USU Task Force On The Clinical Faculty

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1940 Statement of Principles on Academic Freedom and Tenure

with 1970 Interpretive Comments

In 1940, following a series of joint conferences begun in 1934, representatives of the American Association of University Professors and of the Association of American Colleges (now the Association of American Colleges and Universities) agreed upon a restatement of principles set forth in the 1925 Conference Statement on Academic Freedom and Tenure. *This restatement is known to the profession as the 1940* Statement of Principles on Academic Freedom and Tenure.

The 1940 Statement *is printed below, followed by Interpretive Comments as developed by representatives of the American Association of University Professors and the Association of American Colleges in 1969. The governing bodies of the two associations, meeting respectively in November 1989 and January 1990, adopted several changes in language in order to remove gender-specific references from the original text.*

The purpose of this statement is to promote public understanding and support of academic freedom and tenure and agreement upon procedures to ensure them in colleges and universities. Institutions of higher education are conducted for the common good and not to further the interest of either the individual teacher or the institution as a whole.[1] The common good depends upon the free search for truth and its free exposition.

Academic freedom is essential to these purposes and applies to both teaching and research. Freedom in research is fundamental to the advancement of truth. Academic freedom in its teaching aspect is fundamental for the protection of the rights of the teacher in teaching and of the student to freedom in learning. It carries with it duties correlative with rights.[1][2]

Tenure is a means to certain ends; specifically: (1) freedom of teaching and research and of extramural activities, and (2) a sufficient degree of economic security to make the profession attractive to men and women of ability. Freedom and economic security, hence, tenure, are indispensable to the success of an institution in fulfilling its obligations to its students and to society.

Academic Freedom

1. Teachers are entitled to full freedom in research and in the publication of the results, subject to the adequate performance of their other academic duties; but research for pecuniary return should be based upon an understanding with the authorities of the institution.
2. Teachers are entitled to freedom in the classroom in discussing their subject, but they should be careful not to introduce into their teaching controversial matter which has no relation to their subject.**[2]** Limitations of academic freedom because of religious or other aims of the institution should be clearly stated in writing at the time of the appointment.**[3]**
3. College and university teachers are citizens, members of a learned profession, and officers of an educational institution. When they speak or write as citizens, they should be free from institutional censorship or discipline, but their special position in the community imposes special obligations. As scholars and educational officers, they should remember that the public may judge their profession and their institution by their utterances. Hence they

1. The word "teacher" as used in this document is understood to include the investigator who is attached to an academic institution without teaching duties.
2. Boldface numbers in brackets refer to Interpretive Comments that follow.

should at all times be accurate, should exercise appropriate restraint, should show respect for the opinions of others, and should make every effort to indicate that they are not speaking for the institution.[4]

Academic Tenure

After the expiration of a probationary period, teachers or investigators should have permanent or continuous tenure, and their service should be terminated only for adequate cause, except in the case of retirement for age, or under extraordinary circumstances because of financial exigencies.

In the interpretation of this principle it is understood that the following represents acceptable academic practice:

1. The precise terms and conditions of every appointment should be stated in writing and be in the possession of both institution and teacher before the appointment is consummated.
2. Beginning with appointment to the rank of full-time instructor or a higher rank,[5] the probationary period should not exceed seven years, including within this period full-time service in all institutions of higher education; but subject to the proviso that when, after a term of probationary service of more than three years in one or more institutions, a teacher is called to another institution, it may be agreed in writing that the new appointment is for a probationary period of not more than four years, even though thereby the person's total probationary period in the academic profession is extended beyond the normal maximum of seven years.[6] Notice should be given at least one year prior to the expiration of the probationary period if the teacher is not to be continued in service after the expiration of that period.[7]
3. During the probationary period a teacher should have the academic freedom that all other members of the faculty have.[8]
4. Termination for cause of a continuous appointment, or the dismissal for cause of a teacher previous to the expiration of a term appointment, should, if possible, be considered by both a faculty committee and the governing board of the institution. In all cases where the facts are in dispute, the accused teacher should be informed before the hearing in writing of the charges and should have the opportunity to be heard in his or her own defense by all bodies that pass judgment upon the case. The teacher should be permitted to be accompanied by an advisor of his or her own choosing who may act as counsel. There should be a full stenographic record of the hearing available to the parties concerned. In the hearing of charges of incompetence the testimony should include that of teachers and other scholars, either from the teacher's own or from other institutions. Teachers on continuous appointment who are dismissed for reasons not involving moral turpitude should receive their salaries for at least a year from the date of notification of dismissal whether or not they are continued in their duties at the institution.[9]
5. Termination of a continuous appointment because of financial exigency should be demonstrably bona fide.

