THE IDEAL FRAMEWORK FOR BUILDING GOOD RELATIONSHIPS BETWEEN FACULTY MEMBERS AND CLINICAL TRAINING SITES

THINK TANK

COLLEGE OF PHARMACY
The University of Tennessee Health Science Center
Memphis • Knoxville
In December, 2007, Dean Gourley announced the appointment of a College of Pharmacy “think tank” group to study problems associated with the placement of faculty members in hospitals and other clinical training sites. This action was taken in part upon the recommendation of Dr. Richard Helms, Chair of the Department of Clinical Pharmacy. Members of this group included the following:

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**Max D. Ray, Pharm.D., MS, LHD (Co-Chair)**  
Professor, Pharmaceutical Sciences  
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**Alison Apple, MS**  
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Director of Pharmacy  
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**William Greene, PharmD**  
Chief Pharmaceutical Officer  
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**Bob Lobo, PharmD**  
Associate Professor of Clinical Pharmacy  
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Methodist University Hospital  
Memphis, TN

**Richard Malone, PharmD**  
Director of Pharmacy  
Centennial Medical Center  
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**William A. Miller, MS, PharmD**  
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**Shaunta’ Martina Ray, PharmD**  
Assistant Professor, Clinical Pharmacy  
Knoxville, TN

**Kay Ryan, MS**  
Director of Pharmacy  
Regional Medical Center at Memphis  
Memphis, TN

**Tim Smith, PharmD**  
Director of Pharmacy  
Ft. Sanders Regional Medical Center  
Knoxville, TN

**David Solomon, PharmD**  
Professor and Associate Dean  
Chief, Pharmacy Services  
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Memphis, TN
It will be noted that the group included a) ten hospital pharmacy managers (directors, associate directors, program directors) from a wide geographic cross-section of Tennessee; b) five faculty members from the College of Pharmacy (one of whom is also a hospital pharmacy director), representing both the Memphis and Knoxville campuses, and c) one consultant from another college of pharmacy outside of Tennessee.

**CHARGE TO THE GROUP**

Dean Gourley’s charge to this group was to develop a recommended structure, or framework, for the successful integration of full-time College of Pharmacy faculty members into the pharmacy departments of affiliated clinical training sites.

**BACKGROUND**

With the advent of clinical education as part of the curriculum of pharmacy schools and colleges, beginning in the 1960s, a need emerged for clinical faculty members who were actively engaged in practice. It was expected that these faculty members would serve as practice role models for pharmacy students and create active-learning opportunities for students in the delivery of clinical pharmacy services.

Deans and department chairs, in an effort to create practice opportunities for clinical faculty members, turned to hospitals, hospital-based clinics, and other clinical settings in their regions for assistance. They proposed in some cases to co-fund positions with such institutions, based on the assumption that both the college and the clinical site would derive direct benefit from such an affiliation. In other cases, the school/college offered to pay the full salary of the faculty member, in return for the teaching opportunities that such an arrangement would create.

In most cases where a pharmacy school or college was part of a health sciences campus, it was relatively easy for the dean or department chair to make the case that clinical education of pharmacy students fit within the teaching mission of the university hospital. In other cases, where pharmacy schools/colleges were not part of an academic health sciences center, arrangements had to be built with non-university hospitals and other clinical settings not traditionally aligned with the education of health professions students.

In some cases, agreements to embed faculty members within institutional pharmacy programs were based on the premise that the faculty member(s) would develop, or help to develop, a new service program (e.g., a pharmacokinetics consult service, a clinical pharmacy presence in the ICU, or an anticoagulation clinic). In other cases, agreements were based on having a faculty member practice in an area where a clinical service program had already been established.
As models for clinical pharmacy practitioner-educators were developed and explored, it became apparent that some models worked better than others. A number of issues—both organizational and personal—began to emerge, leading in some cases to polarization between academia and the practice community. Problems of this nature have been discussed in pharmacy circles for a number of years, ranging from the local level to the national level (e.g., formal discussions at professional meetings, most notably at meetings of AACP, ACCP and ASHP). It is very likely that the attention given to those settings where problems arose overshadowed the success stories of many other settings where harmonious, mutually-beneficial hospital-college relationships existed.

