

# **Faculty 2000 Clinician Educator Working Group Report and Recommendations**

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March 27, 2000

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## **I. The Clinician Educator Working Group Members**

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## **II. Summary of Recommendations**

The Clinician Educator Working Group did not achieve full consensus on the first two recommendations listed below. Accordingly, these recommendations are marked [majority opinion]; the others are marked [consensus opinion].

1. [majority opinion] Allow Health System Physicians (members of the Clinical track of the Associated Faculty who are also members of the Clinical Practices of the University of Pennsylvania) to practice full time at HUP and CHOP. The medical staff at HUP should remain closed to physicians who are not employees of the University.
2. [majority opinion] Subject to the approval of the Dean, each Clinical Chair should develop and periodically update a Faculty Allocation Plan that determines the maximum fraction of faculty members within their department who can hold Clinician Educator or Clinical track appointments

at any given time. These allocation plans should be designed to preserve the academic primacy of each department, while also taking into consideration the unique teaching and clinical service expectations and opportunities of the various disciplines within the Medical School. The departmental plans should be assembled into a Medical School Faculty Allocation Plan. This needs-based plan should serve as the basis for future Medical School recommendations to the University regarding the cap on the size of the Clinician Educator faculty.

3. [consensus opinion] Medical School and University policies and procedures regarding faculty affairs should be assembled into a cohesive document that might be called The Medical Faculty Handbook. The contents of the Handbook should include, but not be limited to, medical faculty governance, appointments, promotions, privileges, responsibilities and disciplinary actions. After approval by the Medical Faculty Senate and the Dean, the Handbook should be posted for unrestricted Internet access on the Medical School Web site and distributed to new faculty members.
4. [consensus opinion] The Medical Faculty Handbook should reaffirm the original intent of the Clinician Educator Track with a clear, current Statement of Purpose. This statement of purpose should include the following key elements:
  - a. Outstanding clinical service. By example, clinician educators set standards for the “best practice of medicine.”
  - b. Exemplary medical teaching. Clinician educators take the lead in teaching the principles and practice of clinical medicine to medical students, post-doctoral trainees and junior faculty at Penn.
  - c. Advancing the practice of medicine. Clinician educators contribute to the discovery, synthesis or dissemination of current knowledge in medicine as well as the delivery of health care services to the profession and the general public using any and all effective media for communication.
5. [consensus opinion] Expectations for promotion on the Clinician Educator track should be reformulated by the Medical School Committee on Appointments and Promotions consistent with the new Statement of Purpose. After approval by the Medical Faculty Senate and the Dean, the new criteria for promotion should be included in the Medical Faculty Handbook. These expectations and instructions should:
  - a. Emphasize the diversity of career trajectories encompassed within the Clinician Educator track.
  - b. Include as a common theme the demonstrated attainment of recognized excellence in one or more of the academic missions of the Medical School.
  - c. Define the nature and quantity of scholarship expected of clinician educators for promotion.
  - d. Replace requirements for a “regional” or “national” reputation with an expectation that clinician educators demonstrate attainment of a highly regarded reputation among established experts in their field.
  - e. Clearly delineate the differences between the Clinician Educator and Tenure tracks.

6. [consensus opinion] The benefits and privileges of promotion on the Clinician Educator Track should be reaffirmed and clearly stated in the Medical Faculty Handbook
7. [consensus opinion] Department Chairs should submit to the Dean a clear academic plan for all candidates who are considered for appointment or reappointment as Assistant Professors on the Clinician Educator track. These plans should include identification of faculty mentors and a credible statement of the time and resources available to the candidate for pursuit of his or her academic plan. Academic plans should be signed by the faculty candidate as well as the chair and appended to standard proposal letters for appointment or reappointment.
8. [consensus opinion] New mechanisms should be developed to obtain and distribute funding for faculty leadership of medical school and graduate medical education.
  - a. The University of Pennsylvania Health System should establish and maintain an Education Fund supported by annual allocations from sources identified by the Dean/CEO, including CPUP. A designated fraction of this fund should be allocated annually to the Vice Dean for Education in support of the Medical School curriculum. The remainder should be allocated to the Department Chairs for support of post-doctoral and graduate medical education. The Education Fund should be used primarily for salary and administrative support of designated faculty who organize and lead major components of the medical school, graduate school and post-graduate curriculums, such as Coordinators of Modules in the Medical School Curriculum, and Residency and Fellowship Program Directors. The Dean should report annually to the faculty on the distribution of this Fund.
  - b. The Medical School faculty should aggressively pursue new revenue-generating biomedical education services, including Internet-based distance learning and print or electronic publications for professionals and the general public.
  - c. The Medical School should develop a new category of endowed funds in support of medical and graduate education to be called Medical Educator Funds. The annual proceeds of these named funds should be used to provide partial salary support for a designated member of the standing faculty--whether Clinician Educator or Tenure track--of any academic rank who fulfills a specified leadership role in a medical school, graduate school, or graduate medical curriculum.
  - d. The Medical School should initiate a major development program to endow the educational mission of the School.
9. [consensus opinion] The structure and operation of the Medical School Committee on Appointments and Promotions (COAP) should be reexamined by the Dean in light of the changing composition of the faculty and the growing number of decisions addressed each year by the committee. Clinician Educator promotion dossiers should be primarily reviewed by at least two committee members. Consideration should be given to creating committees or sub-committees for each of the major faculty tracks.
10. [consensus opinion] The Medical School Office of Faculty Affairs should be expanded to meet the essential administrative and educational needs of a large, diverse faculty. In addition to current responsibilities, the Office should be charged with developing and implementing a professional development program for Medical School faculty that could include orientation of new faculty members, and regular faculty training programs in such areas as organizational

management, mentoring, teaching effectiveness, preparation for promotion, and management of laboratory or a clinical practice.

11. [consensus opinion] To emphasize the commonality of all standing faculty at Penn, the requirement that clinician educator faculty use modified academic titles (e.g. Associate Professor of Surgery at the Hospital of the University of Pennsylvania) should be eliminated.
12. [consensus opinion] To encourage appropriate conversions of associate or full professors from the Clinician Educator to the Tenure track, the following requirement should be deleted from the University Faculty Handbook: “Transfer from the clinician educator category to a tenured position requires a full national search” (Faculty Handbook II.B.2. Standing Faculty—Clinician Educator; Timing of Appointments and Shifts of Faculty Category.)
13. [consensus opinion] The Medical School and University Handbooks should affirm that members of the Clinical Track of the Associated faculty may apply for an available position on the standing faculty and may be appointed if qualified.
14. [consensus opinion] The Health System and Children’s Hospital of Philadelphia should invest in clinical information systems and the development of a paperless medical record to improve the productivity of the professional staff and to reduce errors and redundancy in patient care.
15. [consensus opinion] To communicate in a straightforward manner the magnitude of the educational commitment of the Medical School, the Dean should report annually the total number of student and trainee months of full-time education supported by the school in each of several major categories.
16. [consensus opinion] The Dean should name a Task Force to advise on the academic career development, responsibilities, privileges and oversight of physicians within the Clinical track of the Associated Faculty.
17. [consensus opinion] Medical Faculty Senate should create a subcommittee to recommend specific changes in the University Faculty Handbook that may be required to implement the recommendations of Faculty 2000.

### III. Charge to the Committee

In the summer of 1999, James Saunders, PhD, Chair of Faculty 2000, asked the Clinician Educator Working Group to consider broadly the purpose and structure of the Clinician Educator track within the standing faculty of the University of Pennsylvania School of Medicine after a decade of extraordinary change in health care delivery.

