Guest Editorial

Perceptions of Geriatric Medicine Junior Faculty on Success in Academic Medicine: The Saint Louis University Geriatric Academy (SLUGA) Faculty Development Program

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THE quadruple-threat “gold standard” of a successful academician: researcher, educator, clinician, and leader, is becoming increasingly difficult to achieve in the current academic environment. Success, for promotional purposes, has traditionally focused on research activity and grant funding. With fewer physicians engaging in research and the competition for grant dollars increasing, faculty, and to a lesser extent, institutions, are focusing on other means of demonstrating achievement and productivity.

One such strategy is to allow promotion based on nonresearch-dominant “tracks.” Tenure as a “Clinician-Educator” is a relatively new phenomenon, and the most common of these alternative pathways. The American Geriatrics Society has even published guidelines for the promotion of Clinician Educators in Geriatric Medicine (1). These guidelines suggest that promotion should be based on the impact of teaching activities, educational contribution, and scholarly activity related to teaching.

Alternative tenure pathways are not uniformly accepted, and the promotional criteria are often nebulous. In 1997, nearly 75% of medical/osteopathic schools had promotional pathways for nonresearch faculty; however, only 20% of these tracks offered tenure status (2). The impact and importance of tenure is of growing concern to academic clinicians. Salary guarantees, appointment continuance, and protected time, even with tenure, are far less secure (2,3).

Applying credit for nonclinical/research duties, as a measure of productivity, is of increasing importance for faculty on a tenure track. Academic “worth” has traditionally been measured in research and clinical revenue. This has caused much consternation for faculty with responsibilities that are neither 100% patient care nor 100% research. Of late, models for measuring productivity and performance-based compensation plans have been implemented in some academic medical centers.

At Vanderbilt University School of Medicine, faculty are appointed to one of five tracks based on research, educational, and clinical responsibilities (4). Relative Value Units (RVUs) are assigned for clinical care revenue, grant revenue, nonclinical revenues (i.e., medical directorships), and major educational activities (i.e., course directorships). Base salary and bonus calculations are based on the generated and expected RVUs.

Like other academic organizations, the Veteran’s Affairs Medical Center (VAMC) system is facing similar academic challenges. Changes in VAMC service utilization and patient demographics have lead to a reallocation of research funding and a greater emphasis on career development programs. At one VAMC, a productivity model has been used to link current procedural terminology codes to RVUs (5). In this system, physician productivity is measured in clinical Full Time Equivalents, research, educational activities, and administrative responsibilities. Resources are allocated based on a research, teaching, and patient care model. These methods attempt to credit academicians for all forms of work and provide means for measuring success.

To address the new academic challenges, faculty development programs (FDPs) have evolved to prepare young physicians for an academic career (6). In a prospective study, faculty participating in FDPs were compared with nonparticipating control faculty. Teaching ability was rated significantly higher by trainees for postcourse FDP faculty compared with control faculty (7). At one institution, 80% of faculty who participated in career development program coursework felt that it had a positive impact on their academic potential (8).

Well-known FDPs in the United States include Stanford’s “Train the Trainer” Program and the Harvard Medical School Macy Program for Physician Educators (9). Graduates of FDPs are likely to be highly productive.
members of the faculty. A survey of Harvard FDP graduates from 1995–1997 (n = 99; 64% respondents) found that more than 85% of these scholars were now engaged in new educational projects and were involved in educational committees. Over half had submitted or received grant funding (10).

The Saint Louis University Geriatrics Academy (SLUGA) is a newly initiated faculty development program in the United States, based at the Saint Louis University Division of Geriatric Medicine. This academy addresses the career needs of geriatric medicine junior faculty who engage in research, teaching, and clinical care. This program is based on the European Academy of Medicine for Ageing, a similar program that was developed in Europe many years ago to train junior faculty (11). The goal of SLUGA is to provide a forum for participants to network and to develop skills for career advancement. This Academy met in January 2004 for the first of four workshops over the next 2 years. Each week-long session provides exposure to the core competencies of a successful academician: leadership, finance, medical education, research, and mentoring. Didactic instruction, small group activities, case-based discussions, and problem-solving assignments allowed this group of 30 scholars from around the United States to gain the knowledge and experience necessary for career advancement. SLUGA scholars benefited from the diverse expertise of distinguished speakers and senior academic geriatricians.

