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The Ivory Tower: Rest Home or Rat Race?

SUMMARY

In this review the author considers the need for academic family physicians, describes their work, reviews the rewards and stresses of the jobs they do, and finally offers direction for someone considering such a career. (*Can Fam Physician* 1987; 33:2731–2735.)

RÉSUMÉ

L'auteur de cet article examine la pertinence des médecins de famille en milieu académique, décrit leurs tâches, passe en revue les gratifications et les tensions générées par ce travail et, finalement, tente d'orienter ceux qui envisageraient une telle carrière.

Key words: academic family physicians, education, medical careers

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TAKE AN AVERAGE family doctor's work load. Subtract 20%. Add 700 hours per year of committee work. Stir in participation in two or three research projects, the direct clinical supervisory responsibility of two to four family-medicine residents per year and three to six family-medicine clerks per year, reading and preparation time for one to four teaching situations per week, and on-call responsibilities from one in three to one in nine. There you have it: a full-time academic family physician's work.

Take an average family doctor's income. Subtract 20%. Add the following fringe benefits: the right to apply for a sabbatical at approximately 40% of one's total income every seven years; pension plan (based on one-third of one's annual income, limited in tax relief to the salaried employee limit, contributions matched by the employing university); other fringe benefits of supplementary health insurance, dental insurance, group life insurance, two weeks CME time, and four weeks vacation. There you have it: a full-time academic physician's compensation.

The past 20 years in North America have seen the emergence of a new career option for family physicians: that of the academic family physician. Known as "full-timers", "GFTs" (geographic full-timers), or as "with the university", these clinical teachers have been the subject of admiration, ridicule, envy, and disdain by their service-based colleagues.

The Need for Family Medicine's Academic Clinicians

Why do we need academic Departments of Family Medicine staffed by GFTs? The academic clinical department's job in the medical school includes the following responsibilities: to teach all medical students sufficient knowledge about family medicine to enable them to work effectively as doctors in our communities, whatever branch of medicine they choose; to teach students planning to become family physicians; to advance knowledge about family medicine; to develop and test new ways for future family physicians to work; to teach other kinds of doctors in the faculty about family medicine; to contribute the expertise of family medicine to the general programs of the university; and to compete for the necessary resources to do all of the above. As McWhinney has written, the university department serves as "the academic spearhead to give a lead in teaching and research."[1]

Ruhe has argued, as have others, that residency programs should be based in the teaching centres:

> The desirability of having approved residency programs in the medical centre is obvious. On the one hand, the medical student will see health officers in training engaged in the delivery of health care in a model of family practice. On the other hand, the resident himself will feel that he is a member of their health care delivery team and will be engaged in regular educational exercises involving student instruction, as well as his own growth and development. Neither of these things is likely to be accomplished as effectively if the residency is in a community hospital some distance away from the medical centre. While medical students may be sent there on a rotational basis or permitted to go on an elective basis, there is still an implication that the family practice program is second best or non medical centre medicine.[2]

Jason has made a strong case for the full-time clinical teacher:

> It is the part time teacher who can bring the perspective of community medicine, who is exposed to some of those 249 out of 1,000 individuals per month who are ill but are not admitted to a university hospital. But, we must ask, "Is this exposure, this possession of a particular body of subject matter, sufficient qualification for medical teaching?" The unequivocal answer must be 'no'. Effective teaching requires time for planning, an intimate association with students which permits adaptation to their individual needs, and frequent contact with one's fellow instructors. Clearly, this requires that the primary burden of instruction be carried by full time teachers.[3]

In discussing the relative values of university and service practices for teaching family medicine, McWhinney has taken a middle ground.

> Either kind of practice can create a superb learning environment. Better still, the two kinds of practice can be melded into one educational programme, so that each can contribute its own particular strengths.[4]

What Is Expected of Family Physician GFTs?

GFTs are expected to provide "exemplary" patient care, be good teachers, conduct satisfactory research, capably administer their professional duties, and be wise politically.