Although the conversation on these problems (as some of us can remember) was at times rather strident, there has been surprisingly very little in the literature describing such problems. The references attached to this report (Appendix 2) include several papers that describe successful models, and it can be inferred in some cases that these models were developed to replace earlier models that were less successful.

The experiences of the University of Tennessee College of Pharmacy have in some respects paralleled those that have been reported at other schools/colleges of pharmacy. We have examples of relationships that work very well, as well as examples where problems have arisen. In appointing this “think tank” and commissioning it to pursue the charge set forth above, the Dean demonstrated his intention to guide the College to a new level of understanding regarding the criteria for success of faculty practice models in affiliated clinical sites.

With the implementation of the most recent set of accreditation standards for schools and colleges of pharmacy (ACPE’s Standards 2007), the need for clinical training sites, and for practice opportunities for pharmacy practice faculty members, has greatly increased. The unprecedented growth of new pharmacy schools in the nation over the past ten years has created considerable competition for access to the available number of potential clinical training sites. It is critical, therefore, that the College stabilize and maintain the relationships that it has already established and approach the establishment of new relationships with a clear understanding of how to make them succeed.

**PROCESS**

Prior to the “think tank’s” first meeting a set of key articles (selected primarily from the pharmacy and nursing literature) was identified and provided to each member (see Appendix I). These papers helped to provide a frame of reference for discussions at our meetings.

The “think tank” group held its initial meeting on January 18, 2008. At this meeting the charge to the group was reviewed and a general working plan was discussed. It was agreed that an organizational improvement framework known as “S-T-P” would be used to guide the group’s discussions. In this model, $S =$ current situation (i.e., a description of “what’s wrong”), $T =$ target
(desired outcome), and $P =$ the process to achieve the desired outcomes (i.e., a roadmap to get from $S$ to $P$).

Each member of the group was then given an opportunity to present his or her individual views or perspectives on the issue. This led to a rich discussion, resulting in a number of preliminary recommendations for further consideration by the group.

The group agreed to host a “town hall” session at the 2008 Midyear Meeting of the Tennessee Pharmacists Association, to engage a broader range of stakeholders in its discussions. This session was held on February 24 in Nashville.

Drafts of the proceedings of both the January 18 meeting and the February 24 “town hall” session were circulated to all members of the “think tank” group for comment. Several e-mail messages were received from individual members in response to these drafts, and these were considered in preparing the final report.

On March 3, 2008, the two co-chairs (Max Ray and Brad Boucher) conducted a telephone conference with Dr. Tim Smith, Director of Pharmacy Services at the Ft. Sanders Regional Medical Center in Knoxville, to gain his perspectives and insights on potential problems in having a full-time faculty member based in a hospital pharmacy practice setting. (Dr. Smith is a member of the “think tank” but was not able to participate in either the January 18 or February 24 meeting). He provided very useful recommendations, based on his first-hand experience. These recommendations are reflected in the group’s final report.

On April 1, the co-chairs conducted a telephone interview with Dr. Heather Draper, a current faculty member who formerly held a co-funded position at Ft. Sanders Hospital in Knoxville, to get her thoughts, from the perspective of a faculty member, on how such a relationship could be improved. Dr. Draper’s comments were also felt to be quite useful.

Finally, a meeting was held on April 7 with three members of the “think tank” who had not been able to participate in any previous meeting: Drs. Bill Greene, David Solomon, and Richard Malone (who joined the meeting by telephone). Both of the co-chairs participated in this meeting. This session focused primarily on the expectations of directors of pharmacy services for faculty members based in their organizations.

Key points from each of these meetings are summarized below.
**FINDINGS: SUMMARY OF THE CURRENT SITUATION**

The “think tank” concludes that several of the relationships that the College has established for placing faculty members in clinical practice sites are very stable and productive. It also finds that problems in the past in certain other sites, may have led to decisions to discontinue the relationship. We believe the following statements identify the major problems, particularly in the case of co-funded positions:

