Defining "Faculty" in Academic Medicine: Responding to the Challenges of a Changing Environment

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Abstract

Academic medicine in the United States is at a crossroads. There are many drivers behind this, including health care reform, decreased federal research funding, a refined understanding of adult learning, and the emergence of disruptive innovations in medicine, science, and education. As faculty members are at the core of all academic activities, the definition of "faculty" in academic medicine must align with the expectations of institutions engaged in patient care, research, and education. Faculty members' activities have changed and continue to evolve. Academic health centers must therefore define new rules of engagement that reflect the interplay of institutional priorities with the need to attract, retain, and reward faculty members.

In this Commentary, the authors describe and explore the potential effects of the changing landscape for institutions and their clinical faculty members. The authors make a case for institutions to adapt faculty appointment, evaluation, and promotion processes, and they propose a framework for a standardized definition of "faculty" that allows for individual variability. This framework also provides a means to evaluate and reward faculty members' contributions in education, research, and clinical care. The authors propose a deliberate national conversation to ensure that careers in academic medicine remain attractive and sustainable and that the future of academic medicine is secure.

Academic medicine is at a crossroads. In adapting to new realities, U.S. medical school leaders must define what it means to be "faculty." This definition must reflect the interplay of institutional economic priorities with the need to attract, retain, and reward individual faculty members[1] and the need to secure the future of academic medicine.

In this Commentary, we explore the potential effects of changes in the academic medicine environment on roles and expectations for faculty members, and we make a case for institutions to adapt their faculty appointment, evaluation, and promotion processes in response. We propose a framework for a standardized definition of "faculty" that allows for individual variability and provides a means of evaluating and rewarding faculty members' diverse accomplishments while ensuring that careers in academic medicine remain attractive.

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Acad Med. XXXX;XXX:00–00.
First published online
doi: 10.1097/ACM.0000000000000575

Academic Medicine in Evolution

The missions of academic medicine are undergoing changes driven by health care reform, decreased federal research funding, shifts in research focus, a refined understanding of adult learning, and the emergence of disruptive innovations in medicine, science, and education. Clinical faculty members are being held accountable for increasing levels of productivity to support their salaries and to maintain institutional margins. This economic focus is changing faculty members' perceptions of their roles and priorities, and it has the potential to marginalize academic pursuits such as medical education and research.[2–4]

The evolving clinical landscape is the primary driver of the changes. Medical schools, which have long depended on clinical revenue to subsidize their research and education missions, are now increasingly reliant on funding from endowments, philanthropy, and student tuition.[5] The strategies that medical schools and academic medical centers are adopting to meet their academic obligations while ensuring financial success frequently involve creating large, integrated health care delivery systems, with mergers, affiliations, or acquisitions of systems and physician practices.[6,7] Medical schools must decide whether the physicians in these expanded networks should have faculty appointments. Thus, there is a pressing need for a national conversation on the definition of the modern-day faculty member.

To complicate matters, the aging U.S. population and the projected physician workforce shortage have created the need for more medical graduates,[8] which has resulted in increased medical school class sizes, new medical schools, and new regional campuses. While the numbers of learners, teachers, and teaching sites are expanding, medical education is undergoing a metamorphosis in its curricula, pedagogic methods, and settings. As part of this transformation, clinical teaching will increasingly occur in the ambulatory setting, where most medicine is practiced. To ensure uniform high quality of educational experiences, the Liaison Committee on Medical Education (LCME)[9] requires that

medical students engaged in any aspect of learning, including practical clinical experiences and clerkships, be supervised by the medical school's faculty (standards ED-25 and ER-9 for the current review process, and standards 1.4 and 9.2 for the revised process). The expansion of the educational enterprise and the shift to the ambulatory setting will create challenges and opportunities for medical schools to develop faculty appointment criteria for clinicians recruited to the faculty from the expanded clinical networks, as well as to devise methods for training, developing, and promoting them to ensure that they meet the standards required for excellence in education and are rewarded for their efforts. Currently, many physicians who provide clinical experiences in community practices or on regional campuses are not compensated for their teaching, and yet they must be accountable for providing experiences that are equivalent to those provided across all of the medical school's clinical education sites.[9] Ensuring a high level of professionalism and eliminating learner mistreatment is more difficult when faculty members are volunteers.