This editorial is a discussion by participants of the first SLUGA workshop. We reflect on the challenges of succeeding in academic medicine and the role of junior faculty in this environment. We present our faculty development needs for career success as the future generation of leaders in geriatrics. We discuss how SLUGA addresses the specific training needs for a successful academic medical career.

LEADERSHIP TRAINING NEEDS OF GERIATRICS JUNIOR FACULTY

Historically, academic physician leaders gained their experience by becoming proficient researchers. Often starting with National Institutes of Health (NIH)/National Institute on Aging (NIA) training fellowships, faculty then moved to academic centers where they built reputations as outstanding researchers. Hazzard has proposed that geriatricians need at least 10 years of experience in order to build the foundation for academic leadership: an initial 3 or 4 years of geriatric fellowship, followed by 5 to 6 years of experience at a research institute (12). As funding for research becomes increasingly competitive, and the clinical demands on academic physicians escalate, it is less likely that we will see leaders born by this process. With many division and department heads approaching retirement age, and fewer physicians recertifying in geriatric medicine, it is crucial for the next generation of geriatricians to be prepared to assume leadership roles in the near future.

This process of leadership and academic career development should begin during geriatric medicine fellowship training. With only 1 year of training required for the Certificate of Added Qualification in Geriatric Medicine, only 21% of fellows currently complete 2 or more years of training (13). This has had a substantially negative impact on the influx of future leaders into academic medicine. Because the majority of Year 1 fellowship training focuses on clinical care, little time is spent on developing the skills needed for an academic career.

Compared to the 1-year-trained counterparts, geriatrics junior faculty who have completed 2 or more years of fellowship training are more likely to be engaged in academic activities such as teaching, publishing, and research (14). With 69% of fellowship-trained geriatricians taking academic medicine appointments, greater emphasis must be placed on the career benefits of extended-training programs (15).

In the evolving academic environment, junior faculty have substantially less time for academic pursuits, including the development of leadership skills. There is greater pressure to generate clinical revenue and a dwindling role for the “part-time” researcher. The quadruple-threat academic leader who excels in teaching, research, clinical care, and leadership is at risk of extinction.

Given the current challenges of academic medicine, a structured and systematic training of junior faculty is necessary to grow the young geriatric leadership talent. Presently, there are few mechanisms whereby faculty can receive continued training in negotiation skills, academic economics, program building, and mentoring. New methods must be developed for faculty to engage in these important leadership development activities.

Faculty may pursue leadership training through a number of well-established degree programs such as a Master’s in Health Administration (MHA), Master’s in Business Administration (MBA), and Master’s of Public Health (MPH). The long-term benefits of these programs for academic physicians are not well known. Not all academic centers offer advanced degrees, and faculty may not receive financial support to pursue this additional training. Care must be taken to ascertain the quality and reputation of the training program.

Less-intensive options for leadership training include participation in formal faculty development programs or workshops. Some academic centers offer these services on-site through a Department of Continuing Education or other structured educational center. Formal leadership training can also take place on a regional or national level. Associations such as the American College of Physicians and the American Medical Director’s Association offer such leadership training programs.

“On the job” leadership experience can be obtained by developing clinical services or centers of excellence such as an Acute Care for the Elderly unit, Comprehensive Geriatric Assessment clinic, or Palliative Care Team. Physicians can quickly be recognized as clinical care leaders and may be invited to speak about these programs. Leadership roles are also possible within the academic center. Regional and national reputation may grow out of these experiences.

Junior faculty need exposure to geriatric experts and leaders in academic medicine. SLUGA offers participants an opportunity to not only meet, but to learn from such experts. Leadership training exercises at this workshop are designed to meet the needs of geriatric faculty. The role of medical
director, fellowship program director, and educational course director are discussed in detail. Because faculty frequently engage in these programs without formal training, SLUGA offers advice and direction to participants who engage in these activities. The insight and advice from senior faculty who have succeeded in academic geriatrics is invaluable to younger faculty preparing for future leadership positions in geriatrics.

EDUCATIONAL TRAINING NEEDS OF GERIATRICS

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Each year, U.S. Allopathic Medical Schools graduate nearly 16,000 new physicians, and over 10,000 Internal and Family Medicine residents complete postgraduate training (16). Less than 1% of graduating residents will seek out a career in geriatric medicine; however, nearly all (with the exception of pediatricians) will provide care to the growing population of elderly adults (13).