1940 Interpretations

At the conference of representatives of the American Association of University Professors and of the Association of American Colleges on November 7–8, 1940, the following interpretations of the 1940 *Statement of Principles on Academic Freedom and Tenure* were agreed upon:

1. That its operation should not be retroactive.
2. That all tenure claims of teachers appointed prior to the endorsement should be determined in accordance with the principles set forth in the 1925 *Conference Statement on Academic Freedom and Tenure.*
3. If the administration of a college or university feels that a teacher has not observed the admonitions of paragraph 3 of the section on Academic Freedom and believes that the extramural utterances of the teacher have been such as to raise grave doubts concerning the teacher's fitness for his or her position, it may proceed to file charges under paragraph 4 of the section on Academic Tenure. In pressing such charges, the administration should remember that

teachers are citizens and should be accorded the freedom of citizens. In such cases the administration must assume full responsibility, and the American Association of University Professors and the Association of American Colleges are free to make an investigation.

1970 Interpretive Comments

Following extensive discussions on the 1940 Statement of Principles on Academic Freedom and Tenure *with leading educational associations and with individual faculty members and administrators, a joint committee of the AAUP and the Association of American Colleges met during 1969 to reevaluate this key policy statement. On the basis of the comments received, and the discussions that ensued, the joint committee felt the preferable approach was to formulate interpretations of the* Statement *in terms of the experience gained in implementing and applying the* Statement *for over thirty years and of adapting it to current needs.*

The committee submitted to the two associations for their consideration the following "Interpretive Comments." These interpretations were adopted by the Council of the American Association of University Professors in April 1970 and endorsed by the Fifty-sixth Annual Meeting as Association policy.

In the thirty years since their promulgation, the principles of the 1940 *Statement of Principles on Academic Freedom and Tenure* have undergone a substantial amount of refinement. This has evolved through a variety of processes, including customary acceptance, understandings mutually arrived at between institutions and professors or their representatives, investigations and reports by the American Association of University Professors, and formulations of statements by that association either alone or in conjunction with the Association of American Colleges. These comments represent the attempt of the two associations, as the original sponsors of the 1940 *Statement*, to formulate the most important of these refinements. Their incorporation here as Interpretive Comments is based upon the premise that the 1940 *Statement* is not a static code but a fundamental document designed to set a framework of norms to guide adaptations to changing times and circumstances.

Also, there have been relevant developments in the law itself reflecting a growing insistence by the courts on due process within the academic community which parallels the essential concepts of the 1940 *Statement;* particularly relevant is the identification by the Supreme Court of academic freedom as a right protected by the First Amendment. As the Supreme Court said in *Keyishian v. Board of Regents*, 385 U.S. 589 (1967), "Our Nation is deeply committed to safeguarding academic freedom, which is of transcendent value to all of us and not merely to the teachers concerned. That freedom is therefore a special concern of the First Amendment, which does not tolerate laws that cast a pall of orthodoxy over the classroom."

The numbers refer to the designated portion of the 1940 *Statement* on which interpretive comment is made.