“What should the Clinician Educator track look like in the future to achieve its purpose and retain its academic character?”

### IV. Preamble

An enduring strength of the University of Pennsylvania is the integration of diverse approaches to the creation and dissemination of new knowledge. At its root, the University is a vehicle for discourse amongst people of myriad backgrounds and opinions on topics that cover the entire range of human activity. This philosophy is evident in the structure of this great University at every level.

Consider how this integrative approach to education permeates the University. Essentially all of the Schools are geographically contiguous, allowing for the daily contacts between scholars from diverse disciplines. The alignment and distribution of the student body in the Schools at the University of Pennsylvania is equally fluid. Students move between schools with relative ease as they craft their unique educational experiences. Programs that cross department and school bounds are common. The “unusual” student who pursues a dual degree program in disciplines which are not traditionally aligned is not unusual at Penn. Finally, consider that this University is structured with *one* standing faculty. In contrast to the faculty at some other leading research Universities, all Penn faculty face scrutiny by the same Provost Staff Conference as a condition of appointment and promotion, and all standing faculty are voting members of one University Faculty Senate.

The School of Medicine has traditionally reflected this philosophy of integration. The venues for teaching medical students, practicing medicine and performing biomedical research are coordinated across the Health System under unified leadership in a structure that encourages multidisciplinary collaboration.

The Clinician Educator tract of the University of Pennsylvania School of Medicine is a product of Penn’s integrative philosophy. This faculty tract uniquely incorporates the three academic missions of the medical school--teaching, research, and health care into one blended package. This assimilation of the art and science of Medicine is a rich and powerful paradigm that reflects a holistic approach to human biology. Clinician educators are strategically positioned to create, incorporate, use, and pass on new medical knowledge. This assimilation process has its own special value, for without this step, the translation of scientific advances into patient care proceeds at a ponderous rate.

The concept of *one University--one standing faculty*, with the clinician educator faculty as the paradigm for integration, served as the foundation for the deliberations of the Clinician Educator Working Group of the Faculty 2000 process, as represented in this document.

## **V. Process of Inquiry**

The Clinician-Educator Working Group was comprised of junior and senior faculty members of the School of Medicine and a faculty member from the School of Social Work who is also a member of the University's Senate Executive Committee. The Working Group met bi-weekly from September 1999 through February 2000. Several invited members of the University community met with the committee, including three department chairs who are clinician educators, and the current and former chairs of the Medical School Committee on Appointments and Promotions. Others were consulted informally by the Working Group co-chairs. The committee also reviewed recent published articles on clinician educators and the current Faculty Handbooks of several other research-oriented medical schools. Successive drafts of the Working Group report were widely distributed within the Medical School faculty for comment.

## **VI. Background**

### **A. Clinician Educators: A National Perspective**

The University of Pennsylvania was one of the first institutions in the country to develop a separate faculty track for clinician educators (1). Since that time, nearly three-quarters of the medical schools in the United States have followed suit. In each instance, the goal has been to integrate direct patient care with the two traditional academic missions of teaching and scholarship. The integration has been difficult, as documented by more than 50 analytical studies and commentaries on this subject published in the medical literature since 1980.

Recent descriptive studies reveal considerable diversity of structure and promotion criteria for clinician educator faculty in United States medical schools. One survey of 146 medical schools published in 1997 reported that criteria for evaluation of clinician educators most commonly include teaching skills, clinical skills, mentoring, academic administration, developing educational programs, and educational research (13). Another survey performed in 1997 reported that 71% of medical schools require evidence of scholarship for promotion on their Clinician Educator track (15). Thirty United States medical schools now have two separately defined tracks for faculty who actively participate in patient care (e.g., Clinician Educator and Clinical tracks) (15).

Commentaries published in the past ten years have focused on the growing difficulties faced by clinician educators in meeting multiple expectations, which typically include the generation of clinical revenues in addition to unfunded scholarship, teaching, hospital and practice administration, and the care of indigent patients. Several articles have drawn particular attention to the pressures faced by academic primary care physicians or by junior faculty who are also mothers of young children. Proposed solutions have included further expansion of faculty tracks, extension of the probationary period for clinician educators, modification of criteria for promotion including relaxation of the requirement for a national reputation for primary care specialists, and new methods for evaluation of teaching. Representatives of four sister medical schools who participated in the Dean's Symposium on Faculty Organization also emphasized the need for flexibility in the academic career development of clinically active medical faculty.

## **B. Origins of the Clinician Educator Track at Penn**

Faculty members who recall the initial development of the Clinician Educator track at Penn nearly 25 years ago recognize important similarities and differences between the circumstances that prevailed then and now.

In 1976, the University owned HUP and Graduate Hospitals. Medical students and house staff also trained at several affiliated hospitals, including Pennsylvania Hospital, Presbyterian Hospital and Philadelphia General Hospital (PGH). There were approximately 500 standing faculty in the Medicinal School at that time. The clinical departments were supported by the Federal Training Grants and by grants from the NIH. Clinical income was an important source of support for faculty in the surgical departments, but less so for faculty in other departments. Many faculty members worked full-time at PGH and were supported primarily by that institution.

Prior to 1976, the standing faculty of the medical school included tenured and tenure probationary faculty, and a second, smaller group who had, or were working toward, “tenure of title.” Faculty in the latter group used the title “Assistant/Associate/Professor of Clinical [Department] with Tenure of Title.” Faculty members with tenure of title were not assured a University salary; instead, they derived all of their income from clinical practice. Their academic activity consisted primarily of teaching through preceptorships, and of publishing descriptive clinical reports. At HUP, many of these individuals were members of hospital-based, private practices. These practices hired their own office staff and did their own billing and collection. Their patients comprised a significant proportion of the in-patient census.

There were problems with this faculty configuration. By the mid-1970s, the Trustees were increasingly concerned about the financial liability of a growing tenure track faculty within the medical school. At the same time, clinical Chairs were concerned that they had limited control over the quality of the patient care and teaching provided by financially independent clinical faculty. Also, their departments derived little or no financial benefit from these individuals. The pharmaceutical industry, in its relative infancy, was developing new drugs that would require clinical trials, and the need for other areas of clinical investigation beyond description of disease was becoming apparent. Finally, “the growth of public and private third-party coverage of hospital costs leading to a one-class system of medical care in which every patient would be entitled to the services of a personal and identifiable physician” provided more impetus for the school to examine the issue of whether it “should rely on a part-time volunteer faculty or a full-time, fully employed faculty for teaching and patient care.”

Faculty sentiment favored the latter approach. A new Clinician Educator track was proposed to evaluate and support fully employed clinicians within the standing faculty. The proposal gained broad support. However, controversy arose over the academic titles of faculty in the proposed track. Some faculty members thought that clinician educators should be distinguished from tenure track faculty by a modified title. In a mail ballot, the Medical School faculty overwhelmingly approved creation of a new Clinician Educator track, but split on the issue of academic title, with the majority favoring no modification of title.

Faculty outside of the Medical School supported modified academic titles for clinician educators. Many also expressed concern over the potential size of the Clinician Educator track relative to the tenure track. After much discussion, the Faculty Senate approved the new Clinician Educator track with two provisos: 1) clinician educators were to use the modified academic title,

“Assistant/Associate/Professor of [department] at [base hospital],” and 2) the Clinician Educator track could comprise no more than 25% of the standing faculty in the Medical School.

