Separate and Equitable Promotion Tracks for Clinician-Educators

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Most academic medical centers (AMCs) have missions that aim for excellence in 3 areas: education, research, and patient care. For decades, “triple-threat” faculty members were able to substantively contribute to all 3. However, heightened competition for research grants, changes in the health care delivery system, more sophisticated instructional and evaluation methods, and increased requirements to account for time and productivity make it less feasible for individual faculty to significantly contribute to all 3. Instead, faculty members are likely to focus their efforts in 1 or 2 of these areas. Although exceptions exist, physician faculty members focus either on patient care and research or on patient care and education.

The problem is that promotion and tenure systems work well for faculty members pursuing the former but not as well for those focusing on the latter. For instance, 1 report found that, compared with research faculty, the odds of holding a higher academic rank were 85% lower for academic clinicians and 69% lower for teacher-clinicians. In another report, faculty devoting more than 50% of their time to clinical care were more likely to be on a nontenure track and more likely to report slower career progress than those devoting less than 50% of their time to clinical care. In a third report, the time to promotion was significantly shorter for physician-scientists (with 80% designated research time) than for clinician-scholars (with 30% research time). If this issue is not resolved, AMCs run the risk that faculty charged with patient care and education will view their contributions as having limited value, which will decrease motivation and reduce incentives for future efforts.

In this article, we briefly review the evolution and early promise of faculty promotion and tenure tracks. We explore ways clinician-educators are designated within academic promotion and tenure models, address the value of these faculty to the AMC system and the challenges they face, examine measurement and evaluation issues, and offer suggestions for change.
ulty, a conclusion of virtually every study that has examined promotion among these groups, contributes to turnover. Whether promotion is less likely \(^2\) or delayed, \(^4\) the disparate outcome has clear implications for buy-in and job satisfaction, both of which lead to turnover.

One compelling shortcoming of the current system may be the identification of clinician-educator tracks as separate but equal to research tracks. Under the separate but equal system, clinician-educators will always fall short when traditional yardsticks are used to measure outcome.

**Clinician-Educator Tracks**

The approaches to promotion for clinician-educators can be categorized in 3 ways. In the first category, faculty members are perceived as clinicians with some teaching responsibilities and no expectation for research. These faculty members are typically adjuncts or instructors, or offer contributed service, and are valued by the prevailing reward system to the extent that they serve the mission of education and clinical service. Some argue that this strict boundary between clinical and traditional faculty is necessary to maintain the integrity of academe. \(^1\) Another category structures clinician-educators to hold rank in the department without tenure eligibility. This system purports an expectation for separate but equal scholarship, and traditional scholarship of discovery is required for promotion. This model creates a tiered system in which faculty researchers maintain the more venerated tenured positions and higher rank, while the lower ranks are disproportionately filled by clinician-educators. \(^1,12,13\) The third category addresses these shortcomings by creating tenure-eligible, separate and equitable clinician-educator tracks. This categorization recognizes that requiring “traditional” scholarship is inconsistent with the job description of clinician-educators and that scholarship must be redefined to include those pursuits appropriate to the duties and activities of these faculty. \(^3\) The trend toward separating tenure from salary guarantees should make this option more appealing to institutions.

Clinician-educators are the invaluable front line for both patient care and the training of future physicians, each of which faces increased competition from a variety of sources. Top AMCs in the United States have launched aggressive advertising campaigns to attract patients and promote clinical services, \(^14\) indicating a current climate of intense competition for clinical revenue. There is, likewise, increased competition for top students, residents, and fellows into education programs. Given these demands, individuals trained in and committed to education scholarship, curricular development, and education assessment and evaluation are essential to the education mission of all medical schools and AMCs.

Although some institutions have found creative ways to recognize and reward their best teachers, the most valued currency in academe, promotion and tenure continues to be reserved for the faculty carrying out “traditional” scholarship, and as the separate but equal structure would predict, clinician-educators are not measuring up. If the requirement of scholarship is not shaped to fit the activities of clinician-educators, then faculty so tracked will continue to fall short in the process. \(^3,15-17\)

Several approaches may help address these inequities. First, different forms of scholarship must be valued. Boyer\(^18\) first articulated distinct forms of scholarship, defining traditional research as the scholarship of discovery and providing labels and descriptions for 3 others: the scholarship of integration, application, and teaching. The meaning of “scholarship of teaching” and the question of quality and measurement have been subsequently explored. \(^19\) Activities reach the level of scholarship when they are (1) made public, (2) available for peer review and critique according to accepted standards, and (3) reproducible by and foundational for other scholars. \(^20\) Several AMCs have successfully broadened their definition by way of policy changes to embrace a more inclusive view of “scholarly contribution.” \(^1,21,22\) This is made possible by venues such as the Association of American Medical Colleges’ new resource, MedEdPortal, \(^23\) which provides peer review and dissemination of educational materials. Valuing different forms of scholarship may involve institutional transition, which can be difficult. It is encouraging that the use of an established model to navigate the change process has been successfully demonstrated. \(^13\)