1. The Association of American Colleges and the American Association of University Professors have long recognized that membership in the academic profession carries with it special responsibilities. Both associations either separately or jointly have consistently affirmed these responsibilities in major policy statements, providing guidance to professors in their utterances as citizens, in the exercise of their responsibilities to the institution and to students, and in their conduct when resigning from their institution or when undertaking government-sponsored research. Of particular relevance is the *Statement on Professional Ethics*, adopted in 1966 as Association policy. (A revision, adopted in 1987, may be found in AAUP, *Policy Documents and Reports*, 10th ed. [Washington, D.C., 2006], 171–72.)
2. The intent of this statement is not to discourage what is "controversial." Controversy is at the heart of the free academic inquiry which the entire statement is designed to foster. The passage serves to underscore the need for teachers to avoid persistently intruding material which has no relation to their subject.
3. Most church-related institutions no longer need or desire the departure from the principle of academic freedom implied in the 1940 *Statement*, and we do not now endorse such a departure.

4. This paragraph is the subject of an interpretation adopted by the sponsors of the 1940 *Statement* immediately following its endorsement which reads as follows:

> If the administration of a college or university feels that a teacher has not observed the admonitions of paragraph 3 of the section on Academic Freedom and believes that the extramural utterances of the teacher have been such as to raise grave doubts concerning the teacher's fitness for his or her position, it may proceed to file charges under paragraph 4 of the section on Academic Tenure. In pressing such charges, the administration should remember that teachers are citizens and should be accorded the freedom of citizens. In such cases the administration must assume full responsibility, and the American Association of University Professors and the Association of American Colleges are free to make an investigation.

Paragraph 3 of the section on Academic Freedom in the 1940 *Statement* should also be interpreted in keeping with the 1964 *Committee A Statement on Extramural Utterances*, which states inter alia: "The controlling principle is that a faculty member's expression of opinion as a citizen cannot constitute grounds for dismissal unless it clearly demonstrates the faculty member's unfitness for his or her position. Extramural utterances rarely bear upon the faculty member's fitness for the position. Moreover, a final decision should take into account the faculty member's entire record as a teacher and scholar."

Paragraph 5 of the *Statement on Professional Ethics* also deals with the nature of the "special obligations" of the teacher. The paragraph reads as follows:

> As members of their community, professors have the rights and obligations of other citizens. Professors measure the urgency of these obligations in the light of their responsibilities to their subject, to their students, to their profession, and to their institution. When they speak or act as private persons, they avoid creating the impression of speaking or acting for their college or university. As citizens engaged in a profession that depends upon freedom for its health and integrity, professors have a particular obligation to promote conditions of free inquiry and to further public understanding of academic freedom.

Both the protection of academic freedom and the requirements of academic responsibility apply not only to the full-time probationary and the tenured teacher, but also to all others, such as part-time faculty and teaching assistants, who exercise teaching responsibilities.

5. The concept of "rank of full-time instructor or a higher rank" is intended to include any person who teaches a full-time load regardless of the teacher's specific title.[3]

6. In calling for an agreement "in writing" on the amount of credit given for a faculty member's prior service at other institutions, the *Statement* furthers the general policy of full understanding by the professor of the terms and conditions of the appointment. It does not necessarily follow that a professor's tenure rights have been violated because of the absence of a written agreement on this matter. Nonetheless, especially because of the variation in permissible institutional practices, a written understanding concerning these matters at the time of appointment is particularly appropriate and advantageous to both the individual and the institution.[4]

7. The effect of this subparagraph is that a decision on tenure, favorable or unfavorable, must be made at least twelve months prior to the completion of the probationary period. If the decision is negative, the appointment for the following year becomes a terminal one. If the decision is affirmative, the provisions in the 1940 *Statement* with respect to the termination of service of teachers or investigators after the expiration of a probationary period should apply from the date when the favorable decision is made.

3. For a discussion of this question, see the "Report of the Special Committee on Academic Personnel Ineligible for Tenure," *Policy Documents and Reports*, 9th ed. (Washington, D.C., 2001), 88–91.

4. For a more detailed statement on this question, see "On Crediting Prior Service Elsewhere as Part of the Probationary Period," *Policy Documents and Reports*, 10th ed. (Washington, D.C., 2006), 55–56.

