Clinician-Educators and General Internal Medicine Fellowships

General internal medicine fellowships come in many varieties. The Fellowship Program Directory distributed by the Society of General Internal Medicine (SGIM) describes fellowships for people looking “to serve as future faculty or for leadership positions in government, foundations, or the health care industry.”¹ Most fellowships focus on research, but not just any research. One program specializes in health services research, another in medical informatics, and another in clinical practice guidelines. A few institutions have fellowship tracks for developing and evaluating curricula, doing educational research, and learning how to be a medical educator.

In 1984, the percentages of time fellows spent in clinical work, research, and teaching were roughly 30%, 30%, and 25%, respectively, according to fellowship directors. In the same year, chairs of internal medicine departments identified epidemiology, decision analysis, and education science as more important for the preparation of academic general internists. (They also projected a shortage of general internal medicine faculty for the nineties.)² In 1990, fellowship graduates believed that ambulatory medicine, teaching skills, grant-writing skills, proficiency in medical consultation, and expertise in prevention were underemphasized and should be given high priority. They believed that research skill, which was well emphasized, should hold the highest priority.³

Recognizing the growth and diversity of general internal medicine fellowships, SGIM published a policy statement in 1994 describing the components that fellowships should contain. While leaving latitude for program variation, the statement recommended that all programs should ensure competency in biostatistics and epidemiology. Critical appraisal and decision analysis skills were “encouraged” for all fellowship programs. Fellowships were supposed to refine the clinical skills of fellows and prepare graduates for supervising students and residents. Skills in bedside teaching, lecturing, and facilitating small conferences were recommended for both clinician-educators and clinician-researchers. The statement said that “research training should be targeted to meet the needs” of fellows interested in clinician-educator or clinician-researcher pathways.⁴

In this issue, Zakowski and associates demonstrate a “great divide” between the distribution of time some fellows expect to spend in job activities after they graduate and the actual distribution of time they spend in these activities once they have graduated.⁵ In Zakowski’s study, clinician-educators were defined as those who spent less than 33% of their time doing research; those doing more research were defined as clinician-researchers. The study found that clinician-educators expected to spend 25% of their time in research and 32% in outpatient care, but they ac-

tually spent 9% and 42% in these respective areas. Their expectations contrasted with those of the administrators who hired them, who expected the graduates to spend 7% of their time in research and 44% doing clinical work (with 28% time for teaching and 5% for administration). Unlike clinician-educators, clinician-researchers found the positions they expected, with 57% of their time for research and 17% for outpatient care.

Zakowski et al. sent their employer surveys to all the programs listed in the Graduate Medical Education directory, of which approximately two thirds are in nonuniversity, community-based medical centers. Are the needs of these community-based programs different from those of the university-based centers, creating a bias toward a lower amount of research activity? Perhaps not, according to another article in this issue. Sheffield and associates examined one university’s policy to reserve 20% of a clinician-educator’s time for scholarly activity.⁶ Clinician-educators in this university, however, actually spent only 13% of their 60-hour work week in scholarly activities, and 3.3 of those hours occurred after 6 P.M. Faculty who had completed a fellowship had significantly more scholarly products than those who had no fellowship training. Unfortunately, we do not know if these clinician-educators were satisfied with the amount of scholarly work, if the amount was their own choice, or if the amount affected their promotions.

Before deciding how these results should affect fellowship training, additional information should be considered. First, research is a time-intensive activity. Fletcher commented that, “If a general internist is to be mainly a researcher [clinician-researcher], he must be excellent at it, win grants to protect his time, and publish papers to establish his excellence.”⁷ How much more difficult it is for a clinician-educator who lacks the time to carry out research and must compete with clinician-researchers who have the time. This problem is worse when research funds are limited, as they have been recently. The National Institutes of Health approved only 14.2% of new investigator grant applications in 1990, compared with 40% in 1965 and 1975.⁸ Second, three quarters of U.S. medical schools have separate tracks for clinician-educators, and 71% of these schools require scholarship for promotion,⁹ although scholarship may include more than research. In 1997, chairs of promotion committees expected a clinician-educator to have at least 5.7 peer-reviewed publications for promotion to associate professor, compared with 10.6 for a clinician-researcher.¹⁰

Perhaps the academic institutions just sent those involved with general internal medicine fellowships a message about what they need from clinician-educators. According to these studies, if clinician-educator fellowship graduates in general internal medicine are to meet the

needs of the academic institutions, their fellowship directors should prepare them to spend the vast majority of their time after graduation in patient care and teaching. If they can be trained to have efficient and "cost-effective" research skills, all the better.

Finally, who should be the one to categorize a person as a clinician-educator or a clinician-investigator? Is the nomenclature useful? Is 33% research time an important breakpoint outside a statistical model? In an informal SGIM survey, clinician-educators felt that their role was poorly defined.¹¹ In reality, there is a wide spectrum of faculty who consider themselves clinician-educators, from people who spend 95% of their time caring for patients in a private practice but precept a medical student 5% of their time to academicians who spend 50% of their time in research, 25% in teaching, and 25% in patient care. These terms are not useful to individuals. They only become useful when examining the promotion process for equity between broadly defined categories of faculty. What is important to individuals is that the sum of their contributions is adequately, fairly, and quantitatively assessed, whether those contributions are research or patient care.—**BRENT W. BEASLEY, MD**, *Kansas University School of Medicine, Wichita*.

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