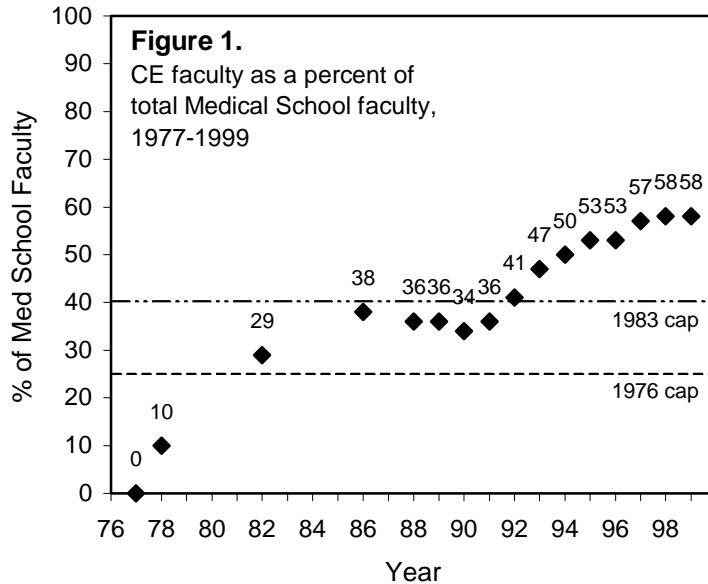
The Trustees of the University approved the new appointment category for the Medical School in May 1976, and for the three other health schools shortly afterwards, “The four health schools have found it desirable to make long-term, full-time faculty appointments to individuals whose primary responsibilities are in patient care and in the instructional programs of the University rather than in the research activities engaged in by members of the tenured and tenure-probationary faculties. These faculty members are called “clinician educators”; such a group is essential for program stability, development and continuity.” The track became part of the standing faculty in 1979. Over the next several years, most clinical members of the standing faculty in the Medical School became full-time employees of a single practice association, the Clinical Practices of the University of Pennsylvania (CPUP).

The initial description of the Clinician Educator track included a ten-year probationary period leading to a faculty appointment of *indefinite* duration, guidelines concerning eligibility for transfer between the two tracks of the standing faculty, and the general criteria for promotion.

The Medical School Committee on Appointments and Promotions established additional criteria for faculty rank. Clinician educators required the same standard of teaching performance as faculty on the tenure track. Unspecified special importance was attached to the evaluation of clinical performance. Specialty certification; membership and participation in local, national and international professional organizations; election to honorary offices; invitations to speak at national or international seminars, courses and symposia; and/or contributions to the literature were to be used to document national recognition for promotion into the two senior ranks.

**C. Growth of the Clinician Educator Track at Penn**

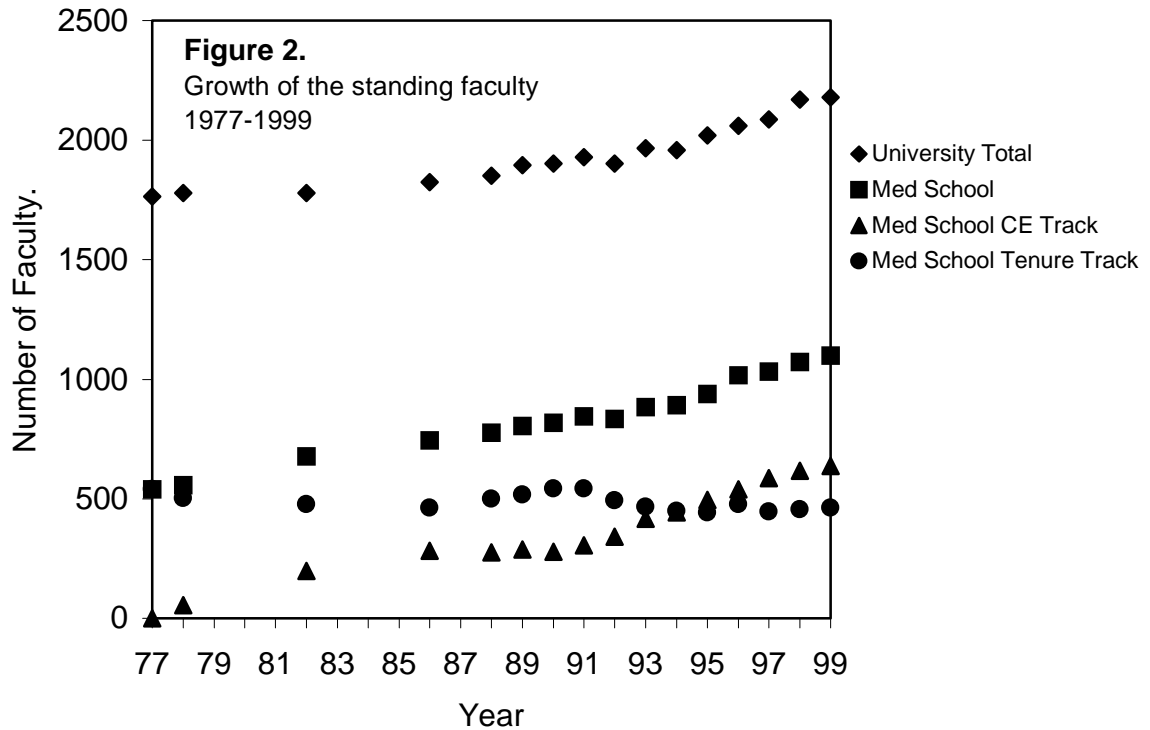
From the time of inception, the Clinician Educator track expanded steadily in response to growing needs for clinical service at the teaching hospitals and growing opportunities for clinical research. Some clinical department chairs appointed virtually their entire faculty into the Clinician Educator track in order to avoid a two-tier system within their departments.

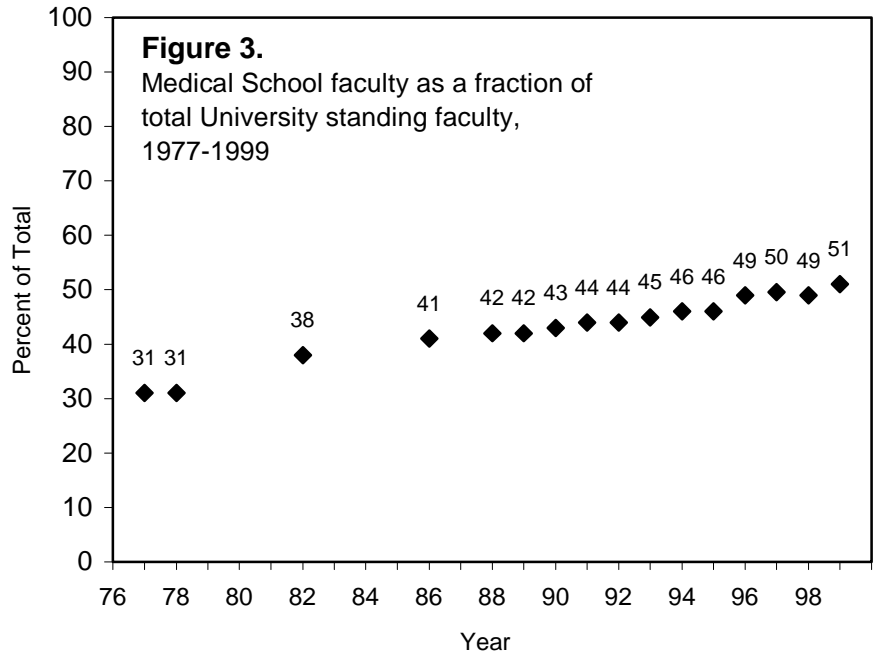


By 1982, it became clear that the 25% cap would not be practical (Figure 1). Some suggested that the cap be eliminated altogether, but the University faculty worried that this would threaten the concept of tenure. An increase of the cap to 40% was approved in 1983 by a vote of the University Senate in a meeting that was particularly well attended by the medical faculty. This “meeting of the white coats” is still remembered as an indication of the potential importance of the clinician educator faculty in University governance.