The general principle of notice contained in this paragraph is developed with greater specificity in the *Standards for Notice of Nonreappointment*, endorsed by the Fiftieth Annual Meeting of the American Association of University Professors (1964). These standards are:

> Notice of nonreappointment, or of intention not to recommend reappointment to the governing board, should be given in writing in accordance with the following standards:
>
> 1. *Not later than March 1 of the first academic year of service*, if the appointment expires at the end of that year; or, if a one-year appointment terminates during an academic year, at least three months in advance of its termination.
> 2. *Not later than December 15 of the second academic year of service*, if the appointment expires at the end of that year; or, if an initial two-year appointment terminates during an academic year, at least six months in advance of its termination.
> 3. At least twelve months before the expiration of an appointment after two or more years in the institution.

Other obligations, both of institutions and of individuals, are described in the *Statement on Recruitment and Resignation of Faculty Members*, as endorsed by the Association of American Colleges and the American Association of University Professors in 1961.

8. The freedom of probationary teachers is enhanced by the establishment of a regular procedure for the periodic evaluation and assessment of the teacher's academic performance during probationary status. Provision should be made for regularized procedures for the consideration of complaints by probationary teachers that their academic freedom has been violated. One suggested procedure to serve these purposes is contained in the *Recommended Institutional Regulations on Academic Freedom and Tenure*, prepared by the American Association of University Professors.

9. A further specification of the academic due process to which the teacher is entitled under this paragraph is contained in the *Statement on Procedural Standards in Faculty Dismissal Proceedings*, jointly approved by the American Association of University Professors and the Association of American Colleges in 1958. This interpretive document deals with the issue of suspension, about which the 1940 *Statement* is silent.

   The 1958 *Statement* provides: "Suspension of the faculty member during the proceedings is justified only if immediate harm to the faculty member or others is threatened by the faculty member's continuance. Unless legal considerations forbid, any such suspension should be with pay." A suspension which is not followed by either reinstatement or the opportunity for a hearing is in effect a summary dismissal in violation of academic due process.

   The concept of "moral turpitude" identifies the exceptional case in which the professor may be denied a year's teaching or pay in whole or in part. The statement applies to that kind of behavior which goes beyond simply warranting discharge and is so utterly blameworthy as to make it inappropriate to require the offering of a year's teaching or pay. The standard is not that the moral sensibilities of persons in the particular community have been affronted. The standard is behavior that would evoke condemnation by the academic community generally.

Endorsers

Association of American Colleges and Universities 1941
American Association of University Professors 1941
American Library Association (adapted for librarians) 1946
Association of American Law Schools 1946
American Political Science Association 1947
American Association of Colleges for Teacher Education 1950
American Association for Higher Education 1950
Eastern Psychological Association 1950
Southern Society for Philosophy and Psychology 1953

American Psychological Association 1961
American Historical Association 1961
Modern Language Association of America 1962
American Economic Association 1962
American Agricultural Economics Association 1962
Midwest Sociological Society 1963
Organization of American Historians 1963
American Philological Association 1963
American Council of Learned Societies 1963
Speech Communication Association 1963
American Sociological Association 1963
Southern Historical Association 1963
American Studies Association 1963
Association of American Geographers 1963
Southern Economic Association 1963
Classical Association of the Middle West and South 1964
Southwestern Social Science Association 1964
Archaeological Institute of America 1964
Southern Management Association 1964
American Theatre Association 1964
South Central Modern Language Association 1964
Southwestern Philosophical Society 1964
Council of Independent Colleges 1965
Mathematical Association of America 1965
Arizona-Nevada Academy of Science 1965
American Risk and Insurance Association 1965
Academy of Management 1965
American Catholic Historical Association 1966
American Catholic Philosophical Association 1966
Association for Education in Journalism and Mass Communication 1966
Western History Association 1966
Mountain-Plains Philosophical Conference 1966
Society of American Archivists 1966
Southeastern Psychological Association 1966
Southern Speech Communication Association 1966
American Association for the Advancement of Slavic Studies 1967
American Mathematical Society 1967
College Theology Society 1967
Council on Social Work Education 1967
American Association of Colleges of Pharmacy 1967
American Academy of Religion 1967
Association for the Sociology of Religion 1967
American Society of Journalism School Administrators 1967
John Dewey Society 1967
South Atlantic Modern Language Association 1967
American Finance Association 1967
Association for Social Economics 1967
Phi Beta Kappa Society 1968
American Society of Christian Ethics 1968
American Association of Teachers of French 1968
Eastern Finance Association 1968
American Association for Chinese Studies 1968
American Society of Plant Physiologists 1968
University Film and Video Association 1968
American Dialect Society 1968