1. lack of a clear up-front understanding (written agreement) between the College and the institutional pharmacy director regarding the roles and responsibilities of the faculty member
2. lack of accountability by faculty members to the pharmacy director (or the perception that such a lack of accountability exists)
3. lack of clarity on which set of human resources policies (the University’s or the hospital’s) applies to a co-funded faculty member (e.g., who conducts performance evaluations for the faculty member, which organization’s policies regarding holidays and vacation leave apply to the faculty member, etc.)
4. inability of the full-time pharmacy staff to provide service when the faculty member is not present (especially in the case where the faculty member has established a new service program and has created the expectation that the service will be provided on a regular, ongoing basis)
5. lack of willingness of faculty members to provide service at night or on holidays or weekends, or to take call during those hours
6. lack of understanding on the part of pharmacy directors and/or their staffs that faculty members have a full-time Monday through Friday commitment, and that it is impractical for the faculty member to take a day off during the week to compensate for working on weekends or nights
7. lack of understanding on the part of the pharmacy director and staff of the full range of faculty member commitments (especially regarding research and scholarship)
8. the perception among full-time staff that faculty members get to do the “fun” jobs while they (the staff) are responsible for the more routine tasks in the department
9. lack of guidance to faculty members (especially younger, less-experienced faculty members) in terms of establishing a new practice environment
10. inadequate involvement by the College (or the Department of Clinical Pharmacy) with the pharmacy director during the formative stages of a new hospital-College relationship
11. lack of ongoing communications between the College and the pharmacy director, even in cases where initial communications may have been adequate
12. perception of some pharmacy directors that the College takes their cooperation and support for granted
13. salary differences between faculty members and full-time hospital pharmacists (in those cases where the salary of the faculty member is less than that of the full-time staff)
14. the development in some cases of an “us against them” attitude, both on the part of the faculty member and the hospital pharmacy staff
Although we found less evidence of such problems in the case of faculty members who are paid 100% by the College of Pharmacy, we believe that the same potential problems exist and that measures should be taken to prevent them from becoming actual problems.

**DESCRIPTION OF AN IDEAL RELATIONSHIP: THE TARGET TO AIM FOR**

The “think tank” group believes that the following statements characterize the ideal relationship between a college of pharmacy and an affiliated clinical training site for the purpose of establishing a faculty member in a teaching/practice role in that site:

1. **A shared vision** — The relationship between the College of Pharmacy and the clinical site where a faculty member is based exists for the mutual benefit of the College and the clinical site. The perceived benefits can be clearly articulated by the director of pharmacy, the appropriate representatives of the College (the Dean, the Chair of the Department of Clinical Pharmacy and appropriate Vice Chairs), and the faculty member who is to be based at that site.

2. **A written agreement** — The relationship is based on a written agreement that includes, but is not limited to, the following points:

   - the amount to be provided by each party (the College and the clinical site) for the faculty member’s salary
   - a clear statement of the roles and responsibilities of the faculty member, including those pertaining to patient care, clinical education, and scholarship
   - a clear indication of accountability (to whom is the faculty member accountable and when?)
   - procedures for input into evaluation of the faculty member by both the College and the pharmacy department. (In cases where the agreement stipulates that the faculty member is accountable solely to the College, provisions should be made for input by the director of pharmacy related to the service component of the faculty member’s responsibilities, and for how this input will be used. In cases where the agreement stipulates that the faculty member is accountable solely to the director of pharmacy, provisions should be made for input by the College related to the teaching and scholarship components of the faculty member’s responsibilities, and for how this input will be used.)
   - procedures to be followed if a conflict should arise between the faculty member and the director of pharmacy or his/her staff
   - key performance indicators for the faculty member, which can be monitored on an ongoing basis (e.g., quarterly, semi-annually, annually)
• the faculty member’s work schedule, with a clear statement of expectations regarding nights, weekends, and holidays
• clarification of which organization’s human resources policies apply in the faculty member’s case (i.e., the University’s or the hospital’s)

3. The faculty member who is based in a particular site, or who is being considered for the site, receives a copy of the written agreement.

4. **Good communications** — The relationship is nurtured through regular three-way communications between and among the College administration, the director of pharmacy, and the faculty member. Problems are identified and resolved quickly.

5. **Collegiality** — The relationship is based on mutual professional respect between the faculty member and the professional staff of the clinical site. Each understands the roles, responsibilities and unique challenges of the other. The faculty member (being initially an outsider to the clinical site) has good interpersonal and relations-building skills.

6. **Measures of effectiveness** — The relationship is regularly assessed, both by the College and the clinical site, and appropriate steps are taken to improve the relationship, based on assessment data.

