EDITORIALS

Erstwhile Triple Threat

Thirty years ago, when I was a first-year medical student, many faculty were “triple threats.” The triple threat term came from the 3 major legs of the academic stool: clinician, educator, and investigator. In those days, the entire department of medicine had approximately 40 faculty. Many subspecialty divisions had between 3 and 5 members, and my medical school had no General Internal Medicine division.

While many faculty members are capable of excellence in clinical medicine, education, or investigation, few if any can excel at all three. The pace and complexity of clinical work in 2002 make it very difficult to keep one's clinical skills current without a significant time commitment.

Although many academic leaders have suggested that brilliant teachers are born, not made, I would argue that developing excellence as an educator requires a significant commitment. Educators need to polish their teaching skills and spend significant time on updating their knowledge base. Our departments and divisions need this dedication, which division chiefs should foster.

Research in all specialties becomes more complex every year. The competition for research funding makes it standard for successful researchers to devote 80% or more of their time to research. This much time is needed because of the effort needed to get research funding, perform the research and analyze the data, then both publish and present the results.

Given that we don't have enough hours to become a true triple threat, then how should we consider the concept? I believe that the triple threat now becomes a divisional goal rather than an individual goal. As we look at the divisions of a Department of Internal Medicine, we expect them to have a clinical presence, an educational presence, and a research presence.

With this formulation, we must plan how the members of the division can work together to produce this triple threat. A great challenge of leading a large division of General Internal Medicine or a subspecialty division in 2002 involves keeping the clinicians, educators, and investigators happy and cooperative. Mukamal et al. have suggested some methods used in their division of General Internal Medicine.¹ I don't believe that the challenge is different for GIM and subspecialty divisions. As we develop our own special interests within our GIM divisions, so does almost every subspecialty division. In many ways, we are more homogeneous than are most divisions of cardiology, where the clinicians themselves are divided up into 3 or 4 different groups.

In running a large division, one must fall back on leadership and management skills.² The article by Mukamal et al. presents some specific suggestions for getting the disparate division members to work together. I applaud the creativity that they have used in developing methods for keeping the division whole. However, programs do not lead and do not manage. Success in working with a large group depends upon leadership and management.³

Much has been written about leadership in the business literature. While there are many leadership techniques and skills, in this case it seems that the most important skill is in clearly delineating where the division is going. Fortunately, in our divisions, we have very intelligent faculty. They work hard and they are dedicated to the field; but unless they know where the division is trying to go, they are unlikely to participate in achieving its goals. Leadership expresses those goals clearly, explicitly, and understandably.

But leadership is not enough. Leadership might express goals, but the systems that would allow faculty to achieve those goals may not be present. So in many ways, as important as leadership is, we need to deal with management. The best guide that I have personally found to management is *First Break All the Rules*, by Marcus Buckingham and Kirk Kaufman.⁴ They state:

People don't change that much.

Don't waste time trying to put in what was left out.

Try to draw out what was left in.

That is hard enough.

I interpret their philosophy to suggest that not every faculty member is a pluripotent stem cell for academic success. They imply that different faculty members have different skills and that we should focus on the strengths of individual faculty members, allowing them to develop their strengths and hide their weaknesses. According to the Gallop organization researchers, the great managers break the rules of conventional wisdom.⁴ They play favorites; they help people differentially. They state:

Select a person, set expectations, motivate the person, and develop the person.

I would argue that division chiefs must understand who will fit in the division, make sure that the goals are clear, and help each individual, understanding that each faculty member responds to different motivation. Most importantly, the division chief should help each individual meet his or her goal. Often, that goal is promotion or

tenure, but this may not be true of every faculty member. Some want to succeed as researchers, others as educators. Understanding the goals of faculty members and seeing how one can help them to achieve their goals defines successful division management.

The new Association of Chiefs of General Internal Medicine (ACGIM) focuses much attention on leadership and management training. We hope to provide the skills and understanding needed by current and future division chiefs. Helping the chiefs should help the divisions.

I applaud the authors on considering in depth the problem of running large, complex divisions in 2002. I urge divisions to focus on understanding their goals (both group and individual), developing a logical path for success and allowing each member to contribute to the

division's success.—**ROBERT M. CENTOR, MD**, *University of Alabama School of Medicine, Department of Medicine, Birmingham, Ala.*

REFERENCES

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