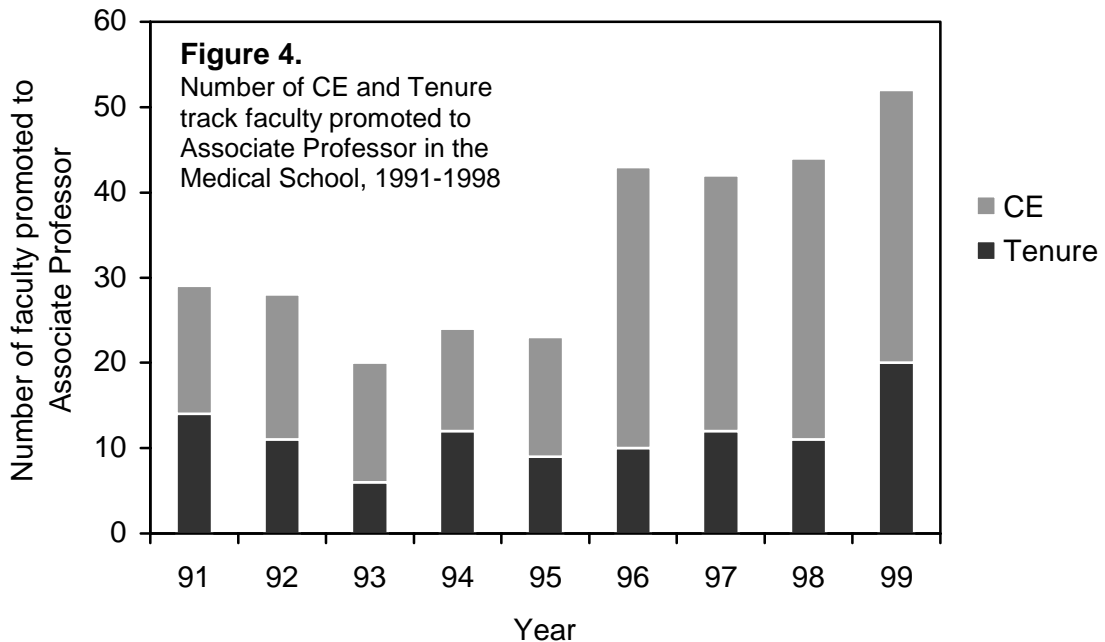
As the Health System developed in the early 90’s, an even greater increase in demand for clinical services led to a substantial increase in the number of junior faculty recruited into the Clinician Educator track. The 40% cap was breached by 1993. In 1997, when the Clinician Educator track reached 58% of the total standing faculty in the medical school, the Chair of the University Faculty Senate wrote a letter to the Provost drawing attention to the 40% cap. The Provost threatened to freeze appointments to the Clinician Educator track in the Medical School until the cap was restored. The need for a response to this concern was one major consideration that gave rise to the Faculty 2000 initiative.

Examination of Figure 2 shows that all of the growth of the standing faculty at Penn since 1977 can be attributed to expansion of the Clinician Educator track within the Medical school. The size of Medical School faculty in the Tenure track actually declined during that time. As a consequence of the growth of the Clinician Educator track, the Medical School faculty now constitutes the majority of all standing faculty in the University (Figure 3).





Examination of Figure 4 suggests that the Clinician Educator track is likely to continue growing relative to the Tenure track in the foreseeable future. During the past four years, clinician educators have comprised approximately two-thirds of the standing faculty who were appointed or promoted to the rank of Associate Professor in the Medical School.



**D. Changing Expectations of Clinician Educators at Penn**

In addition to growing, the Clinician-Educator track has evolved considerably in other ways over the years, and especially during the past decade. From the mid-1970 through the late 1980's,

generous third-party payments for health care services allowed academic physicians to cover their salaries, teach and participate in clinical scholarship. In fact, clinical revenues more than replaced the loss of funding for clinical departments that occurred after the closure of Philadelphia General Hospital in 1977 and the termination of training grants for house staff training, thereby fueling further growth of academic programs.

Rapid expansion of managed care in the early 1990's dramatically slowed the annual rate of increase of payments for clinical services. This, plus heightened competition for NIH funding, created new pressures on faculty performance and productivity, both locally and nation-wide.

Expectations of the medical faculty at Penn changed accordingly. When William Kelley was recruited to lead the medical school in 1989 he brought to Penn a new model for allocation of faculty effort that was designed to improve productivity in research and patient care. Tenure track faculty members were expected to devote fully 80 % of effort to funded research, while clinician educators were to commit 80% of effort to revenue-generating health care service. Dr. Kelley also introduced financial incentives to reward faculty members who were highly productive in generating research or clinical revenues.

These two changes dramatically increased faculty productivity as measured by extramural research funding and professional service units. However, other academic activities suffered as a consequence. Department chairs and individual faculty were left to find support and time for teaching, administration and unfunded scholarship, with varying results. Indeed, these essential academic activities are increasingly viewed as "inefficiencies" to the extent that they restrain generation of clinical and research revenues. For example, recent studies have shown that teaching in an ambulatory care setting reduces clinical productivity by an average of 20 percent.

During the past five years, revenues for clinical professional services have declined sharply relative to the cost of living in Philadelphia as the two dominant private health insurers have taken full advantage of a perceived surplus of physicians in this region. The number of uninsured patients has increased as well, particularly within the inner city. Physicians must see many more patients in a day to compensate for lower fees and lower collection rates. Requirements for documentation of clinical services have also increased to the extent that some clinicians now spend two or more hours a day writing in medical charts.

Criteria for academic promotion of practicing physicians have not been modified at Penn to compensate for new expectations of higher clinical productivity. Indeed, rapid, continued growth of the Clinician Educator track and new opportunities for extramural funding of methodologically rigorous clinical research may be having the opposite effect. Many senior faculty members believe that standards for promotion on the Clinician Educator track are higher currently than ever before, particularly for the minimum quantity and quality of publications expected for promotion.

Today, many clinician educators at Penn feel torn between the high expectations of a great research University on the one hand and the inescapable needs of a beleaguered Health System on the other. Primary care specialists in particular report that they are no longer able to cover their salaries by caring for patients while also earning a national reputation for excellence in clinical scholarship. Unsustainable pressures on clinician educators to meet multiple expectations at the interface between the University and the Health System provided a second major impetus for the development of the Faculty 2000 initiative.

## **E. Problems with the Clinician Educator Track At Penn**

In preparing this report, members of the Clinician Educator Working Group spoke with many members of the University and Health System communities, including more than 50 clinician educators. In these conversations, members of the Working Group uncovered several perceived problems with the Clinician Educator faculty track, as summarized below.

### ***Problems perceived by faculty within the clinician educator track***

1. Time available to clinician educators for unfunded effort (teaching, scholarship, administration) is diminishing, while expectations for these contributions are remaining the same or increasing. Faculty members have responded by increasing work hours to the point that those who have substantial family responsibilities are increasingly disadvantaged. As pressure grows, the quality and quantity of unfunded effort is compromised. Faculty career satisfaction and fulfillment suffer as a consequence.
2. The criteria for promotion on the clinician educator track are discordant with the actual responsibilities of many clinician educators. Funded clinical and laboratory investigators are evaluated for promotion according to work they are paid to perform, whereas clinicians are evaluated, to a considerable extent, according to work they perform on their own time. Expectations for a professional reputation outside of the Philadelphia area are inherent in some faculty career trajectories, but not in others, particularly within the primary care fields.
3. The criteria for promotion on the clinician educator track seem to vary over time. The expectation for scholarship is particularly ill defined and variable.
4. Faculty mentoring is well developed for funded investigators, but not for academic clinicians, and is inconsistently available across divisions and departments.

