EDITORIALS

Promotion for Clinician-educators

Time for a Fresh Approach?

To recruit and retain the best and the brightest faculty, academic medical centers must support career paths that provide development opportunities and rewards for all faculty. With the dramatic growth in full-time clinical faculty that started in the 1980s, academic medical centers realized that promotion systems designed to guide and reward research-oriented faculty for the scholarship of discovery were not a good fit for clinician-educators engaged in the scholarship of dissemination and application. In response, many institutions developed separate clinician-educator promotion tracks. These tracks have been criticized as still incongruent with the job descriptions, career aspirations, and skills of today's clinician-educators.[1–3] The critical issue at hand is whether this change in promotion structure has provided a career path for clinician-educator faculty that rewards them for their unique contributions to their institutions. Articles by Atasoylu and Beasley in this month's *JGIM* suggest that while we have come a long way in recognizing the importance of the skills of teaching and patient care, we have much work to do before clinician-educators feel that they are on equal footing with their research colleagues.[4,5] If we hope to provide enduring academic career paths for clinician-educators, it may be time for a fresh approach.

Two views of the clinician-educator promotion ladder are evident from these surveys. Looking down the ladder are department and promotion committee chairs who agree that teaching and clinical skills are the most important domains for evaluation of clinician-educators.[4] Viewing promotion ladders from this vantage point, clinician-educators should feel confident that if they excel at what they were hired to do, i.e., care for patients and teach about caring for patients, they will be promoted. Unfortunately, the view looking up the ladder is strikingly different. Clinician-educators believe that their success in the promotion process is dependent less on excellence in their core responsibilities and more on research, written scholarship, and national reputation.[5] Are educators looking at the academic world with a jaundiced eye, or are department chairs and promotion committees wearing unusually rosy glasses? Over time, Beasley and Wright's *Prospective Study of Promotion in Academia* (PSPA) should provide answers to this question. For now, several potential explanations for this divergence in opinion deserve consideration and may provide insights for future strategies for career development for clinician-educator faculty.

First, concerns expressed by department and promotion committee chairs about the quality of available data supporting excellence in clinical and teaching skills may derail their intent to support the promotion of clinician-educator faculty.[4] Promotion committees can easily calculate the institutional value of a research-oriented faculty member by summing up patents, indirect funds from R-01 grants, and publications in top biomedical journals. The value of an individual clinician-educator to the institution can be harder for the department chairs to prove and promotions committees to quantify, especially if they are asked to rely on data whose validity is unproven. For clinician-educator faculty to succeed through academic promotion, valid and reliable methods to assess clinical and teaching skills must be developed.

Second, clinician-educators may be discouraged about their chances of success in the promotion ladder they desire (tenured, unmodified positions), not the one for which they are eligible. While the majority of institutions have adopted clinician-educator promotion tracks, the Association of American Medical Colleges has data from the time period of these surveys documenting that only 20% of institutions considered their clinician-educators to be eligible for tenure and only 34% allowed them to use an unmodified professorial title.[6] Although the days of salary guarantee with tenure are gone, none can deny that a tenured position is more distinguished than a clinical position. Furthermore, the creation of tracks that are tenure-ineligible often divide faculty into those with full faculty privileges and those who are often ineligible for such core responsibilities as voting on the faculty senate.[6] For clinician-educator faculty to be full contributing members of the academic medical center faculty, rewards must be equal.

Third, while department and promotion committee chairs may be proud of the 'right sizing' of research and publication requirements for promotion of clinician-educators, clinician-educators may still be daunted by the outlined expectations. Both articles suggest that scholarly activities are often an unfunded mandate for clinician-educators.[4,5] Almost half of responding institutions offer their clinician-educators less than one half day per week of protected time for scholarly activities. Equally problematic is the lack of funding/time to attend professional meetings reported by a third of responding institutions. Finally, the absence of mentoring relationships described by clinician-educators, in contrast to their

clinician-investigator peers, magnifies these problems. It would be the highly skilled and extraordinarily efficient clinician-educator who could carry out research and achieve a national reputation in 1 session per week with no funding for travel and little mentoring from experienced colleagues. For clinician-educators to be successful at scholarship in their field, protected time, money, and mentoring must be available.

Promotion is about more than rewards for a job well done. Promotion ladders provide career templates for junior faculty. Promotion ladders are a unifying structure for faculty who, with different talents and careers, should be working together to advance the care of our patients, educate our future physicians, and develop new knowledge. Well-intended attempts to foster the careers of clinician-educator faculty by changing promotion standards have not been successful. An alternate or complementary approach would be to enhance the career path of clinician-educator faculty and in doing so, make it easier for all to recognize and measure what we know to be the value of this group to the success of our institutions. A change in the fundamental nature of the job of clinician-educators will require effort and innovation from those on all rungs of the ladder.

Those at the bottom of the ladder looking up should heed the lessons contained in Beasley's article and prospectively plan for career success. Know the promotion requirements of your institution and find a mentor to help you meet them. Learn the research methods necessary to help you evaluate the success of your interventions. Immortalize your innovations by publishing articles, book chapters, and electronic resources. Avail yourself of any opportunity to present at national meetings or volunteer in national societies. Work with colleagues to truly protect your unscheduled time and then use it wisely. Do what you love, but document what you do.

It is time for those at the top of the ladder to embrace bold strategies to enhance the careers of clinician-educators. Rather than assuming that clinician-educators are incapable of meeting the standards of promotion committees and thus need an alternate track, we should work to support clinician-educators in careers that all recognize as fully academic. It is time to develop valid, reliable measures of teaching excellence and to advocate for their use by promotion and tenure committees across the country. It is time to consciously cultivate the clinician-educators of tomorrow. We must begin in medical school to educate students about the existence of a clinician-educator career and to encourage them to develop the skills needed to succeed in this career. Combined medicine-education degree programs may be tremendously beneficial. Special residency tracks could incorporate courses in teaching, writing, and administrative skills. Finally, it is time to move medical education research into the mainstream of medical research. There are currently 20 Institutes and 7 Centers in the National Institutes of Health (NIH). The success of the discoveries generated by support from the NIH is dependent on effectively educating new and established physicians. It is time for a National Institute of Health Education, designed to support and fund investigation into effective educational strategies across the continuum of medical learners. The availability of funds for multi-center trials of educational interventions would contribute to improved quality of medical education research as well as more protected time for the educators conducting the research. Ultimately, our patients will benefit from better-educated doctors.

Changes of this magnitude will be neither easy nor swift. They will require methodical planning, ongoing collaboration among professional societies and institutions, and intense and persistent advocacy. The success of this approach needs to be evaluated not only in terms of its impact on clinician-educator promotion but also according to its impact on the quality of education and patient care in our institutions. Although this is not an exclusively generalist issue, divisions of General Internal Medicine and the Society of General Internal Medicine, academic and professional homes for many of the nation's clinician-educator faculty, should accept this challenge and lead this charge.—**Catherine R. Lucey, MD, FACP,** *Department of Internal Medicine, The Ohio State University College of Medicine and Public Health, Columbus, Ohio.*

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