Trainees are influenced throughout their education by classroom activities and clinical experiences. Attending physicians serve not only as educators, but as role models in these settings. For geriatric medicine to grow in respect and importance in the eyes of trainees, geriatricians must impart excellence in teaching and a positive perspective on the subspecialty field. Without exposure to skilled geriatric educators, trainees are less likely to develop the skills, knowledge, and attitudes needed to provide excellent patient care, and less likely to consider geriatrics as a medical career (17).

In a 2001 survey, medical school faculty spent only a median of 5% of their time on student education in geriatrics (18). The Association of American Medical Colleges survey of graduating medical students reported that over one third of the students felt their instruction in geriatrics was inadequate. Only 9% of schools reported a strong geriatrics curriculum in the preclinical years, while 39% had a very limited geriatrics education (19). A survey of graduating medical residents found that only half felt “very prepared” to care for elderly people and less than 15% felt “very prepared” to provide nursing home care (20).

To counter the limited attention paid to medical education in geriatrics, organizations such as the John A. Hartford Foundation, the Donald W. Reynolds Foundation, and the Health Resources and Services Administration (HRSA) provide funding to physicians and institutions for geriatric education. The Association of Directors of Geriatric Academic Programs study team anticipates that the investment by these foundations will significantly expand the quality and quantity of geriatrics training at academic centers.

Junior faculty in geriatrics are frequently responsible for medical teaching in both geriatrics and general medicine. Unfortunately, physicians frequently lack the time and training needed to be effective teachers. Being a talented educator is an acquired skill. Although some teachers are “born,” most develop into reputable educators through personal training in medical education. Awards such as the HRSA Junior Faculty Geriatrics Academic Career Award (GACA) strongly encourage this professional development, educational training, and promotion along a Clinician-Educator pathway. Unfortunately, other than the GACA, few resources are targeted to the training of academic educators.

For promotion in academics on a Clinician-Educator pathway, faculty must demonstrate excellence in clinical care and teaching, and a regional or national reputation in the academic field. The scholarly work needed for promotion usually includes clinical reviews, textbook chapters, curriculum modules, and original articles (21). Faculty document and track their progress in a “teaching portfolio” rather than a curriculum vitae.

Some institutions are formally recognizing faculty for excellence in educational activities. Baylor College of Medicine grants peer-reviewed, performance-based awards to teaching faculty (22). The University of California at San Francisco Academy of Medical Educators, established in 2000, and the Academy at Harvard Medical School, in 2001, have similar missions. Faculty with exceptional educational merit and commitment can apply to be members of the academy, which supports and promotes educational scholarship (23,24).

Assisting geriatrics junior faculty with the promotional process requires a concerted effort in educational mentoring. Quality teaching requires practice and training well beyond the “see one, do one, teach one” model that is so frequently used in medical education. Without proper training, educators become mediocre at best, and reinforce the notion that teaching is an activity of minor importance and is performed at the expense of other academic pursuits.

The SLUGA program offers participants an opportunity to critique their own teaching skills and those of their peers. Faculty present mini-lectures and received suggestions to improve the structure and delivery of this material. Sessions on preparing and delivering a presentation offer participants an opportunity to discuss their strengths and weaknesses in public speaking. Small group sessions give faculty the opportunity to practice being a group facilitator, leader, and presenter. These experiences allow faculty to see themselves as others (students) might see them and to benefit from the feedback of colleagues with a similar interest in quality education.

FINANCIAL TRAINING NEEDS OF GERIATRICS

JUNIOR FACULTY

The management and administrative responsibilities of medical practice are a significant source of job dissatisfaction among physicians (25). Medical students, residents, and fellows currently receive no mandated training in practice management (26–28). Limited educational experiences in practice management make the transition from trainee to junior faculty challenging, and often stressful. The changing economic roles undertaken by residents and junior faculty provide examples of missed educational opportunities to improve the understanding of the financial practice of academic medicine.