### ***Problems perceived by clinical chiefs and chairs***

1. The structure of the Medical School faculty no longer provides clinical chiefs and chairs with sufficient flexibility to sustain excellence in research, teaching and clinical service. In particular, certain health care needs at HUP and CHOP are no longer well served by standing faculty who must divide clinical effort with academic responsibilities.
2. In the past, resourceful chiefs and chairs covered the costs of medical and graduate education primarily by redistributing clinical revenues. This is no longer uniformly possible at the division or department levels. New funding distribution methods and new sources of funding are needed to preserve educational excellence across the various disciplines.

### ***Problems perceived by faculty in other schools at Penn***

1. The fraction of Medical School standing faculty within the Clinician Educator track (58%) now substantially exceeds the cap set in the Faculty handbook (40%). Current trends project an even higher fraction of clinician educators in the future. Perpetuation of this discrepancy undermines the integrity of University policy as set forth in the Handbook.
2. The size of the clinician educator faculty in the medical school threatens the balance of representation of other faculty in University governance.

3. Current or potential future compromises in expectations for promotion of clinician educators threaten the academic standards of the entire standing faculty.

## **F. Specific Objectives of the Working Group**

After considering the problems described above, the Working Group identified several objectives for improving the Clinician Educator track. These are summarized below.

1. Bring expectations for promotion on the Clinician Educator track into closer alignment with actual faculty “job descriptions.”
2. Improve the clarity, consistency and accessibility of criteria for promotion on the Clinician Educator track and improve the perceived fairness of the promotion process.
3. Increase flexibility for individual faculty in pursuit of clinical academic careers and for chiefs and chairs in meeting the three academic missions of their divisions and departments.
4. Address University-wide concerns about the growing size of the Clinician Educator faculty relative to the tenure track faculty.
5. Secure adequate, stable funding for medical student and graduate medical education.

## **VII. Recommendations and Discussion**

The most appropriate response to first four objectives listed above proved highly controversial within the Working Group. A number of possible solutions were considered. These coalesced into the three possible approaches summarized below:

- Considerably expand the criteria for promotion in the Clinician Educator track to encompass the breadth of interests, skills and achievements necessary to meet all of the health service and educational needs of the Medical School and the Health System in an era of rapid and continuing change. By this approach, promotion on the Clinician Educator track would recognize demonstrated, sustained excellence in one or more of the three academic missions of the Medical School. All standing faculty, including clinician educators, would be expected to enhance the reputation of the University, either locally or nationally.
- Allow Clinician Educator faculty to serve indefinitely as Assistant Professors on the standing faculty. To address University faculty concerns about the disproportionate size of this faculty track, clinician educators might be granted a reduced vote in University governance, for example, 0.4 of a vote.
- Preserve scholarship as the unifying theme of the standing faculty at Penn, but carefully reexamine the meaning of scholarship for clinician educators who are also expected to achieve and sustain definitive expertise in health care. To increase flexibility, allow Health System Physicians to practice full-time practice at HUP and CHOP, subject to the limits of a pre-approved faculty allocation plan. Keep HUP closed to practitioners who are not employees of the University. Identify and implement “safeguards” to ensure that

the academic purpose and character of the Clinician Educator track are preserved and that promotion on this track remains desirable and achievable.

Problems were identified with all three general approaches. The committee recognized that successful implementation of the first approach (expansion of criteria for promotion) might require a separate Provost or Vice Provost for the health schools so that final decisions on appointment and promotion of clinician educators would be made by faculty who have first-hand understanding of the imperatives of careers in health care service. Likewise, the second approach (elimination of a probationary period for clinician educator assistant professors) has succeeded elsewhere primarily at institutions such as Harvard and Johns Hopkins where final decisions on faculty appointments and promotions are made by the individual schools, not by the University Provost. Both of these approaches undermine the concept of *one University--one standing faculty* that served as a foundation for the Working Group discussions.

The third approach also generated important concerns. Some members of the committee believe that the viability and vitality of the Clinician Educator track may be destroyed over time if HUP and CHOP are opened to the full time practice of Health System Physicians. Essential functions of the Clinician Educator track, including clinical leadership and teaching, may also be adversely affected (see additional discussion below).

No consensus was achieved. However, after much discussion, a strong majority of the committee supported the third approach, tempered by a combination of “safeguards” designed to preserve and protect the Clinician Educator track, including additional funding for education.

All members of the committee believe that new mechanisms are needed to secure and distribute funds for faculty leadership of medical and graduate education.

The recommendations listed below are marked either [majority opinion] or [consensus opinion] to reflect the opinions of the Clinician Educator Working Group. Each recommendation is followed by a brief discussion.

### **Specific Recommendations**

- 1. [majority opinion] Allow Health System Physicians (members of the Clinical track of the Associated Faculty who are also members of the Clinical Practices of the University of Pennsylvania to practice full time at HUP and CHOP. The medical staff at HUP should remain closed to physicians who are not employees of the University.***

#### Discussion

Presently, Health System Physicians are prohibited from devoting more than 20 percent of clinical effort to practice at HUP or CHOP. Adoption of this recommendation will allow Health System Physicians to practice at the University’s core teaching hospitals without limitation on their fraction of clinical effort at those hospitals.

This policy change should allow clinical chiefs and chairs additional flexibility in pursuing all three academic missions of the Medical School at the core teaching hospitals. The availability of Health System Physician appointments at HUP and CHOP should also offer new, junior faculty additional flexibility in shaping their own careers. Gifted physicians will be enabled to pursue distinguished careers in full-time patient care at HUP and CHOP. In turn, clinician educators should be less constrained by clinical service commitments in pursuit of their academic careers.

In addition, a modest shift of faculty from the Clinician Educator to the Clinical track at the core teaching hospitals should help restore the 40 percent ratio between Clinician Educator and Tenure track faculty that is specified currently in the University Faculty Handbook.

While recognizing these potential benefits, some members of the Working Group expressed concern that expansion of the Clinical track will endanger the long-term viability of the Clinician Educator track at HUP. They fear that differences between the two career pathways in obligations and rewards, including compensation, will favor continued growth of the Clinical track at the expense of the Clinician Educator track. Especially in highly focused fields, conversion of even one or two positions to the Clinical track could leave an insufficient cohort of standing faculty to cover teaching and leadership responsibilities. Over a number of years, the Clinician Educator track could virtually disappear.

Opponents point to previous experience at the University of Michigan where introduction of a Clinical track caused a rapid retrenchment of the clinician educator faculty, and to current experience within the Cardiovascular Division at Penn. This division currently consists of two largely independent practices, one comprised of standing faculty members at HUP; the other primarily of Health System Physicians who admit patients to Presbyterian Medical Center. The two practices have different leadership, different referral patterns and different compensation plan. Only the rule prohibiting full time practice by Health System Physicians at HUP prevents these two practices from competing head-to-head for patients at the University's core adult teaching hospital.

Other senior faculty point to recent experience at CHOP as evidence that academic and full-time clinicians can coexist harmoniously at a University teaching hospital.

The majority of Clinician Educator Working Group members believe that the key to maintaining appropriate balance between three faculty tracks at HUP and CHOP lies in thoughtful, disciplined implementation of the proposed policy change. Also, if responsibility for essential, non-revenue generating functions of the faculty, such as teaching and clinical administration, is to be distributed unequally across faculty in the three tracks, adequate funds must be pooled and allocated to support those who contribute a disproportionate share of this effort.

