Institutional Change

Experiences in Two Departments

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In the early 1970s, two faculty committees at the University of Chicago questioned whether or not there was sufficient flexibility in the traditional categories of faculty appointment to support those whose academic life consisted primarily of teaching and patient care. In response, a new category of clinical academic appointments was implemented in 1981 and was distinguished from the traditional academic categories by the prefix "clinical" in the academic title. However, these appointments met with little acceptance by full-time clinicians at the university because the same category of appointment was used to designate part-time physicians based at other hospitals who often had significantly less interest in educational activities than many of the newly appointed full-time clinician-teachers.

Within 3 years the university's medical school realized that it was essential to attract and retain an academic staff with a broad range of expertise in diverse areas including clinical care and education. It inaugurated the present system of three full-time and two part-time faculty tracks, distinguished as follows:

- ◆ The full-time tenure track emphasizes research and its publication. Faculty on this track are expected to make important contributions to the teaching programs, and almost all physicians maintain clinical privileges and participate in clinical activities.
- ◆ The clinical scholars' track emphasizes clinical scholarship through clinical practice and teaching, but advancement to senior ranks also requires a continuing record of clinical scholarship.
- ◆ The clinician-educator track recognizes distinguished clinical practice, teaching, and administrative work. Faculty appointed to this track are full-time salaried physicians whose academic title is modified by the insertion of the word "clinical" following the academic rank.
- ◆ The part-time clinical track, designated by the prefix "clinical" in the academic title, is essentially equivalent

to the clinician-educator track, but reserved for private practitioners who make significant and ongoing contributions to the clinical teaching programs.

- ◆ The clinical associate track differs from the clinician-educator and part-time tracks in that the major emphasis is on clinical service. It is the only track without a requirement for participation in teaching. Although the track was originally intended for private practitioners, it was expanded in July 1996 to include full-time salaried appointees who are employees of the university. The clinical associate track will undoubtedly play an important role in the future as the Medical Center's network for health care delivery expands.

Perhaps because of these changes, the greatest growth in numbers of faculty has been on the clinician-educator track. Since its inception, a total of 120 appointments have been made to this track. There have been 26 promotions to the rank of associate professor and 11 promotions to the rank of professor. The clinician-educators have given us the academic structure and support to implement a variety of significant changes within the department. A few of these changes include growth in numbers of women, implementation of a teaching dossier, faculty-development workshops, and new processes for housestaff evaluations of faculty.

Change in Faculty

Growth in Numbers of Women

The number of women faculty in the Department of Medicine has grown both in relative and absolute terms, and these women most frequently choose careers on the clinician-educator track. Presently, forty-two of the 185 total faculty (23%) are women. The majority (57%) of all the women in the Department hold appointments on the clinical educator track. A third (33%) of the total number of faculty on the clinical educator track are women.

The women faculty in the Department of Medicine are important to institutional change because they provide the increasing number of women medical students and housestaff with crucial role models and mentors. This is critical to the educational mission of the institution for both men and women trainees.

The majority of women faculty, however, are at junior faculty ranks and are themselves in need of mentoring. This will present a challenge as the institution evolves from a smaller, primarily male faculty to one which is larger and is one quarter female. In addition, the percentage of women will most likely continue to increase for the foreseeable future.

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Educational Change

Implementation of a Teaching Dossier

In 1993 the Department of Medicine formed a committee to develop a formal and rigorous process to evaluate faculty teaching. The committee made several recommendations, which are in varying stages of implementation. One recommendation was for the use of a teaching dossier by faculty on a voluntary basis. In the early phases of implementation, the dossier system is especially attractive to clinician-educators who often spend considerable effort in nonlecture teaching activities. These activities are expected to be a part of the dossier and therefore highlight the individual faculty member's effort and success, which are often substantial.

Faculty-Development Workshops

Several years ago some of the faculty with significant teaching responsibilities recognized that ineffective feedback from faculty hampered the overall process of student education. As a result, they developed a series of popular workshops to help faculty and housestaff develop basic skills in giving feedback to students. Participants have acquired skills in teaching peers and launching new career initiatives of their own. Although this activity started within the Department of Medicine, faculty from all of the major clinical departments and from many of the major basic science departments have also recently participated.