In addition, as health care reform takes hold in the United States, the clinical enterprise will need increasing numbers of skilled physicians to deliver high-value health care. Given that faculty appointments are the purview of the medical school and/or its parent university, it will be important to reconcile the traditional academic role of the faculty with the workforce needs of the health care system. Medical schools must decide under what conditions to confer faculty titles, and they must define expectations for patient care, research, and teaching that provide clear pathways to academic promotions. They must also take into account the variety of compensation plans and recognition systems that exist among faculty members with different titles, ranks, and roles.

Historically, physicians, scientists, and educators have been attracted to working at medical schools because of activities and associations not found in the nonacademic sector. Broadly, opportunities for participation in research and education are attractive, but a medical school's community of scholars, traditions, and atmosphere also play a part. It is incumbent on both faculty members and institutions to deal with the future of the faculty head on, rather than allowing the priority placed on clinical productivity at the expense of the academic atmosphere to drive away individuals who could contribute to the future success of academic medicine. If, however, faculty status is perceived as sufficiently rewarding in its academic dimensions, then medical schools will continue to attract and retain outstanding people.

A Framework for the Definition and Reward of Clinical Faculty

For medical schools, the answer to the question of whom to call "faculty" has implications in areas ranging from appointment processes to promotion and tenure policies to faculty development programs. Furthermore, any changes made to faculty appointment criteria must be informed by LCME accreditation standards.

In February 2014, the Association of American Medical Colleges (AAMC) Group on Faculty Affairs conducted an informal survey via its listserv to identify approaches to faculty appointments and titles. The responses revealed diverse approaches, with no consensus on whether physicians newly affiliated with academic health centers should receive academic appointments or what titles those who do receive appointments should hold. Most respondents reported alignment of faculty titles with participation in the research and/or education missions of the medical school. Respondents whose institutions have appointed newly affiliated physicians to the faculty described the use of conventional titles, sometimes with the modifier "clinical" or "adjunct" (e.g., clinical assistant professor of pediatrics). Promotion pathways for these faculty varied, with some respondents reporting no opportunity for promotion and others describing promotion on a clinician–educator track or its equivalent. Few respondents indicated that their institutions had processes to help these faculty members with professional development and advancement.

It is interesting to consider the origin of the term "faculty." Faculty belong to universities. The word "university" is derived from the Latin *universitas magistrorum et scholarium*, which roughly means "community of teachers and scholars." Although specific criteria for scholarship vary across colleges and universities, active scholarship is considered essential to the success of all faculty members. Teaching is the responsibility that demands the most immediate faculty attention and consumes the most faculty time and energy.[10] Thus, the term "faculty" implies a fundamental academic component to one's professional roles and responsibilities.

We propose a framework with *fundamental* and *variable* components that we believe will help medical schools define "faculty" and value the roles and responsibilities of their clinical faculty members, ensuring clarity and transparency for all. The *fundamental* essence of being a faculty member relates to the nature of one's educational and scholarly activities. There are additional, *variable* aspects of being a faculty member that reflect all the other activities in which one might participate, given the local environment. The heterogeneity of medical schools enriches the fabric of academic medicine. Thus, a framework such as ours must respect and value local differences while preserving the essence of the fundamental features of academic medicine.

The *fundamental* features are therefore defined as participation in education and/or scholarly activities. The threshold of participation should be defined locally. Participation in administrative activities, particularly at a senior level, can also be regarded as a fundamental feature—in general, one reaches senior administrative positions based on a career-long track record of scholarly and educational accomplishments.

The *variable* features are the expressions of academic focus that vary by individual, and these should be defined by each institution. Examples include service to the institution or community; mentoring; innovation in, or contribution to, a clinical discipline; participation in quality and safety initiatives; clinical, academic, or administrative leadership; and the development of and participation in unique clinical entities.