American Speech-Language-Hearing Association 1968
Association of Social and Behavioral Scientists 1968
College English Association 1968
National College Physical Education Association for Men 1969
American Real Estate and Urban Economics Association 1969
History of Education Society 1969
Council for Philosophical Studies 1969
American Musicological Society 1969
American Association of Teachers of Spanish and Portuguese 1969
Texas Community College Teachers Association 1970
College Art Association of America 1970
Society of Professors of Education 1970
American Anthropological Association 1970
Association of Theological Schools 1970
Association of Schools of Journalism and Mass Communication 1971
American Business Law Association 1971
American Council for the Arts 1972
New York State Mathematics Association of Two-Year Colleges 1972
College Language Association 1973
Pennsylvania Historical Association 1973
Massachusetts Regional Community College Faculty Association 1973
American Philosophical Association[5] 1974
American Classical League 1974
American Comparative Literature Association 1974
Rocky Mountain Modern Language Association 1974
Society of Architectural Historians 1975
American Statistical Association 1975
American Folklore Society 1975
Association for Asian Studies 1975
Linguistic Society of America 1975
African Studies Association 1975
American Institute of Biological Sciences 1975
North American Conference on British Studies 1975
Sixteenth-Century Studies Conference 1975
Texas Association of College Teachers 1976
Society for Spanish and Portuguese Historical Studies 1976
Association for Jewish Studies 1976
Western Speech Communication Association 1976
Texas Association of Colleges for Teacher Education 1977
Metaphysical Society of America 1977
American Chemical Society 1977
Texas Library Association 1977
American Society for Legal History 1977
Iowa Higher Education Association 1977
American Physical Therapy Association 1979
North Central Sociological Association 1980
Dante Society of America 1980
National Communication Association 1981
American Association of Physics Teachers 1982
Middle East Studies Association 1982

5. Endorsed by the association's Western Division in 1952, Eastern Division in 1953, and Pacific Division in 1962.

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National Education Association 1985
American Institute of Chemists 1985
American Association of Teachers of German 1985
American Association of Teachers of Italian 1985
American Association for Applied Linguistics 1986
American Association of Teachers of Slavic and East European Languages 1986
American Association for Cancer Education 1986
American Society of Church History 1986
Oral History Association 1987
Society for French Historical Studies 1987
History of Science Society 1987
American Association of Pharmaceutical Scientists 1988
American Association for Clinical Chemistry 1988
Council for Chemical Research 1988
Association for the Study of Higher Education 1988
Association for Psychological Science 1989
University and College Labor Education Association 1989
Society for Neuroscience 1989
Renaissance Society of America 1989
Society of Biblical Literature 1989
National Science Teachers Association 1989
Medieval Academy of America 1990
American Society of Agronomy 1990
Crop Science Society of America 1990
Soil Science Society of America 1990
International Society of Prostitologists 1990
Society for Ethnomusicology 1990
American Association of Physicists in Medicine 1990
Animal Behavior Society 1990
Illinois Community College Faculty Association 1990
American Society for Theatre Research 1990
National Council of Teachers of English 1991
Latin American Studies Association 1992
Society for Cinema and Media Studies 1992
American Society for Eighteenth-Century Studies 1992
Council of Colleges of Arts and Sciences 1992
American Society for Aesthetics 1992
Association for the Advancement of Baltic Studies 1994
American Council of Teachers of Russian 1994
Council of Teachers of Southeast Asian Languages 1994
American Association of Teachers of Arabic 1994
Association of Teachers of Japanese 1994
Academic Senate for California Community Colleges 1996
Council of Graduate Programs in Communication Sciences and Disorders 1996
Association for Women in Mathematics 1997
National Council for the Social Studies 1997
Philosophy of Time Society 1998
World Communication Association 1999
The Historical Society 1999
Association for Theatre in Higher Education 1999
National Association for Ethnic Studies 1999
Association of Ancient Historians 1999
American Culture Association 1999
American Conference for Irish Studies 1999
Society for Philosophy in the Contemporary World 1999
Eastern Communication Association 1999