Housestaff Evaluations of Faculty

Because housestaff, in particular, are consistently reluctant to negatively evaluate faculty teaching, two new mechanisms are being implemented to gather this important information from them. One is a computerized data collection system that allows evaluations to remain anonymous. This maintains an essential link between evaluator and teacher while freeing housestaff to give negative feedback.

The other component is the "House Staff Evaluation of Faculty Teaching" committee composed of residents and chaired by the chief resident. This committee evaluates faculty at quarterly meetings. These summary evaluations are then reviewed by the program director, respective section chief, and department chairman.

Summary

The features of institutional change highlighted above are successful only when there is strong support for change among those in the highest positions of institutional leadership. We expect further challenges in meeting the needs of an increasingly diverse student body, patient population, and faculty. Specifically, learning to successfully incorporate faculty in part-time tracks, and maintaining overall career satisfaction of full-time and part-time faculty will both remain important priorities.

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In 1991 the University of Nebraska Medical Center was in the process of changing its curriculum from a didactic-based teaching program in the first 2 years of medical school to problem-based learning and small discussion groups. Also, first-year students were exposed to private practices and taught the basics of physical diagnosis. Although these changes greatly improved their clinical skills when students arrived for their rotations, it was clear that they did not have the same basic knowledge that would have been acquired in our standard didactic training program. This observation led the Department of Pediatrics to readjust its curriculum in order to give students a base in primary care for pediatrics. It also led us to recognize that, like many departments, we had focused on specialty care and would need to develop our primary care faculty; at the time we developed our new curriculum, we had only three individuals who were dedicated to primary care in the ambulatory setting and teaching basic pediatrics. In working toward this end, the following strategies appeared to have the greatest impact (Table 1).

Development of a Curriculum Section

The first strategy the Department of Pediatrics initiated was to truly develop a curriculum section and to allow those physicians interested in developing curriculum to maintain a secondary appointment within it. Several specialists elected to focus their careers on curriculum and teaching while continuing clinical practice in their specialty. The goals of the curriculum were to expand the primary care experience of students and decrease their hospital-based experiences. Like many hospitals, our inpatient service focused heavily on tertiary and quaternary care and had a minimal number of general pediatric patients. In an 8-week experience, the students would spend 2 weeks on the inpatient service and 6 weeks in an outpatient setting (including volunteer faculty clinics,

Table 1. Strategies to Strengthen Clinician-Educator Status in an Academic Setting

Develop a separate curriculum section
Give educators responsibilities and secondary appointments within a specialty teaching section
Decrease the importance of tenure
Base long-term employment on contractual agreements for duties, not institutional tenure requirements
Document teaching
Develop a point system and requirements for teaching based on contact hours with trainees
Reward teaching
Promote clinician-educators on the basis of clinical and educational excellence and service
Value teaching
Make educational activities a basis for faculty salary

university outpatient clinics, and the rehabilitation program) in order to observe and participate in an interdisciplinary approach to patients. Lectures were organized around basic principles of primary care pediatrics, and faculty were asked to orient their specialty lectures to care in a primary care office.

Decreasing the Importance of Tenure

In the past decade, the promotion and tenure tract was changed from a classic tenure-requiring position to a Health Sciences Line. The faculty no longer had to achieve tenure to remain employed but had to follow a contractual arrangement with the Department of Pediatrics to provide certain specified duties. For instance, a faculty member heavily involved in teaching would not have the same requirements for publication or research productivity. The expectations for that faculty member would be clearly stated in the contract, and the faculty member's progress would be monitored on a yearly basis. Most contracts begin as 1-year contracts and expand to 3-year contracts with a 1-year grace period if the faculty members have not fulfilled their assigned duties.