Second, “separate and equitable” must be accepted in the medical education culture. Although freestanding AMCs exist, the vast majority of AMCs are part of a college or university. It is not uncommon for such AMCs to have required governance accountability and alignment with that of the institution (college or university) with which the AMC is affiliated. Institutional standards for promotion and tenure, and the extent to which they should remain constant when applied to the institutions’ professional schools (eg, the AMCs), is the source of considerable debate. Some assert that creating a discrepancy in standards between professional schools and home institutions will bring about the ultimate demise of credibility, productivity, and viability of professional schools. \(^11\) However, the strong sentiment in the literature is that faculty who devote 10% to 40% of their time to research cannot reasonably be expected to produce scholarship at the same rate, in the same time frame, as faculty devoting 50% to 90% of their time to such investigation. \(^1,4,24\) A united position within the medical education community would strengthen the position of each individual AMC that takes up this issue with the college or university. That position must acknowledge that faculty increasingly must choose between education and traditional research as their defining function and that both are essential to the mission. The credibility and success of AMCs are threatened more by a divided and differentially valued faculty than they would be by separate and equitable tracks.

Education-related scholarly productivity must be measured and evaluated. The measurement and evaluation issues associated with separate and equitable tracks are considerable. Documentation systems have a variety of labels...
Assessing faculty work products involves both measurement and evaluation, each of which must be considered separately. Measurement requires a “yardstick” with which to quantify objects or personal attributes (eg, number of lectures, ability to provide feedback). The next step is to evaluate the quality of each of these factors. This can only be accomplished with consideration of the context, frame of reference (norm or criterion), and purpose (formative or summative) of the evaluation.

Specialties may weigh in on what qualifies as appropriate criteria for appointment, promotion, and tenure decisions, as the Society of General Internal Medicine did in 1997, but ultimately each institution must determine how those standards would best be applied. It would be helpful for specialty organizations to articulate measurement standards so that AMCs could focus on evaluation issues in the local context. For example, the degree of local recognition could be measured by the number of competitive local teaching awards, local media exposure, community outreach activities or presence, or grand rounds presentations. The extent to which local recognition is valued as part of consideration for promotion, and to which work products are considered in the evaluation process, would be decided by individual institutions.

Conclusions
Clinician-educators represent the front line of AMCs by providing the bulk of clinical care and by upholding the education mission of the enterprise. Conceptualizing this track as separate but equal to the clinician-researcher track, and using the same yardstick to determine value, will continue to be problematic. It is equally inappropriate to water down the traditional standards, applying them differently to clinician-educators, as that creates a culture of “second-class citizenry” between the tracks. One possible solution is to conceptualize the tracks as separate and equitable and create new yardsticks for clinician-educators that are appropriate for their contributions to support the AMC system. Documentation systems can provide the framework for organizing educational efforts, and applying established standards can determine evaluation outcomes. Institutions would retain autonomy in setting standards and in the ultimate judgment of content. The process would be more transparent for faculty, administration, and students without compromising the local standards for rigor and excellence.

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REFERENCES


EDITORIALS

Work Hours and Reducing Fatigue-Related Risk: Good Research vs Good Policy

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WHILE THERE IS LITTLE DOUBT THAT PHYSICIANS-in-training work long hours and experience chronic sleep restriction over many years, the consequences remain unclear. There is not yet a significant body of evidence-based data clearly delineating the relationship between work patterns, sleep duration, and patient safety or practitioner well-being. On the contrary, anecdote and economics have driven much of the public debate over the legitimacy and necessity for extended work hours and any presumed impact on health care consumers and practitioners.

In this issue of JAMA, 2 articles make a significant contribution to a more informed debate. The first article by Fletcher and colleagues1 reviews the impact of restricted working hours on physicians’ well-being and professional competency. This review focuses on describing the types of interventions by specialty and by subsequent impact.

At best, the cited studies can be characterized as naive examples of the “action research” paradigm.2 Few, if any, of the studies had systematic evaluation as a prospective aspect of implementation. The authors rightly assert that the majority of studies in the area can be characterized as poorly controlled and based primarily on subjective, introspective, and poorly defined dependent measures. Indeed, they conclude that only 1 of the cited studies met the basic requirements of an evidence-based trial.3 Thus, the most significant conclusion from this review is the difficulty in drawing any meaningful conclusions from the existing literature that could serve to guide policy.

Nevertheless, setting aside the limitations of and contradictions among individual studies, it is possible to look for converging evidence or broad themes from this body of work. From this perspective, there appears to be a small but significant group of studies for which restricted working hours were associated with self-reported improvements in variables that broadly reflect “quality-of-life” issues. For example, reductions in self-reported stress, increases in the amount and quality of personal and study time, and improved mood and affect were commonly described.4-7

See also pp 1025 and 1088.

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