Many of the recommendations that follow are designed to protect, preserve and strengthen the Clinician Educator track and the essential functions it serves in the event that Clinical track faculty are allowed to practice full time at the University's core teaching hospitals.

2. ***[majority opinion] Subject to the approval of the Dean, each Clinical Chair should develop and periodically update a Faculty Allocation Plan that determines the maximum fraction of faculty members within their department who can hold Clinician Educator or Clinical track appointments at any given time. These allocation plans should be designed to preserve the academic primacy of each department, while also taking into consideration the unique teaching and clinical service expectations and opportunities of the various disciplines within the Medical School. The departmental plans should be assembled into a Medical School Faculty Allocation Plan. This needs-based plan should serve as the basis for future Medical School recommendations to the University regarding the cap on the size of the Clinician Educator faculty.***

### Discussion

The School of Medicine as a whole, as well as each individual department within the School, has an obligation to provide a balanced blend of clinical service, teaching and research. No individual department can be allowed to ignore any one of these three necessary components. A department, that focuses only on service and teaching to the exclusion of research, has failed in its academic mission of advancing scholarship.

The blend of these three components will certainly vary by discipline. The Clinician Educator Working Group recommends that each individual department establish a goal-based faculty allocation plan for the relative distribution of Tenure, Clinician Educator, and Clinical tract faculty within the department. The Working Group further recommends that this plan be periodically reviewed and approved by the Dean. No department should be permitted to neglect any one of the three academic missions.

3. ***[consensus opinion] Medical School and University policies and procedures regarding faculty affairs should be assembled into a cohesive document that might be called *The Medical Faculty Handbook*. The contents of the Handbook should include, but not be limited to, medical faculty governance, appointments, promotions, privileges, responsibilities and disciplinary actions, After approval by the Medical Faculty Senate and the Dean, the Handbook should be posted for unrestricted Internet access on the Medical School Web site and distributed to new faculty members.***

### Discussion

Over the years, the Medical School has developed and modified a number of separate policies and procedures regarding faculty affairs that augment the University Faculty Handbook. For example, three separate statements have been issued in recent years on criteria for promotion in the Clinician Educator track. There are gaps, overlaps and discrepancies among the separate documents, which are not readily assessable to the faculty.

Our Medical School should follow the lead of other comparable schools by assembling and maintaining the relevant policies and procedures into a single document that is updated regularly and assessable by Internet. Examples of Medical School Faculty Handbooks at other institutions include:

- Duke University Medical Center Faculty Handbook:  
[www2.mc.duke.edu/admin/aa/handbook/faculty/org\\_rank.htm](http://www2.mc.duke.edu/admin/aa/handbook/faculty/org_rank.htm)
- University of Michigan Medical School Faculty Handbook:  
[www.med.umich.edu/medschool/faculty/handbook/appointments.html](http://www.med.umich.edu/medschool/faculty/handbook/appointments.html)
- Johns Hopkins University School of Medicine Goldbook:  
[wysiwyg://5http://infonet.welch.jhu.edu/policy/goldbook/iv.html](http://wysiwyg://5http://infonet.welch.jhu.edu/policy/goldbook/iv.html)
- Harvard Medical School Purple Book:  
<http://www.hms.harvard.edu/fa/faculty.html>

In keeping with general principles of University governance, the policies and procedures described in the Medical Faculty Handbook should be subject to approval by the Medical Faculty Senate as well as the Dean and should be subservient to the University Faculty Handbook. Appropriate resources must be made available by the Dean to update and maintain the Handbook.

4. ***[consensus opinion] The Medical Faculty Handbook should reaffirm the original intent of the Clinician Educator track with a clear, current Statement of Purpose. This statement of purpose should include the following key elements:***
  - a. ***Outstanding clinical service. By example, clinician educators should set standards for the “best practice of medicine.”***
  - b. ***Exemplary medical teaching. Clinician educators take the lead in teaching the principles and practice of clinical medicine to medical students, post-doctoral trainees and junior faculty at Penn.***
  - c. ***Advancing the practice of medicine. Clinician educators contribute to the discovery, synthesis or dissemination of knowledge in medicine as well as the delivery of health care services to the profession and the general public using any and all effective media for communication.***

#### Discussion

The Clinician Educator tract was created at Penn nearly 25 years ago out of a perceived deficit in the University’s ability to retain and promote excellent clinicians and teachers who also participate in meaningful scholarship. The Clinician Educator tract identifies those faculty members who seek to participate simultaneously in all three aspects of the School’s mission, i.e. teaching, research, and patient care. The Clinician Educator tract faculty, through this integration, provide the fundamental “glue” which holds together the concept of an integrated academic medical center. This adhesion process is not duplicated in any other component of the faculty.

A clear Statement of Purpose is needed to define and preserve the Clinician Educator track through a period of rapid, unpredictable change in health care and organization. After approval by the Medical Faculty Senate and the Dean, the Statement of Purpose should be included in the Medical Faculty Handbook.

5. ***[consensus opinion] Expectations for promotion on the Clinician Educator track should be reformulated by the Medical School Committee on Appointments and Promotions consistent with the new Statement of Purpose. After approval by the Medical Faculty Senate and the Dean, the new criteria for promotion should be included in the Medical Faculty Handbook. These expectations and instructions should:***
  - a. ***Emphasize the diversity of career trajectories encompassed within the clinician educator track.***
  - b. ***Include as a common theme the demonstrated attainment of demonstrated excellence in one or more of the academic missions of the Medical School.***
  - c. ***Define the nature and quantity of scholarship expected of clinician educators for promotion.***

- d. Replace requirements for a “regional” or “national” reputation with an expectation that clinician educators demonstrate attainment of a highly regarded reputation among established experts in their field.*
- e. Clearly delineate the differences between the Clinician Educator and Tenure tracks.*

### Discussion

Scholarship and teaching are the themes common to the entire standing faculty at the University. Without these functions, it becomes difficult to recognize clinical faculty as providing a societal function distinct from that of non-academic practitioners. The scholarly activity of clinician educators may, however, have a broader demonstration than the scholarship expected of tenure tract faculty. Some clinician educators may contribute to the development of new knowledge or ideas; others may excel in synthesizing current knowledge for targeted audiences. In addition to peer-reviewed publications, scholarship in the Clinician Educator tract may take a variety of other forms, including published chapters, reviews, books, practice guidelines, symposia, videos, web publications, interactive software and publications in the lay press. All of these vehicles should be recognized as scholarship if they convey or disseminate new knowledge.

While the essential nature of Clinician Educator tract is to blend the missions of teaching, scholarship and clinical service, individual faculty may emphasize one or more of these missions. The demonstration of excellence, which is a requirement for promotion at the University of Pennsylvania, need not be distributed equally across all three missions.

Recognition of broadly defined scholarship and flexibility in documentation of excellence will allow for support of multiple prototypical pathways in the Clinician Educator tract, as recently enumerated by the Medical School. .

As institutions have consolidated, the requirement for academic “regional” or “national” referees not aligned with the Health System has become problematic. This artificial requirement should be replaced with an expectation that clinician educators demonstrate attainment of a highly regarded reputation among professional peers for outstanding clinical service and the discovery, synthesis or dissemination of knowledge. Highly regarded clinicians should be afforded commentary on service activities; physicians performing translational research should comment on investigative aspects; and educators should critique progress in teaching without strict adherence to geographic bounds.