Establishing a Point System to Document and Reward Teaching

To handle the large number of small-group and problem-based learning sessions with the first- and second-year students, increased time was required of those who were primary teachers. To reward those individuals who elected to do more teaching, the Department of Pediatrics developed a point system based on contact hours with students and residents. Also, students and residents were asked to fill out questionnaires to evaluate the quality of teaching, and these were included in the materials available to the chairman for review. The exact contact hours were developed as a database, which could be entered through the existing departmental computer network. The faculty member is responsible for documenting these specific teaching areas. Each faculty member is expected to teach a minimum of 40 contact hours per year. In some sections, certain individuals were elected as primary teachers and the section was given a specific number of teaching hours that could be met by the section as opposed to an individual faculty member. The advantage of a point system was apparent to those faculty who felt their promotion would be based on heavy teaching load and their value as a clinician. The Department of Pediatrics still strongly recommended scholarly activity but expanded its definition to include participation in curricular development or in the development of teaching tools.

Rewarding Teaching by Promotion

The most important change in the Department of Pediatrics was the promotion of teaching as an important

aspect of faculty development to create an atmosphere in which other faculty truly valued individuals who spent a great deal of their time in the teaching role. An example is a faculty member who had not been promoted from assistant professor for 23 years and decided to make a major commitment to teaching in the medical school. His scores and documented points were sufficient for him to be promoted to the associate professor rank in 3 years. This sent a clear message to the rest of the faculty that teaching could be valued and rewarded. It should also be noted that the Dean of the College of Medicine and the Chancellor of the University of Nebraska supported the primary clinician-educator role by changing the criteria for promotion to include excellence in two areas, such as teaching and clinical service, with adequate performance in some scholarly pursuits. Although initially some basic scientists felt uncomfortable with this approach, it was clear that the major departments in the college strongly supported this move, and many faculty have now achieved promotion to the associate professor level within the clinician-educator tract. Traditional promotion and tenure criteria of national reputation, publications, teaching, and service still apply for promotion to full professor. It is noteworthy that requests for tenure permitted within the Health Sciences Line decreased markedly among the clinical faculty, while those in the basic sciences remained at approximately the same number as before the development of the Health Sciences Line. Because tenure was no longer required to maintain one's employment, it was clear that many of the faculty did not feel tenure was necessary to ensure their security.

Summary

Though the principle may seem simple or fundamental, it has been our experience that the best way to develop clinician-educators in an academic setting is to value their contributions. This means that those contributions must lead to promotion, they should be valued by colleagues, they must be valued by the administration and the chairman, and they must be considered when determining faculty salary. As faculty members perceived that they were valued for teaching and clinical service, and would not be punished for the amount of time they were spending in these endeavors, there was a clear group of faculty who came forward to take on a primary teaching role. This group was not limited to general pediatricians or ambulatory pediatricians, but included some specialists who felt that their pediatric background was sufficient for them to teach in a primary care setting. Two of our leading teachers in the generalist curriculum are specialists in nephrology and hematology/oncology. Although this requires them to go back and increase their knowledge in general pediatrics, it is far less difficult according to these faculty members than they expected. Our specialists continue to maintain their specialty practices, but have oriented their didactic lectures and clinical

teaching to specialty and general aspects of pediatrics. It is not difficult to teach about parenting and psychosocial skills when describing a complicated specialty patient and to orient the students and residents to the general care of such a patient.

Although the majority of strategies described in this article deal with departmental and college initiatives, the reason that these strategies have become an integral part of the Department of Pediatrics is the changing health care environment in Nebraska. Managed care has mandated that physicians be more flexible and be willing to take on a primary care role within their specialty. This has made the transition for many faculty much easier and has been reinforced by financial reimbursement for their

services. The transition would not have been as easy had there been no movement of the community toward primary care, or no shift in the university's interest in primary care as a mechanism for providing sufficient patient numbers to fulfill our teaching missions. Clinical research has become the area of focus for many of the primary care physicians and some specialists in the past few years, and the university is in the process of developing a clinical research center to allow for outpatient studies. Although the strategies summarized are specific to the University of Nebraska Medical Center, many of the principles could be adapted to other teaching programs. The most basic element is to tie reward and recognition to efforts in primary care.