Patient care

In providing care the academic family physician accepts the close scrutiny of specialist colleagues, residents, medical students, and service-oriented family physician colleagues. The association of experienced staff physicians, high quality residents, and other committed health professionals offers a high-quality comprehensive service to patients. But whether care is judged to be good or bad, others will usually hear about it from the judge before the one who has been judged. Most GFTs I've met would appreciate hearing from colleagues and learners when they have miscued. The most common negative criticism I've heard about GFTs practices is that patients go elsewhere when they haven't been able to receive continuous care from the doctor they regard as their own. A less common, but politically devastating, criticism is that the Family Medicine Faculty have not always responded quickly and enthusiastically to accepting patients referred by specialty colleagues.

Teaching

GFTs ought to be good teachers. What that truism means is subject to many opinions. Even the *Canadian Living* magazine has its view, and it's probably the best statement of what constitutes a good teacher that I've seen. Super teachers are characterized as follows.

They have a profound respect for each student. They are able to see potential, rather than shortcomings, in students. They accept personal responsibility for their students' learning, continually investigating new methods of teaching, and believing that different people learn in different ways. They are obsessed with learning. They listen carefully to students. They develop a "can do" orientation to learning. When their students run into difficulty, they come in to help, but only to the next step. They learn to recognize procedures in the learning setting that work against students.[5]

Others emphasize certain specific aspects of teaching:

> The teacher of practical matters must be one who experiences what he teaches.
>
> I have seen some teachers try to organize their whole style around the dropping of 'pearls' and you really cannot do that constantly—unless you are away from home a lot. What you really have to teach as a family physician is your experience. That is the "stuff" you have been building all these years, and so you have to ask yourself what you know about your own experience.[7]
>
> It is certainly a good quality in a teacher to be skeptical, but it is not a good quality to be cynical,[7]
>
> Prominent among the skills required by current physicians is the capacity to critically analyze new knowledge and when appropriate, reflect and replace old knowledge.[3]

Academics are expected to lead the way in teaching this critical analytic ability.

Research

Lack of research activity has probably been the most worrisome deficiency perceived by academic family physicians of themselves. If 'research' is defined for the academic as securing grants, conducting double-blind randomized control trials, and publishing the results in refereed journals, the great majority of all academics, not only family physicians, are failed researchers. On the other hand, research can be more broadly considered to mean gathering knowledge, looking at it and rearranging it in creative ways, and applying it in critically comparative tests; it may involve longitudinal case studies, curricular innovations, and clearly expressed curiosity well written for publication. A questioning attitude and an academic environment that encourages challenge and skepticism (but not cynicism) create a research-stimulating learning setting.

Administration

Dill reports that faculty members in major public and private universities spend an average of 17% of their professional time on committees and administrative work. These educators often find such work boring and burdensome, but the complexity of academic organizations makes committees essential devices for integrating specialized fields and activities.[8]

About one in four academic family physicians are required to accept administrative responsibility such as directing a family-practice teaching unit, serving as chief of a hospital department of family practice, directing a residency program, or chairing a department. The reward for such activities is usually to get out of some of the teaching (the activity most GFTs enjoy most), or some of the patient-care responsibilities (the area of work they enjoy next best), or some of the research expectations. The last consequence incurs the risk of being passed over by most faculty-promotions committees for lack of research and publishing endeavours. Some departments offer a financial reward for administrative work by allowing a higher income ceiling or providing a greater proportion of university "hard" money, which reduces dependence on clinical earnings.

In a study of 986 American academic family physicians, Garr found that chairpersons and residency directors were more satisfied than the aggregate of respondents with their opportunity to do administrative work and with its quality.[9]

Politics

Traditionally, the academic is expected to perform well in clinical care, administration, teaching, and research. Rarely do those writing about academic physicians mention politics. But the medical school world is full of political intrigues which would challenge the ethics of a saint. For example, a chief of family medicine in a teaching hospital was complimented by an internal hospital review com-

mittee for having presented the most comprehensive and impressive report of all clinical departments. One week later the same committee recommended the discontinuation of the family-practice ambulatory teaching unit and the 12-bed family-practice teaching unit. Six months later, after a public appeal, the premier's office advised the hospital to back off from the proposed closure of the family-medicine teaching services.