Currently the distinction between the Clinician Educator and the Tenure tracks is perceived as an arbitrary and moveable line along a continuum of faculty career trajectories. As a consequence, faculty near the edge--particularly those engaged in patient-oriented research--tend to “play it safe” by choosing the Clinician Educator track. This tendency may help to explain the lack of growth of the tenure track within the Medical School since 1977. A clear, consistent statement of the difference between the two tracks will be even more important in the future if HUP and CHOP are opened to Clinical track faculty.

To avoid perceptions of a two-class standing faculty, the distinction should not be based on quality or quantity of scholarship alone. An alternative foundation for the distinction between the two tracks could be based on examination of a faculty member’s core competency. For example, at the time of consideration for promotion, Tenure track faculty members might be expected to demonstrate that they can sustain and financially support a career devoted primarily to

scholarship. In contrast, Clinician Educator track faculty might be expected to demonstrate that they can financially support themselves by providing a clinical service. In other words, if all other sources of income are lost, can this individual earn a living as a health care provider? By this approach, only occasional individuals would be eligible for promotion on either track.

- 6. [consensus opinion] The benefits and privileges of promotion on the Clinician Educator Track should be reaffirmed and clearly stated in the Medical Faculty Handbook.***

#### Discussion

The opening of HUP and CHOP to Clinical track faculty will introduce a new choice of faculty tracks to physicians considering appointments at one of those hospitals. To encourage consideration of the Clinician Educator track by appropriate candidates, the relative benefits of promotion on the standing faculty should be clearly defined and communicated.

In contrast to Clinical Track faculty, promoted clinician educators receive appointments of indefinite duration. As members of the standing faculty, promoted clinician educators are not to lose their academic titles or hospital privileges except by due process, unless they leave the University or retire. Promotion on the Clinician Educator track does not guarantee a salary, but does allow the opportunity to earn a salary supported by extramural funds, payments for professional services, and funded teaching or administrative effort. As standing faculty, clinician educators are members of the Medical School and University Faculty Senates.

- 7. [majority opinion] Department Chairs should submit to the Dean an academic plan for all candidates who are considered for appointment or reappointment as Assistant Professors on the Clinician Educator track. These plans should include identification of faculty mentors and a credible statement of the time and resources available to the candidate for pursuit of his or her academic plan. Academic plans should be signed by the faculty candidate as well as the chair and appended to standard proposal letters for appointment or reappointment.***

#### Discussion

In the past, some physicians were appointed to the Clinician Educator track without a clear academic plan, expressly to meet pressing clinical service needs. As pressures for clinical productivity increased, some worked primarily on free nights and weekends to pursue promotion. Others left the University shortly after establishing their reputations because they were unable to develop quality scholarship around heavy clinical service commitments.

The opening of HUP and CHOP to the Clinical track provides an opportunity to restore a direct relationship between faculty job assignments and expectations for promotion without compromising the clinical mission of the Medical School. New appointments to the Clinician Educator track should be limited to those that can be supported by adequate time and resources for academic career development.

- 8. [consensus opinion] New mechanisms should be developed for obtaining and distributing funding for faculty leadership of medical school and graduate medical education.***

- a. The University of Pennsylvania Health System should establish and maintain an Education Fund supported by annual allocations from sources identified by the Dean/CEO, including CPUP. A designated fraction of this fund should be allocated annually to the Vice Dean for Education in support of the Medical School curriculum. The remainder should be allocated to the Department Chairs for support of post-doctoral and graduate medical education. The Education Fund should be used primarily for salary and administrative support of designated faculty who organize and lead major components of the medical school, graduate school and post-graduate curriculums, such as Coordinators of Modules in the Medical School Curriculum, and Residency and Fellowship Program Directors. The Dean should report annually to the faculty on the distribution of this Fund.***
- b. The Medical School faculty should aggressively pursue new revenue-generating biomedical education services, including Internet-based distance learning and print or electronic publications for professionals and the general public.***
- c. The Medical School should develop a new category of endowed funds in support of medical and graduate education to be called Medical Educator Funds. The annual proceeds of these named funds should be used to provide partial salary support for a designated member of the standing faculty--whether Clinician Educator or Tenure track--of any academic rank who fulfills a specified leadership role in a medical school, graduate school, or graduate medical curriculum.***
- d. The Medical School should initiate a major development program to endow the educational mission of the School.***

### Discussion

Since Lloyd Zackery and Thomas and Phineas Bond, the first three physicians to practice medicine at Pennsylvania Hospital, charged apprentices one English guinea per year for clinical training, Philadelphia physicians have struggled to find adequate time and funding for teaching. After a decade of cutbacks in payments for physician services, accompanied by continued increases in practice overhead expenses, the problem is particularly acute at Penn today. The medical faculty are concerned that the preeminence of the nation's first medical school could be lost if adequate funding is not secured in continuing support of faculty efforts to plan, organize and implement our major curriculums.

Currently, the faculty does not know how much money the Health System allocates to medical education each year, or how that money is distributed. The development of a pooled Education Fund will promote systematic allocation of available resources and improve accountability at all levels for utilization of the funds. To ensure continuity of major teaching programs, every effort must be made to maintain or increase the size of the Education Fund from year to year.

The faculty should join the administration in identifying and aggressively pursuing potential new sources of income for the educational mission of the Medical School, such as the new Penn medical education web site, Educate.MD.

In the long run, the Medical School will best be served by development of a substantial endowment in support of medical and graduate education. A major, sustained development program will be necessary to establish this endowment.

One objective of this development campaign should be the creation of 50 Medical Educator Funds. If the minimum endowment required to establish each of these funds is set at approximately one half of that required for a Chaired Professorship, these named endowments will fill an important gap in our current portfolio of named gift-giving options. Medical Educator Funds may emerge as a particularly attractive gift-giving option for retiring faculty and grateful patients.

To ensure that these funds are used continuously for their intended purpose, they should be awarded for a pre-determined, renewable term. The non-monetary value of these funds can be enhanced by attaching an academic title to each award that is distinct from the titles used by chaired professors. For example, a recipient might be known as:

Jane Smith MD, PhD  
Joan D. and John H. Brown Medical Educator  
Associate Professor of Surgery

9. *[consensus opinion] The structure and operation of the Medical School Committee on Appointments and Promotions (COAP) should be reexamined by the Dean in light of the changing composition of the faculty and the growing number of decisions addressed each year by the committee. Clinician Educator promotion dossiers should be primarily reviewed by at least two committee members. Consideration should be given to creating committees or sub-committees for each of the major faculty tracks.*

#### Discussion

The number of decisions on faculty appointments, retentions and promotions considered annually by the Medical School COAP has increased dramatically over the past decade. The size of the Committee has not.

The ratio of Clinician Educator to Tenure track appointment and promotion decisions considered by the COAP now exceeds 2:1. Yet the ratio of Clinician Educator to Tenure track faculty on the COAP remains at 1:2.5.

Currently, one member of the Medical School COAP reads complete promotion dossiers for Clinician Educator promotion candidates. In contrast, selected Ad Hoc committee reviews tenure track promotion dossiers. Penn admission committees and NIH study sections likewise assign a minimum of two or three members to the primary review of all submissions.

For these and other reasons, some members of the Clinician Educator faculty question whether COAP decisions are consistently thorough and fair. The structure and process of the Medical School COAP should be reviewed and modified as necessary to restore the full confidence of the faculty.