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Association for Canadian Studies in the United States 1999
American Association for the History of Medicine 2000
Missouri Association of Faculty Senates 2000
Association for Symbolic Logic 2000
American Society of Criminology 2001
New England Historial Association 2001
American Jewish Historical Society 2001
Group for the Use of Psychology in History 2001
Society for the Scientific Study of Religion 2001
Society for German-American Studies 2001
Society for Historians of the Gilded Age and Progressive Era 2001
Eastern Sociological Society 2001
Chinese Historians in the United States 2001
Community College Humanities Association 2002
Immigration and Ethnic History Society 2002
Agricultural History Society 2004
National Council for Accreditation of Teacher Education 2005
American Council on the Teaching of Foreign Languages 2005
Society for the Study of Social Biology 2005
Association of Black Sociologists 2005
Society for the Study of Social Problems 2005
Dictionary Society of North America 2005
Society for Buddhist-Christian Studies 2005
National Women's Studies Association 2006
National Coalition for History 2006
Society for Armenian Studies 2006
Society for the Advancement of Scandinavian Study 2006
American Physiological Society 2006
College Forum of the National Council of Teachers of English 2006
Society for Military History 2006
Society for Industrial and Applied Mathematics 2006
Association for Research on Ethnicity and Nationalism in the Americas 2006
Society of Dance History Scholars 2006
Association of Literary Scholars and Critics 2006
Society for Applied Anthropology 2006
Society for Music Theory 2006
Society for Historians of American Foreign Relations 2006
American Society of Plant Taxonomists 2006
Law and Society Association 2006

Faculty Tenure in American Medical Schools

Mitchell W. Spellman, M.D., and Gordon Meiklejohn, M.D.

Abstract—Advantages and disadvantages of academic tenure for clinical faculties, including an appraisal of its financial burdens, the utility of modified or alternative systems, and the issue of abolition of tenure, were examined through a questionnaire to which deans and faculty representatives of 106 American medical schools responded during 1975-76. Tenure is valued by most deans and faculty members. A flexible tenure policy permitting appointment of some faculty members to senior academic posts without tenure was endorsed by the deans of 10 selected medical schools who were interviewed. Growth of medical faculties is decelerating; a steady state has not been attained but is imminent. Financial pressures and demands for change will increasingly challenge the tenure system.

Tenure in American medical schools is under progressively intensive scrutiny. The number of salaried faculty members began to increase following World War II. Growth of faculties accelerated during the 1960s and continued in the 1970s (1). In 1976 the number of full-time faculty members in the medical schools of the United States reached more than 36,000. Eighty-two percent of these were in clinical departments. Approximately 17,000 held the rank of associate professor or professor, 12,445 the rank of assistant professor, and 6,144 the rank of instructor (2). As the expanded pool of younger faculty members advances in academic rank during the next decade, few schools may be able to mobilize the resources to meet the financial obligations of tenure.

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Significant increases in funding for the educational activities of the medical schools from state, federal, or private sources seem unlikely in the immediate future. Moreover, it is difficult to convince state legislatures or governing boards of universities of the need for further increases in faculty size in view of the high faculty-student ratios which exist in most medical schools. Research funding, a major factor in faculty support, has already leveled off and is likely to decrease. Income derived from patient care has risen sharply during recent years as federal and state programs have compensated academic physicians for services which previously were provided to indigent patients without reimbursement. However, evolving government policies do not furnish reimbursement commensurate with increasing provider costs. As the financial outlook grows dimmer, there is concern about faculty stagnation, loss of flexibility during a period which demands change, and impediments to affirmative action goals.