Stephens cautioned readers not to confuse political problems with academic ones. In reference to what technical procedures family physicians are allowed to do, he notes:

> We should stop trying to solve political problems among medical specialists as though they were knowledge problems. They aren't![7]

On the other hand, to avoid inappropriate defensiveness towards our colleagues, Pellegrino reminds us not to "misread the academic critique as a political one."[10] And so it is necessary to identify accurately what are primarily political issues and then deal with them as such.

How academics see it

GFTs generally enjoy most and feel best about their teaching and clinical roles. Examples taken from in-house reports written by two of my current colleagues say it very well:

> From the moment I became a GFT, my chief and continuing concern has been patient care. I have spent a great amount of time and effort to improve and maintain our services to patients. I feel, as a result, that I am able to be absent from the team for other endeavours. If at any time it became evident that patient care was being adversely affected by my absence, I would be obliged to decrease my off-team endeavours.
>
> One of the GFT's most important roles is endeavouring to create an atmosphere on the team which is conducive to effective learning. It is important, I think, to see one's self as a learning facilitator, trying as best one can to remove or minimize "road blocks". Primarily this involves efforts to ensure that patients are comfortable being taught upon, and in fact, generally supportive of the whole idea. (*John Biehn*)
>
> In brief, the teacher of family medicine should recognize the importance of his role in educating the student to a view of the patient as a whole person in his socio-cultural and physical environment at any point in this human development. (*Michael Brennan*)

The Real World of the Academic

One indirect criticism made concerning academic family physicians and university teaching practices is that they do not represent the "real world". Academic clinicians would concede that 100% of their work effort is not direct service to patients. Excluding most department heads, 50% to 90% of the work effort of GFTs in family medicine is directed to patient care, mostly within the teaching-team model, involving residents and students under supervision.

For example, in the combined two university departments of which I have been a GFT member, 27 GFTs (including two department heads and an 80/20 researcher/clinician) were responsible in the course of the 1986/87 academic year for 104,000 patient visits. These involved supervising residents for a total of 342 months. Two GFTs were on call one in three, three were on call one in four, eight were on call one in five, and nine were on call every ninth night and weekend. Two did not take call. Seventeen of these 27 GFTs do hospital obstetrics.

It has been shown that the kinds and mix of problems seen in university family practices are similar to those seen in purely service practices, including rural practices.[11] Patients seen in teaching practices require house calls, undergo surgery, enter hospital, have babies, and die. That's pretty real! Probably the main difference between family practices within and outside of the university environment is found in the nature of hospital family practice. The inability of many GFTs to provide directive in-hospital care to their patients in teaching hospitals is, to my mind, the most unsatisfactory clinical aspect of a GFT family physician's job and is in need of definitive correction. And so I concede that the GFTs practice is different, but it is most emphatically very real!

The Rewards

Satisfaction from teaching is most often cited as the primary reward of the academic family physician.

In a review of 33 family physicians who moved into full-time faculty positions after 15 years or more in private practice, Black found that the most satisfying aspects of their jobs were teaching first and patient care second.[12] In his review of 986 academics out of 214 American Family Medicine residency programs, Garr reported that 79% were pleased with the opportunities they had to teach. His review indicated, however, that their perception of the quality of their teaching was not quite so high as that of their clinical work. Chairpersons and program directors felt better about their administrative work than the rest. Research opportunities and skills were rated lowest in Garr's study, with about one respondent in five feeling satisfied with research opportunities and skills.[9]

Financially, it is difficult to compare the rewards of service practice with those of academic practice because of the valuation of fringe benefits. Again, contractual arrangements differ in each of the 16 Canadian medical faculties. Regional differences exist from province to province in both private service practices and university practices. Generally, the university department will look at the "market value" of the family physician in the city or province and begin negotiations from that starting point, assuming that the quality of clinicians to be hired as faculty is somewhat higher than average and therefore worth a proportional level of income. That level then becomes a "parity" or "average" guideline for the department, and new less-experienced recruits are brought in at some proportion below parity.