10. *[consensus opinion] The Medical School Office of Faculty Affairs should be expanded to meet the essential administrative and educational needs of a large, diverse faculty. In addition to current responsibilities, the Office should be charged with developing and implementing a professional development program for Medical School faculty that could include orientation of new faculty, and regular faculty training programs in such areas as organizational management, mentoring, teaching effectiveness, preparation for promotion, and management of a laboratory or a clinical practice.*

Discussion

A strong, effective Office of Faculty Affairs is essential to implement the recommendations of Faculty 2000 and to maintain a vigorous “faculty politic” within the Medical School. The Office is under funded for this purpose. Additional staff and resources are needed to meet current commitments, and would enable the Office to plan and coordinate a professional development program for the faculty comparable to that offered at several other leading medical schools.

- 11. [consensus opinion] To emphasize the commonality of all standing faculty at Penn, the requirement that clinician educator faculty use modified academic titles (e.g. Associate Professor of Surgery at the Hospital of the University of Pennsylvania) should be eliminated.**

Discussion

The upcoming twenty-fifth anniversary of the Clinician Educator Track at Penn provides an opportunity to celebrate the extraordinary academic contributions and vitality of this faculty group by removing the distinction of title between Clinician Educator and Tenure faculty. Let there be one, united standing faculty at Penn.

- 12. [consensus opinion] To encourage appropriate conversions of associate or full professors from the Clinician Educator to the Tenure track, the following requirement should be deleted from the University Faculty Handbook: “Transfer from the clinician educator category to a tenured position requires a full national search” (Faculty Handbook II.B.2. Standing Faculty—Clinician Educator; Timing of Appointments and Shifts of Faculty Category.)**

Discussion

After promotion to associate professor, some clinician educator faculty members change the focus of their careers toward scholarship to the extent that they become appropriate candidates for tenure. When the departmental Faculty Allocation Plan allows, conversion of these individuals to the Tenure track should be encouraged to preserve the separate identities of the two tracks and to improve the balance between them. The requirement for a pro forma national search unnecessarily inhibits these conversions.

- 13. [consensus opinion] The Medical School and University Handbooks should affirm that members of the Clinical Track of the Associated faculty may apply for an available position on the standing faculty and may be appointed if qualified.**

Discussion

Current University policy neither prohibits nor sanctions conversion from the Clinical track to the Clinician Educator or Tenure track. To preserve and regulate this important option, the process for conversion should be clearly defined in the University and Medical Faculty Handbooks.

This provision allows individual medical faculty additional flexibility in pursuing an academic career without compromising expectations for promotion on the standing faculty. For example, a mother of three young children can remain active and current in the practice and teaching of clinical medicine on a limited work schedule until her children reach school age. Then, with the support of her department chair, she can assume additional responsibilities and set new personal

goals by applying for an available position on the standing faculty and pursuing promotion within the usual probationary period.

Faculty should not be allowed to game this option by switching from the Clinician Educator track to the Clinical track and then back again to the Clinician Educator track, except under exceptional circumstances.

14. ***[consensus opinion] The Health System and Children’s Hospital of Philadelphia should invest in clinical information systems and the development of a paperless medical record to improve the productivity of the professional staff and to reduce errors and redundancy in patient care.***

Discussion

Clinical staff productivity has not been a major priority of the core teaching hospitals at Penn in recent years. The lack of a unified, accessible, electronic medical record hinders the efficient provision of medical care and slows clinicians down considerably. Experience at other institutions suggests that well-designed clinical information systems can considerably improve professional productivity, thereby freeing faculty time for teaching and scholarship.

15. ***[consensus opinion] To communicate in a straightforward manner the magnitude of the educational commitment of the Medical School, the Dean should report annually the total number of student and trainee months of full-time instruction supported by the school in each of several major categories.***

Discussion

Few members of the University community and still fewer government leaders understand the magnitude of the educational commitment of the Medical School. Many have asked, “Why does the Medical School need so many faculty to teach 600 medical students and a limited number of graduate students?”

Attempts to count the total number of faculty teaching hours are methodologically complex and subject to controversy. An alternative approach is to count the annual number of full-time student and trainee months in various categories supported by the faculty. For example, each resident at Presbyterian Medical Center would add 12 months to the annual total for graduate medical education. The grand total number of student and trainee months of full-time instruction supported by the Medical School might compare favorably to the total supported by the rest of the University combined.

In addition to documenting the educational commitment of the Medical School, the number of student and trainee months of full-time instruction might serve as a basis for distributing the Education Fund:

16. ***[consensus opinion] The Dean should name a Task Force to advise on the academic career development, responsibilities, privileges and oversight of physicians within the Clinical track of the Associated Faculty.***

Discussion

After careful consideration, the Faculty 2000 Steering Committee concluded that Clinical Track faculty issues fell beyond the scope of this initiative. Nevertheless, a pressing need is recognized

to further define this important group. In addition to their health care contributions, the Clinical track faculty currently supports office-based and bedside teaching to a degree that is not widely recognized within the Medical School or the University. Nevertheless, the University Faculty Handbook currently contains only one paragraph on the responsibilities and privileges of faculty in the Clinical track. That paragraph was last updated in 1983. Additional documents developed more recently within the Medical School regarding Health System Physicians leave key issues unaddressed. The proposed opening of HUP and CHOP to Clinical track faculty will create important additional concerns.

Shortly after Faculty 2000 is completed, a separate Task Force should be named by the Dean to advise on the further development of this vital but relatively undefined track within the Medical School faculty.

- 17. [consensus opinion] Medical Faculty Senate should create a subcommittee to recommend specific changes in the University Faculty Handbook that may be required to implement the recommendations of Faculty 2000.***

## **VIII. Summary**

The Clinician Educator Working Group considered several general approaches to addressing faculty concerns regarding the purpose, structure and size of the Clinician Educator track. If scholarship is to remain the primary unifying theme of the standing faculty at Penn, and if all standing faculty are to face an “up or out” decision at the end of a defined probationary period, then the core teaching hospitals must open to Health System Physicians to remain competitive in health care delivery.

If carefully implemented, this change in Medical School policy will also: 1) realign expectations for promotion on the Clinician Educator track with faculty “job descriptions” while preserving the academic focus of the track 2) allow clinical chiefs and chairs new flexibility in meeting all three academic missions of the medical school, 3) provide new members of the medical faculty with additional flexibility in shaping professional careers at Penn, and 4) reduce the size of the Clinician Educator track relative to that of the Tenure track in the Medical School.

Opening of the core teaching hospitals to the Clinical track will also place new pressure on the Medical School and the University to define the purpose, expectations and rewards of promotion on the Clinician Educator track. To prevent a stampede of clinical faculty into the Clinical track, promotion on the Clinician Educator track must be desirable and achievable, and new faculty allocation safeguards must be implemented. This report offers several recommendations for preserving the vitality of the Clinician Educator track if the current restrictions on clinical service of Health System Physicians at HUP and CHOP are lifted.

More important than the survival of any one faculty track is the long-term preservation of the academic missions of the faculty. Medical education is acutely jeopardized at Penn by major, ongoing changes in payments for health care services. In response to these changes, adequate, stable funding must be secured to support the educational mission of the Medical School. Contributions to medical and graduate education from the revenues of the Health System should be channeled through an Education Fund to faculty who fulfill designated leadership roles in the various curriculums. To supplement those funds, the faculty should assume a leadership role in identifying and pursuing new sources of funding for education, such as Educate.MD. A major development campaign should be launched as well to endow faculty leadership of the curriculum.

The Clinician Educator track has been extraordinarily successful in the Medical School at Penn. The upcoming twenty-fifth year anniversary of the track should be celebrated by the Medical School and the University with a renewed commitment to exemplary medical care, teaching and clinical scholarship. Achievable mid-course corrections that are consistent with the guiding principle of *one University—one standing faculty* will ensure the continued vitality of the Clinician Educator track at Penn for another quarter century and beyond.

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