For many years, trainees are, in fact, educational consumers; they purchase a service (education) for a price (tuition). Few students understand how tuition dollars are spent by medical schools and do not appreciate the direct and indirect costs of medical education. Students are frequently unaware of the clinical, teaching, and research
responsible of faculty, and the relationship between
a University Hospital, Veteran’s Affairs Hospital, or County
Hospital to the medical institution. Understanding the
educational structure is an important lesson for future
academic faculty.

Residency is the first “real” job held by many physicians
for which they receive a regular paycheck. The economic
role of residents and fellows shifts to a labor model: they
work for a wage. Given work duties and hours, many feel
they are undercompensated for work performed. Residents
infrequently understand the origin of their salary or the costs
associated with training and are not provided the experi-
ences needed to become solvent, independent physicians.
Training in billing, coding, practice management, and
generation of revenue is limited. Few residents graduate
with an understanding of the financial requirements and
guidelines needed for survival in clinical practice and as
academic physicians.

Upon becoming junior faculty, we take on the new
economic role of healthcare suppliers; we provide a service
(healthcare) for a fee (revenue). We are graded on our ability
to “justify our existence” by generating revenue that
exceeds our costs. Lack of formal instruction in practice
management and academic financing leave junior faculty
ineffective in maximizing clinical and personal revenue.
Junior faculty underestimate the costs associated with
practice; salary, malpractice, benefits, support staff, medical
supplies, and office space must all be supported by our
revenues. Training in revenue generation and cost allocation
is important if junior faculty are going to become academic
leaders.

Unfortunately, the grading system used to measure
“successful” financial productivity is often poorly defined,
and, in many cases, seems illogical and unfair. Governmental
moneys for medical school support have dropped by
almost 50% from 1960 to 1990 (29). With the decline in
government support of medical schools, there is increased
reliance on the clinical revenue generated by individual
physicians, regardless of position or career track. Junior
faculty feel pressure to see more patients or spend more time
in clinical duties. Obtaining grants to conduct research or
teaching projects allows faculty to purchase “protected time”
away from clinical duties. While all junior faculty feel
pressure to produce clinically, the pressure could be
lessened by appropriate training in the financial manage-
ment of an academic medical practice.

At SLUGA, junior and senior faculty were able to discuss
the “grading system” for clinical productivity, as well as the
components of direct and indirect research costs. On several
occasions, the group discussed the RVU for measuring work
performance as applied to geriatricians. Topics included the
merits and demerits of the RVU system, the bias of the RVU
system toward procedural specialties, the creation of the
geriatric RVU system, and the use of the RVU system
within an academic medical department. While this system
produces a universal structure for payment, many in-
adequacies exist such as the lack of designation for medical
directorship revenues. Another example is the lack of
accounting for lower revenue-generating departments (i.e.,
family and internal medicine), which provide a referral base
for the higher revenue-generating specialty divisions or
departments.

SLUGA sessions focused on how the RVU system was
applied to the revenue and cost structure of an academic
medicine department. A session entitled “No Margin, No
Mission” allowed conference participants to compare RVU
generation among many divisions within one medicine
department. In discussing margin, we learned about direct
cost allocation; it was clear that junior faculty underestimate
the costs associated with clinical care and research. Senior
faculty shared their expertise in the financial pitfalls and
successes of day-to-day life for a typical physician in
academic medical. SLUGA provided a valuable opportunity
to learn and discuss the financial details and challenges
faced in medical practice.

RESEARCH TRAINING NEEDS OF GERIATRICS
JUNIOR FACULTY

The generation of federal grants and research money has
become a cornerstone for the financial survival of academic
centers. As such, a core understanding of the funding
process, establishment of collaborations and research
networks, familiarity with grant application processes, and
grant management are imperative skills for junior faculty.
To meet these challenges, institutions and their leaders must
be proactive in the research training of junior faculty if they
wish to remain financially viable.

Kindig and colleagues outlined necessary elements in
helping faculty develop research skills. The building blocks
of a solid research program include: a) organization of core
institutional resources, b) career development support for
individual researchers, c) enhancement of health services
research training, and d) establishment and support of
research partnerships. These authors questioned researchers
from across the country on the organization of core
institutional resources. Most, although not all, centers
provided their researchers with some level of core financial
support (30). Initial capital was given by some institutions,
while others provided permanent financial support.