Specifically, during 1986/7, in the two departments I know best, the ceiling salary range varied from about $65 000 to about $145 000 annually as net before tax income, spanning a seniority difference of 30 years, with differing fringe-benefit packages estimated at 9%–17% of the university or "hard money" component. These "hard money" packages ranged from 35% of the net to 85%, depending mainly on administrative responsibil-

ities or "protected" research activity. Pension contributions are based on the university component, are matched according to vesting formulae which depend on years of service, and are limited in tax deductibility to salaried employee limits.

Most faculties impose ceilings on potential earnings, and the ceilings are met only if sufficient clinical earnings are brought into the department through the practices. During the two years 1985–87, all members of one of my two departments failed to make their ceilings once, and half of the members of the other department did not make their ceilings in either year. Both departments carry substantial overhead costs that must come out of clinical earnings before salaries are attended to. These costs range from 30% to 50% of gross clinical earnings, even though the university or hospitals contribute physical facilities and support staff. Such overhead costs are applied to supplement other health professionals' salaries, purchase physical supplies, finance resident travel and research projects, purchase books and underwrite social events for staff and learners and (in one centre) to pay rent.

Black noted in his study that 20 of 33 family-medicine academics noted a significant reduction in their income when they switched from private practice to academic work.[12] I personally know of no academic who quit a post primarily because of inadequate income, but I know of two practitioners being recruited for academic jobs who refused primarily because they believed that they could not afford to make the change.

Despite the practical constraints, however, 28 of Black's 33 respondents responded absolutely affirmatively to the question, "If you had it to do again, would you still make this move?"[12]

Stresses Faced by Academics

In reflecting on the role of the academic and its work-related stresses, Dill and Aluise cite three main characteristics of the academic physician's role which accumulate extraordinary stress. These are: the complexity of the role; the multiple and shifting expectations placed upon the academic physician; and the necessity to maintain currency in teaching, research, patient care, and administrative skills.[13]

The academic physician is not only a faculty member, but is also a member of a clinical department, usually a member of a particular clinical unit, and an active staff member of a hospital. Each of these positions involves its own environment, relates to its own reference group, and has its own separate set of standards.

Professional stress is created by the ambiguity of the academic work, the inherent conflicts (doctor or administrator or researcher?), and the frequent necessity to set aside one's personal values in order to teach in an objective fashion.[13]

Concerning the academic family physician, McWhinney has written:

> In the university centre, the demands of academic life are often in conflict with the task of being a family doctor. Teaching and scholarship are essential activities that must not be allowed to over-ride the personal care of patients.[4]

In reviewing the situation of 33 academic family doctors, Black found a unanimous sense of an excessive workload which added importance to qualitative aspects of work, although the hours of work were somewhat fewer in comparison with private practice. The qualitative overload, in acquiring new skills, for example, was highly threatening and detrimental to self-esteem, and the word 'depression' occurred frequently in the anecdotal descriptions of the respondents feelings. The second six months in the new position proved to be the low point after the career change. For those who were directors of programs (of which there were 15), the prime source of support during the career adjustment was the general increase they acquired in knowledge base and support given by senior faculty. For non-directors (18 persons), the prime source of support was their own family; an increase in knowledge base was rated second, and support from other junior faculty and patients equally was rated third.[12]

Clinical Supervision

"The key to learning patient management is appropriate supervision of the learner's interaction with patients."[17] One of the many new activities the new full-time teacher must learn is arm's length care: the struggle to let the learner proceed along an acceptable, but often different, management pathway from the one you would have chosen; keeping your hand off the forceps during a delivery; and letting an interview go a few more moments while the resident struggles to answer the critical question that you would have asked four minutes ago.

The feedback one receives, in return, from residents is variable and changes with variability of one's own performance and the resident's perception of one's ability to meet her/his expectations as a teacher.

The following two comments were written to me by the same resident, one during and one at the end of the residency program:

> I wonder if, when you left the office this evening, you had any idea how angry and disappointed I was today. In fact, I was so angry that I was completely unable to express this to you.

And a few months later:

> Many thanks for your time and patience over the past few years. Your contribution has made this family medicine residency a very productive and special two years.

In today's medical schools learners are afforded opportunity to evaluate their teachers. Another example follows of a resident's report on his teacher.