**RECOMMENDATIONS: THE PROCESS FOR ACHIEVING OUR TARGET**

The “think tank” offers the following specific recommendations for improving and strengthening the College’s relationship with affiliated clinical training sites where faculty members are currently based, and for establishing successful future relationships.

1. Meetings should be scheduled at the earliest possible time between appropriate representatives of the College of Pharmacy (e.g., the Dean, the Chair of the Department of Clinical Pharmacy, and/or appropriate Vice Chairs) and the director of pharmacy in each clinical site where faculty members are currently based. The College should take the initiative to schedule such meetings. The intended purpose would be to explore in depth the level of satisfaction, on both sides, with the current relationship. Any problems identified with the relationship should be openly discussed, and actions should be taken to resolve those problems. (It may be appropriate to schedule a meeting with the CEO of the clinical site as well; the director of pharmacy’s advice should be sought on this point.)
2. In cases where no written agreement currently exists between the College and the clinical site, such an agreement should be developed post haste. The agreement should include the following elements at a minimum (these are enumerated above under Description of an Ideal Relationship):

   a. the amount to be provided by each party (the College and the clinical site) for the faculty member’s salary
   b. a clear statement of the roles and responsibilities of the faculty member, including those pertaining to patient care, clinical education, and scholarship. Key performance indicators should be established for each of these three areas of the faculty member’s responsibilities, which can be tracked on an on-going basis.
   c. a clear indication of accountability (to whom is the faculty member accountable?)
   d. provision for input into performance evaluation by both the College and the pharmacy department
   e. a clear understanding regarding who provides coverage for patient when the faculty member is not available. In cases where a faculty member’s principal clinical responsibility involves establishing a new service (e.g., establishing a formal consult service, covering a medical service that has not previously been covered by a pharmacist, or establishing a new disease-management service in an ambulatory clinic), there should be a provision in the agreement for cross-coverage for the faculty member.
   f. the faculty member’s work schedule, with a clear statement of expectations regarding nights, weekends, and holidays
   g. a clear statement regarding procedures to be followed in the event of a conflict between the faculty member and the director of pharmacy or his/her staff.
   h. clarification of which organization’s human resources policies apply in the faculty member’s case (i.e., the University’s or the hospital’s)

The faculty member(s) currently based in such a site should receive a copy of the written agreement.

3. In planning for future practice sites for faculty members, the appropriate College administrators should have an initial joint discussion with the director of pharmacy and the CEO in that site regarding mutual expectations for such a relationship. Assuming there is strong support by the director of pharmacy for having a faculty member based in his/her institution, a formal written agreement, containing those elements listed in No. 2 above, should be prepared and executed.

4. Whenever there is a change in the pharmacy directorship in a clinical site, the written agreement should be re-negotiated with the new director.

5. A structured system for communications should be built into our relationship with clinical sites where faculty members are based. This system should provide for (a) communications between the Department Chair and/or Vice Chairs and the faculty
member, (b) communications between the faculty member and the director of pharmacy in the clinical site, and (c) communications between College administration and the director of pharmacy. Such communications should be held on a regular, scheduled basis. (This would not preclude additional, informal communications on an as-needed basis.)

6. The director of pharmacy in any clinical site where a faculty member is based should be viewed as a key stakeholder in the College. His or her input should be solicited on such matters as curriculum (particularly the experiential component), admissions, and assessment.

7. The College should be sensitive to the perception of some pharmacy directors that their cooperation and good will are taken for granted by the College. Every effort should be taken to assure pharmacy directors in sites where faculty members are based that their cooperation is acknowledged and appreciated.

8. Steps should be taken to ensure that faculty members based in clinical practice sites receive appropriate mentoring, especially with respect to development of their scholarship within the practice site.

9. The College should be mindful of the issues that sometimes arise between full time professional staff in a pharmacy department and a faculty member (who may be viewed initially as an outsider.) To help avoid such issues, care should be taken to ensure that the faculty member exhibits appropriate interpersonal and relations-building skills. Attention should be given to any behaviors on the faculty member’s part that might be interpreted by staff in the clinical site as aloof, arrogant, or non-collegial.

10. A program of assessment should be developed for faculty practice sites. This program should be based on feedback from the director of pharmacy (and any other members of the pharmacy department that the director designates), the faculty member, and students.
APPENDIX 2
LIST OF REFERENCES