The tenure policies of medical schools have tended to parallel those of the parent universities, but there are many exceptions. In general, following a probationary period which does not exceed seven years, assistant professors are promoted to the rank of associate professor or cease to hold a full-time faculty appointment. If the rank of associate professor is attained, the faculty member acquires continuous tenure. Thereafter, the appointment is terminated only for cause and following due process, except in case of retirement at the stipulated age (3).

The criteria for termination of tenure, as recommended in the 1940 Statement of Principles on Academic Freedom and Tenure by the American Association of University Professors (AAUP), are either (*a*) individual, notably for immorality, professional incompetence, or medical reasons, or (*b*) institutional, namely for bona fide financial exigency or discontinuation of a program or department (3). The governing boards of most universities have accepted these principles; and court decisions, as well as custom, have strengthened support for the concept of faculty tenure (4–6). Implicit in this system is a long-term financial commitment by the university to the faculty member. In return the institution expects to gain in the capacity to recruit and hold able faculty members and to create a stable, congenial, and stimulating academic environment in which the faculty—without concern about renewal of appointment or competition between colleagues for reappointment—more effectively pursues the goals of teaching, research, and service.

Relatively little has been written regarding tenure policies applicable to clinical faculties. In the 1974 Association of American Medical Colleges' Delphi survey on the future of medical education, 70 percent of deans indicated a preference for abolition of tenure (6). A communication from the AAUP identified only 38 medical schools in November 1975 which had policies consistent with the 1940 AAUP Statement of Principles on Academic Freedom and Tenure.*

In order to appraise the present status of tenure, data were assembled from each American medical school during the year 1975-76 through a questionnaire transmitted to the deans of the 117 schools and to one or more faculty members designated by the dean as best representing the viewpoints of the faculty. Following analysis of data derived from the questionnaire, the deans of 10 selected schools were interviewed.

Questionnaire Design

The questionnaire was formulated with two purposes: first, to obtain factual information about the contemporary system for tenuring clinical faculties and, second, to solicit opinions regarding the positive and negative features of current tenure policies and procedures.

As indexes of existing attitudes toward tenure, four questions were focused upon perceived benefits and four upon disadvantages of tenure. Among positive attributes, respondents were requested to indicate whether tenure helped (*a*) in recruitment, (*b*) in the retention of a high-quality faculty, (*c*) in maintaining faculty effectiveness, and (*d*) in resisting adverse pressures. Respondents were also requested to indicate whether tenure (*a*) encouraged retention of ineffective faculty members, (*b*) permitted faculty members to evade responsibilities to their institutions, and (*c*) blocked infusion into the faculty of young individuals or of members of minority groups and/or of women.

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* Personal communication, November 8, 1975, from Thomas Truss, American Association of University Professors, Washington, D.C., to the Association of American Medical Colleges.

Medical School Characteristics

Responses were received from 114 of the 117 deans. Four respondent schools were omitted from the subsequent analysis because three did not have an operational relationship with a parent university, and one was in the process of reviewing tenure policies. Four universities which did not award tenure to the clinical faculty were also excluded. Data obtained from the remaining 106 schools are summarized in Table 1.

Responses of Deans

The responding deans confirmed that almost all U.S. medical schools (96 percent) award tenure. However, the faculties of 63 percent of medical schools appoint some associate professors without tenure, and almost 50 percent employ some professors without tenure. Fifty-eight percent of the schools have formally recognized this situation by adopting an alternate faculty title or designation which distinguishes these academic appointments from those of the tenured faculty.

As reported, "institutional funds" to underwrite salaries for all senior faculty with continuous tenure are clearly inadequate. Thus, the majority of schools rely for support of full-time faculty on revenue over and above that derived directly from the institution, for example, fees from private practice and salaries allocated by affiliated hospitals. In three-fourths of medical schools with geographic full-time (GFT) faculty,* the institutional commitment covers the base salary only, whereas in the remaining schools the financial commitment to GFT faculty includes resources to facilitate the generation of practice income for supplementation of salaries.

At the present time 59 percent of the schools have less than 50 percent of the faculty in tenured positions. Thirty-five percent of schools have tenured between 50 percent and 75 percent of faculty members, and in 6 percent of schools more than 75 percent hold tenure. In the third group are several newly established schools which have not yet filled the complement of budgeted positions.