> I did not find him an adequate teacher for the following reasons. I was not encouraged to systematically work through a patient's problem utilizing appropriate history, physical examination and laboratory investigations to arrive at a diagnosis. Rather, I was encouraged to make rapid diagnoses and progress to treatment with conflicting and insufficient data.
>
> My evaluations, although very complimentary, helped very little in identifying my weaknesses.
>
> Overall, I think he is a fine family physician to practise independently, and his patients have a great regard for him, but I question his ability to be an effective teacher.

Promotion: Publish or Perish

Some 20 years ago, medical faculties accepted experienced family phy-

sicians right out of practice as full-time teachers, took into consideration their lack of opportunity to achieve the usual academic credentials, and allowed them high academic rank. The situation is now quite different. There are universities in Canada where highly regarded family-medicine clinicians and teachers have been terminated from faculties of medicine after seven years of work because they lacked the "academic credentials" (translate as "research and publication activities") expected of all academics. But it may be time to consider the practical priorities of medical education. McWhinney has pointed out that, "Primacy of the person may be incompatible with the primacy of publication."[4]

Educationally enlightened medical schools now recognize and actually credit teaching as a major criterion for promotion.

Experiencing Grief

> There is a different set of rewards. You do not have patients coming by and telling you what a good doctor you are. Instead, you have people criticizing you, either implicitly or explicitly. You are not sure what the rewards are.[7]

Loss of direct personal care of patients is a significant change to physicians entering academia from practice. I recall discussing with a very busy family doctor, in the late 1960s, his problem of reducing the size of his practice by a third before he brought it into the residency program as a teaching practice. The purists insisted that he systematically pull every third family record from his files. He did so, but was "caught" late one evening rescuing from the withdrawn third those patients he just couldn't send somewhere else. He later gave up academic life and returned to private practice.

For a physician, moving from the private to the academic environment involves giving up professional autonomy to accept a life under the direction of multiple authorities. It involves, as well, accepting a much greater time lag between the expenditure of work effort and the attainment of objectives. There is the likelihood of having to accept the frustration of abandoning many incomplete assignments because of multiple work challenges.

Opportunities to Prepare for Teaching

Medical teaching is less and less an amateur pursuit. Fortunately for family medicine, coming late onto the scene, the apparent need for teaching expertise and academic skills was recognized, and the Society of Teachers of Family Medicine and the Section of Teachers of the College of Family Physicians, have been major resources for teacher training and general faculty development. In addition, the Kellogg Foundation has funded graduate programs for faculty development at McGill University and the University of Western Ontario. The Kellogg money has run out, but the graduate program at Western continues to offer a Masters of Clinical Science degree in Family Medicine for physicians desiring advanced academic preparation.

There is, as well, a Section of Clinical Teachers of the Ontario Medical Association, which hopes to enhance communication for clinical teachers not only between universities but within universities. And, most recently, Dr. Ian Hart has initiated the formation of the Canadian Association for Medical Education.

Preparing to Apply for Academic Positions

David has outlined six major areas with which to evaluate prospective faculty positions in family medicine. They cover the philosophy of the institution, the department chairperson and faculty; the job description; opportunities for one's family; personal and departmental funding; faculty development; and promotion and tenure policies.[14]

Gayle Stephens has suggested a practical approach:

> If you do get involved in negotiating with a medical school, there are three questions you should ask to find out what the system is like:
> 1. How do I hire a secretary?
> 2. Where do I park my car?
> 3. How do I order paper clips?"
>
> If you get answers to those three questions, they will tell you about the personnel policies of the organization, where you stand on the totem pole, and what the purchasing procedure is.

But, as Stephens also writes, "You cannot know whether you are going to like it until you take the plunge."[15]

I have regularly been impressed with the quality of purely service-oriented family physicians in Canada. I am equally impressed with academic family physicians in Canada. They often work under less than ideal conditions, but their enthusiasm for teaching, their high standards of patient care, their administrative and research development, and their political wisdom continue to make them a strong work-force supporting family medicine's university contribution. It is a work-force any good family physician might contemplate joining, when considering career opportunities. ◉

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