These researchers expressed concern regarding the
appropriation of institutional funds because not all grant
money was returned to the Principal Investigator and some of
the funds were redirected toward overhead costs. Additional
centers included the constraints on faculty time; clinical
work and teaching demands took time away from research
efforts and impeded faculty efforts fostering a research
career. Due to these concerns, the perceived support for
careers in basic or clinical science research was poor (30).

A review done by the Institute of Medicine in 1995
expressed concern that students in health services research
training programs are not always adequately prepared for
independent investigation after graduation (31). Kindig
noted that training programs with a heavy research emphasis
did not have a core, structured curriculum to teach research
because courses were incorporated broadly into the training
program infrastructure (30). A study by the Commonwealth
Fund Task Force on Academic Health Centers indicated that
an innovative research partnership between academicians
and private sector groups could reduce this problem and
provide research physicians with a competitive edge (32).
Kindig noted from his interviews, however, that tensions might arise due to the motives and financial gain from these academic–private partnerships (30).

In another study, Wolf noted that the financial burdens on medical residents and fellowship trainees affected their decisions to work in research settings (33). The trends in NIH grant applications among MD/DO applicants suggest that many physician research careers end with the rejection of the first grant application (32). The lack of grant proposal resubmission is likely a combined effect of overwhelming financial pressure and the presence of attractive alternative career choices. One way of retaining junior faculty researchers has been the development of NIH’s K-30 award and similar programs that providing tuition support as well as career development funds (34–36).

Within the VAMC, the Research Realignment Advisory Committee (RRAC) was established in 1995 to develop the VAMC research agenda. This committee classified research needs into four distinct categories: 1) allocation of research resources among VAMC research programs, 2) acquisition and protection of resources, 3) stability and maintenance of infrastructure, and 4) outreach and communication (37). The main conclusion of the RRAC was that VAMC research should be focused more sharply on the specific needs of Veterans. Secondary suggestions included: a) an overall increase in research funding, b) developing a plan to administer funds for research within the newly created “Veterans Integrated Service Networks” or VISNs, and c) a greater focus on career development of junior faculty.

Similar recommendations were reached by a study from the Commonwealth Fund (31). This group concluded that a) research funding should be increased by NIH, b) training should be improved for students, residents, and junior faculty who have an interest in research, c) institutions should include clinical researchers on internal promotion committees, d) academic leaders should be encouraged to participate in clinical research, e) partnerships should be developed within the institution to help pool clinical research capabilities, f) networks and alliances must be developed among clinicians at multiple locations, and g) the focus of research should shift to reducing technologies and personal relationships, challenges may arise such as personality conflicts, a lack of congruence between the mentor’s and mentee’s goals, and emotional transference or counter transference (45). Fortunately, gender, ethnic, and racial differences have not been shown to be consistent barriers to developing an effective mentoring relationship. One of the goals of mentoring is to help the mentee develop the Professional Academic Skills (PAS) needed for faculty success (46). Bland and colleagues described PAS as three dimensions of socialization skills: 1) knowing how to manage one’s career, 2) understanding the values, norms, and expectations of academic medicine, and 3) developing and maintaining a productive network of colleagues. The ability to succeed in these three areas appears to differentiate those who will succeed as faculty members from those who will not (47).

The SLUGA conference helps to create a better understanding of the research process, funding avenues, and mechanisms by which investigators receive federal grant support. Participants have a greater understanding of the role of research in the academic setting. Future sessions should include workshops on applying for federal grant funding, writing research proposals, and publishing research data. A discussion with an NIH representative would also be helpful in describing the process of the governmental grant application. Representatives from the VAMC could be involved in these workshops to clarify the process of applying for and receiving VAMC-based grants. Case examples would be helpful in demonstrating the grant process from beginning to end: the application process, the receipt of funds, the allocation of funds, and the reapplication process.

MENTORING NEEDS OF GERIATRICS JUNIOR FACULTY

Mentoring relationships have a long history among many professional organizations. This relationship is often cited as the key to successful career development in law, business, and medicine (38–40).

In a consensus statement, The National Academy of Sciences, The National Academy of Engineering, and The Institute of Medicine described mentoring as a personal and professional relationship in which a senior individual works to promote the career of a more junior individual (41). Some of these efforts include maintaining regular correspondence, providing career and research advice, helping mentees to improve communication skills, assisting in the development of professional and peer networks, and establishing a balanced “give and take” relationship between the mentor and mentee (42,43).

