The Evolution of the Clinician - Educator

Leslie Zimmerman, MD

Before the 1950s, much of medical research was directly related to the examination of patients, so academic clinical investigators tended to be gifted clinicians and clinical teachers. In the second half of the twentieth century, research turned increasingly molecular, and researchers became immersed in their laboratories. Researchers found it more and more difficult to maintain clinical expertise or to have time to teach. On the other end of the spectrum, expert teachers had no opportunities for research grants and needed to take on more clinical activities to support their salaries. Out of this diverging academic community, new roles of “Clinician-Educator,” “Clinician-Teacher,” and “Clinician-Scholar” evolved.

In the current era, the definition of “Clinician-Educator” appears to be highly dependent on the institution. Some academic centers use this term to describe a non-tenure track Clinical Instructor appointment, typically populated by those just having finished training. Usually there are substantial clinical responsibilities, a requirement for resident/fellow teaching that often is in the form of being a ward, clinic, or consult attending, and little to no training in the pedagogy of medical education. In these settings, most Clinician-Teachers receive an academic title but are rarely granted tenure. Typically, the appointment contract will provide for a limited number of years of job security (typically about three years) with an opportunity to renew the contract. Reappointment is based on performance as a teacher, less commonly success as a researcher, but most importantly on the ability to generate one’s own salary in clinical income. It is a fine first appointment for those in a transitional time (e.g., between residency and fellowship) or as reflective time for career planning. But because little time is allocated for academic growth, it is difficult for those in this appointment to obtain funding for educational (or any) projects or to be trained in the art and science of teaching. Some are successful, but this is the exception. On the other end of the spectrum are institutions that have a Clinician-Educator/Scholar tenure track with entry points at multiple levels of appointment. These institutions recognize, promote, and reward teaching excellence, provide “buy-out” time for programmatic leadership, support curricular innovation, encourage scholarship in medical

education, and provide a community of like-minded Clinician-Educator Scholars for collaboration. Most institutions are somewhere in between.

All academic institutions value education, but value doesn't always translate into salary support for educational endeavors. In many institutions there has been a subordination of teaching to research, in which research has outstripped teaching in prominence, leadership roles, and resource allocation. Research productivity is the metric by which faculty accomplishment is judged. Payment for educational activities directed towards medical students (typically called "Undergraduate Medical Education") require dollars from tuition and fees and other money sent to the dean's office to flow through the system to the educators. In my case, I teach two of the required first-year courses for medical students, and yet my salary for this is paid by the Department of Medicine, not the School of Medicine or the Dean's Office. These courses cover cardiology, pulmonary, nephrology, GI, and endocrinology courses in which internal medicine is heavily represented. In this sense, there is a reasonable argument that the Department of Medicine has a stake in this teaching activity, but it means that some other member of the Department of Medicine has to earn extra clinical income to pay for my teaching effort for the Medical School. As for Graduate Medical Education or GME, institutions receive Medicare support for residency education. Despite this substantial support, teaching hospitals are struggling financially for a variety of reasons (decreased reimbursements for clinical services, increasing uncompensated care, reductions in federal GME payments, etc.). Department chairs and program directors typically must negotiate with hospital administration for dollars for resident and fellow training. Somehow in these incredibly complex, opaque, highly variable financial circumstances of different academic institutions, you need to convince your department chair that what you do merits salary support. It is not worth your time to try to understand how dollars flow through your medical center. *A better return on your effort is to demonstrate that you are the best investment for these limited educational dollars*.

The entry point is the hardest, i.e., getting that first funded educational project or position. The good news is that once you have proven your value in this first project or position, you tend to be in the loop to hear about other opportunities, and money seems easier to obtain. This is quite similar to traditional research tracks. Success identifies you. And

similar to traditional research tracks, it is useful to develop a focus. There are several classic domains of scholarship in medical education: Direct Teaching, Advising and Mentoring, Educational Administration or Leadership, Curriculum Development/Instruction Design, and Educational Research. The first four domains are judged by teaching awards (typically most valued by institutions as evidence of excellence), formal evaluations by trainees, evidence of career development of former trainees (via advising and mentoring), dissemination of enduring educational material outside of your institution, and your own summary of your innovation and leadership. The last domain of Educational Research is judged similarly to bench and clinical research, by publication and presentations of peer-reviewed work, and by the ability to obtain grants based on peer review of written proposals. Most successful Clinician-Educators excel in two domains. Attempting to excel in all these domains tends to spread your effort too thinly and does not allow time or energy for innovation.

Most of you reading this chapter are subspecialists in some stage of training, and the educational entry point for you might be as a small group facilitators for a medical school course. Bring enthusiasm for the material. Read your evaluations, but understand that just reading your evaluations rarely improves your teaching (though it beats ignoring the evaluations). More improvement occurs by attending a faculty development course or by having a peer directly observe your teaching. Those of you who are fellowship co-directors (or even directors), wear many hats—advising and mentoring, administration leadership, and hopefully curricular innovation. Collaborate with your learners, and seek advice from other fellowship directors at your institution as well as in your subspecialty at other institutions.

Clinician-Educators fill a relatively new academic role. Many medical schools lack experience in evaluating their Clinician-Educators for promotion. Your institution may not have very explicit criteria for success. The promotion subcommittee that evaluates your packet may not have many Clinician-Educators on it. Your CV needs to be very clear about your areas of accomplishment, how this is evaluated (i.e., how do others recognize your excellence), and how this information is disseminated. Dissemination of educational work is one of the more difficult areas for Clinician-Scholars to document, especially if the expertise is in Direct Teaching, Advising/Mentoring, or Leadership at your own institution. Evidence of

Direct Teaching that goes beyond your school may be via chapter writing and speaking at CME courses. An up-to-date list of the academic addresses of former advisees/mentees also demonstrates dissemination. If you have developed curriculum material that you think is particularly illustrative or unique, consider application to the peer-reviewed medical education site of The American Association of Medical Colleges (www.aamc.org/mededportal).

The Clinician-Educator is a relatively new role in academic medicine and one that is evolving and growing. With time, individual medical schools will clarify the role and develop expectations more explicitly. In the mean time, for your success, find good mentor educators at your institution, seek out faculty development opportunities that match your interests, and collaborate with your like-minded peers.

References

1. COGME Fifteenth Report. Financing graduate medical education in a changing health care environment. Rockville, MD: U.S. Department of Health and Human Services; December 2000.
2. Rich ED, Liebow M, Srinivasan M, et al. Medicare financing of graduate medical education. J Gen Intern Med 2002;17(4):283–292.
3. Cooke M, Irby DM, Sullivan W, Ludmerer KM. American medical education 100 years after the flexner report. N Engl J Med 2006;355:1339.
4. The Haile T. Debas Academy of Medical Educators. University of California, San Francisco School of Medicine; ©UC Regents. Available from: http://medschool.ucsf.edu/academy.

Dr. Zimmerman *is Professor of Clinical Medicine at the University of California San Francisco, Veterans Affairs Medical Center.*