Activities comprising the fundamental and variable components that define "faculty" must be evaluated with a higher level of rigor when compared with similar activities that occur in the nonacademic

environment. Such differentiation can be achieved by setting thresholds for the defining attributes of the fundamental and variable components, such as levels of engagement, outcomes, and/or reputation. The defining attributes can then be used to evaluate a candidate for appointment or promotion, as well as to determine the type of modifier (if any) used in a faculty title.

For example, Medical School A believes that both scholarship and education are fundamental to being a faculty member. However, its health system is acquiring many hospitals and physician practices. Therefore, Medical School A creates a new faculty category for volunteer clinical faculty at these newly affiliated sites. In this faculty track, the fundamental emphasis is on teaching without a scholarship requirement. The defining attributes of teaching would then need to be developed: For instance, at this school the minimal level of engagement for a volunteer faculty appointment at any rank is 50 hours of direct teaching time per year. For promotion, a volunteer faculty member would need to show certain outcomes (e.g., teaching evaluations that meet or exceed the school's expectations) and a certain level of reputation (e.g., teaching awards, highly sought-after course). In contrast, Medical School B decides that the fundamental components of a volunteer faculty appointment are participation in teaching and in institutional service. The attributes of the latter could be defined as a function of engagement, outcomes, and reputation, just as in the example provided for teaching.

This fundamental-and-variable approach to defining clinical faculty roles and responsibilities not only preserves the academic nature implied by the term "faculty" but also enables variation that encourages local engagement and innovation. For institutions choosing to value scholarship as a fundamental component of their faculty definition, the seminal work of Boyer[11] and Glassick and colleagues[12,13] provides a framework for enabling many professional activities to be recognized as scholarship.

In *Scholarship Reconsidered: Priorities of the Professoriate*, Boyer[11] redefines "scholarship" as spanning four broad categories, expanding the definition of a term that until then had been synonymous with "research." Boyer's categories are the scholarship of discovery (original research that advances knowledge); of integration (synthesis of information across disciplines, topics within a discipline, or time); of application or engagement (rigorous application of disciplinary expertise with results that can be shared with and evaluated by peers); and of teaching and learning (systematic study of teaching and learning processes).

In *Scholarship Assessed: Evaluation of the Professoriate*, Glassick et al[12] outline standards for evaluating faculty activities for the purpose of academic advancement. These standards, which may be applied to all four forms of scholarship defined by Boyer, include clear goals, adequate preparation, appropriate methods, significant results, effective presentation, and reflective critique. To make these standards practical, Gusic et al[14] propose the application of a "toolbox" for evaluating educators, expanding on the recommendations of the AAMC-sponsored 2006 Consensus Conference on Educational Scholarship that were based on Glassick's work.[15] The toolbox may also be applied to other fundamental features of the faculty role, thus bringing clarity to faculty career planning and a level of rigor to the evaluation of faculty for appointment and promotion.

Boyer's definitions of scholarship may be applied to both the fundamental and variable features of faculty roles, and faculty members can use the Gusic toolbox to effectively describe their scholarship to promotion and tenure committees. Thus, many activities can be expressed as scholarship in addition to those that can be evaluated via the defining attributes we described above (levels of engagement, outcomes, and reputation). For example, the application of these principles and practices to quality and safety work or to institutional service could identify a faculty member's work as scholarship.

As academic health centers define new rules of engagement with their faculty, it will become increasingly important for medical schools and their parent universities to recognize all intellectual, scientific, clinical, and educational work of their faculty members for the purposes of the promotion and retention of those whose contributions differentiate them from physicians employed by nonacademic institutions. Without a means of recognizing the contributions of clinical faculty members with few teaching or research activities, institutions will risk losing some of their most productive workers. Medical schools should define the variable component of the faculty role for themselves, using the elements they deem important and aligning them with Boyer's definitions of scholarship.

We propose a national dialogue, perhaps in the form of a consensus conference, to identify the characteristics that define "faculty" and to develop a taxonomy for faculty roles and titles that is descriptive of these attributes and easily understood across academic medicine. Only then will we be able to answer the increasingly common question of what it truly means to be a faculty member.

Funding/Support: None reported.

Other disclosures: None reported.

Ethical approval: Reported as not applicable.

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