Mentoring is most often an informal process without a distinct beginning or end. A professional relationship develops when two people with common interests seek each other out (44). Unfortunately, there may be barriers that make access and initiation of such informal mentoring difficult. Since mentoring often involves both professional and personal relationships, challenges may arise such as personality conflicts, a lack of congruence between the mentor’s and mentee’s goals, and emotional transference or counter transference (45). Fortunately, gender, ethnic, and racial differences have not been shown to be consistent barriers to developing an effective mentoring relationship.

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The benefits of mentoring are numerous. Mentees benefit through successful promotion, higher salaries, greater career opportunities, increased professional recognition, and greater job satisfaction when compared with nonmentees (48,49).
Mentors benefit by achieving a sense of satisfaction, fulfillment, and self rejuvenation when fostering the career development of young faculty (50). The academic organization benefits through enhanced employee motivation, job performance, and retention rates. Mentor relationships benefit all parties by providing a structured work system that reinforces a common value base and the expectations of the employer–employee relationship (51).

Senior mentors can be especially helpful to junior faculty by introducing them to colleagues with similar research or career interests. Faculty who network in this way produce more scholarly products. Faculty also perceive greater teaching, administrative, and other academic achievement as a result of collegial relationships (52,53).

In a survey of family medicine faculty who participated in a faculty development program, those who maintained intramural or extramural networking contact were significantly more likely to have engaged in educational program development, participated in academic committees, and collaborated on research (54). Junior faculty with mentors reported greater career satisfaction, receipt of research grants, research preparedness, and perception of institutional professional support than faculty without mentors (55).

During SLUGA, junior faculty had the opportunity to interact with successful senior faculty members in both formal and informal settings. Participants also took part in small group workshops that fostered teamwork, collegial relations, and networking. Ample opportunity was provided for junior faculty to meet potential mentors and to develop personal and professional relationships with other SLUGA scholars. Collaborative activities (such as the writing of this article) and peer-mentoring facilitated the exchange of career information and professional advice between participants.

More than ever, the academic world is characterized by shrinking funds for teaching and research, and rising pressure on faculty members to generate more clinical revenue. Junior faculty members must form relationships and networks to support each other by sharing experiences and helpful advice. SLUGA provided a strong mentoring and networking system whereby the participants could continue to share resources and support each other when facing the challenges of academic medicine.

CONCLUSION

For success in academic medicine, faculty must have skills and talents in multiple domains. Faculty must be leaders on a local, regional, and national basis. They must be recognized as outstanding educators within the institution. Faculty must be skilled and efficient clinicians who are respected by patients and colleagues. Those engaging in research must succeed in obtaining grant funding and in carrying out an organized research program. Faculty must be prepared to shine in these multiple arenas when working toward tenure.

As subspecialists, geriatricians are very satisfied with their career choice. Among 33 surveyed specialty fields, geriatric medicine had the highest percentage of physicians (60%) who rated themselves “very satisfied” with their career (56). For the survival of geriatric medicine as a unique discipline, it is important that faculty remain satisfied in their career paths.

Geriatricians must also be accepted and respected by physician peers in order to receive timely career promotions. We must be perceived as productive contributors to the academic environment. To do this, faculty must develop leadership skills in administration and program management. Geriatricians must be trained to be outstanding educators for trainees at all levels. Faculty must understand the finances of academic medicine and be effective in generating research and clinical revenue. Geriatricians must establish mentorships and collegial networks to improve academic productivity.

For individual career success, the academic institution must be open to and accepting of the evolution in faculty development. Too often, “on the job training” for junior faculty becomes a “trial by fire.” This approach is no longer sufficient to provide the proper foundation for a successful academic career. Formal mechanisms are needed to assist faculty in becoming successful leaders, educators, clinicians, and researchers. Regional and national FDP conferences are an efficient and effective means of providing a comprehensive education for the academic physician.

Faculty still need local mentors and leadership opportunities; however, FDP training programs such as SLUGA have resources beyond what many institutions can provide to young faculty. Academic medical centers must see formal FDPs as a priority if the viability of geriatric medicine as a specialty is to be maintained. The SLUGA program provides an important training experience for those junior faculty members in geriatrics who strive for greater success in academic medicine.

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REFERENCES
