.

These activities are found in a central faculty affairs or dedicated faculty development office, throughout departments, and across the university. We were limited in assessing faculty development functions because the 2010 survey did not break down skill development into components of teaching skills, research skills, and clinical skills as did the 2000 survey. Nevertheless, we documented overall expansion of faculty development. Importantly, 87% of new offices have invested heavily in faculty development as a core function. This may be because medical schools increasingly recognize the importance of faculty development, and because the culture of academic medicine is changing from a "sink or swim" mentality to developing faculty as a valuable resource.[1,5,11–13] Department chairs' roles are changing, but one responsibility that persists is facilitating and developing the careers of their faculty members. Thus, departmental mentoring will, and perhaps should, continue to be a primary responsibility of the chair, with faculty affairs offices playing important supportive roles. Other functions that appear to have been distributed to other offices or across the campus include teaching, research, and clinical skills development, development programs for women and minority faculty, scientific ethics, and fellowship selection for new faculty. Practical and pragmatic reasons may drive the location of functions: a research ethics program may be better located within a robust research office, and programs for women and minorities might be part of a university-wide initiative. Faculty affairs offices have a role in coordinating and complementing these distributed faculty-related activities, even when they don't "own" the process. This is an often undervalued but natural evolution for the single office in a medical school that represents (and nurtures) the individuals who carry out all of the missions of the school—that is, the faculty. The faculty affairs office assumes a crucial, though informal, advocacy role for the vitality and advancement of faculty, as well as providing a safety net for faculty.

The third general category of core functions is related to centralized *accountability and reporting*. Faculty affairs offices are responsible for reporting to organizations such as the AAMC and the Liaison Committee on Medical Education (LCME). Maintaining accurate, up-to-date faculty databases is also

essential in providing annual or periodic trend analyses (e.g., faculty recruitment, retention, gender distribution, compensation and salary equity, and other key faculty indicators) for medical schools to effectively manage their valuable faculty resources. In this regard, we were surprised to find that despite *collecting* relevant data, very few schools *use* the data to formally evaluate their faculty affairs offices. This is typical in higher education, where collecting and assembling institutional data is common practice, whereas actually using this evidence to guide changes and enhance institutional performance is much less common.[14] Faculty affairs and development offices regularly conduct needs assessments to determine the changing needs of various stakeholders (faculty, chairs, deans, etc.) and adjust their programs accordingly to provide the most value for the institution.[8] These needs assessments may indirectly provide an evaluation of the office, but there is no widespread methodology for a formal evaluation. Clearly, appropriate metrics still must be defined, and might include such markers as promotion and tenure statistics, successful grant applications resulting from grant writing or other faculty development/mentoring interventions, and improved teaching performance.

We speculate that the lack of formal evaluation of faculty affairs offices may also be related to the relatively young age of the offices and the recent recognition of their personnel as an important component of the medical school leadership. We hope this report will stimulate administrators to both capture and use data to evaluate the performance of the office and the leader, to analyze faculty trends over time, and, very important, to strengthen the institution's faculty in meeting their education, research, and clinical service missions.

The growth in number and breadth of responsibilities of faculty affairs offices likely reflects the complex and dramatic changes facing academic medicine. Initiatives to reform medical education, recognize and reward team science, and integrate interprofessional teams in clinical care require faculty to acquire new competencies.[15] In response to demands for an expanded health care workforce, medical schools have increased medical student class size, leading to faculty growth in central, community, and regional campuses, as well as expansion of the volunteer physician educator workforce. The LCME has raised standards and expectations for faculty administrative services, faculty development, and diversity. A new, multigenerational faculty workforce challenges existing infrastructures and requires innovative solutions and policies that recognize the need to provide flexibility in faculty careers. These challenges drive a need for efficient and effective faculty affairs offices that support the recruitment, development, and retention of faculty working to support the missions of the school.

Troubling data reported in an AAMC Analysis in Brief study showed that 50% of clinical faculty leave their place of employment and 40% leave academic medicine altogether within 10 years.[16] Academic health centers have begun to recognize the significant cost of faculty turnover and to invest in strategies that lead to faculty satisfaction and retention.[2,16–22] Offices of faculty affairs exist to improve the functioning of the faculty and of the organization, leading to organizational improvement and productivity. These offices are also critical resources for upholding institutional values. Formal evaluation and longitudinal analysis of the outcomes of faculty affairs and development initiatives and programs will be crucial in assessing their success. The return on investment will be the increased productivity, retention, and satisfaction of the faculty. A faculty affairs office might pay for itself if it can contribute to the retention of several faculty per year. Thus, investment in the office of faculty affairs is an investment in support of the faculty and in organizational improvement.

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