On the central issue of whether tenure should be retained in its present form, retained with modifications, or abolished, respondents strongly favored re-

TABLE 1

CHARACTERISTICS OF 106 U. S. MEDICAL SCHOOLS WITH TENURE SYSTEMS

Characteristics	Schools	
	No.	Percent
Type of support		
Private	41	38.7
Public	65	61.3
Geographic region		
East	31	29.2
Central	29	27.4
South	30	28.3
West	16	15.1
Age of school (data operational)		
Before 1965	80	75.5
1966–1970	12	11.3
1971–1976	14	13.2
All faculty strict full-time		
Yes	41	38.7
No	65	61.3
Percentage of faculty on strict full-time status*		
100	41	41.8
75–99	11	11.2
50–74	13	13.3
25–49	14	14.3
1–24	11	11.2
0	8	8.2
Faculty Unionized		
Yes	9	8.5
No	97	91.5

* Data missing from eight schools.

* Geographic full-time (GFT) means that the faculty member receives only a portion of his income as a base salary from the school and obtains the rest from nonschool sources, mainly from professional fees. Strict full-time (SFT) indicates that the individual is fully salaried by the school from funds derived from a variety of sources.

taining tenure in some form. Only 17 percent of deans preferred abolition. Twenty-four percent endorsed their present tenure system. The largest group (59 percent) would retain tenure with modifications. Differences between the responses of deans of private and public schools were not significant. The only difference observed between geographic regions was that respondents from medical schools in the central region tended to be less supportive of tenure. Deans of medical schools with a 100 percent strict full-time faculty would, slightly more frequently than others, retain tenure policies without modification.

Among the deans, tenure rated highest (67 percent) as an asset in recruiting faculty of high quality and next highest (53 percent) in retaining a high-quality faculty (Table 2). Approximately one-third of the deans regarded tenure as an asset in contributing to effective faculty performance and in protecting the school against adverse pressures. However, three-fourths viewed tenure as encouraging retention of ineffective faculty members, and one-half acknowledged that tenure permitted faculty members to avoid institutional commitments. Forty-two percent concurred that tenure blocked infusion of younger persons into the faculty, but only 20 percent agreed that tenure policies blocked the entrance of women or members of minority groups into the faculty.

A comparison of the views of the 25 respondents favoring retention of the tenure system in its present form with those of the 18 respondents preferring abolition of tenure disclosed interesting contrasts (Table 2). The former strongly favored the positive features of tenure and minimized the negative, while the latter took an opposite position.

Comparison of Responses

Faculty representatives from 56 medical schools responded to the questionnaire. These responses were compared with

TABLE 2

COMPARISON OF VIEWS OF THE 25 MEDICAL SCHOOL DEANS WHO FAVOR RETENTION OF PRESENT TENURE SYSTEM WITH THOSE OF 18 DEANS WHO FAVOR ABOLISHING TENURE SYSTEM

Attributes	Percent Affirmative Responses		
	Total Sample (n = 106)	Respondents	
		Favoring Retention of Tenure System (n = 25)	Favoring Abolishment of Tenure System (n = 18)
Positive			
Asset in recruitment of high-quality faculty	67	96	39
Asset in retention of faculty	53	92	24
Contributes to effective faculty performance	35	71	11
Protects school against adverse pressures	32	61	12
Negative			
Encourages retention of ineffective faculty members	75	36	90
Permits faculty members to avoid institutional commitments	48	16	72
Blocks infusion of young persons	42	8	61
Blocks infusion of members of minority groups or women	20	4	28

data assembled from the deans of the analogous schools, which, coincidently, matched well with the aggregate derived from the 106 deans. The comparative analysis was limited to responses dealing with positive and negative attitudes toward the tenure system and to views on retention, modification, and abolition of tenure.

In general, the attitudes of deans were congruous with those of faculty members participating in the survey, although faculty respondents were slightly more supportive of tenure. The only significant difference pertained to whether tenure is an asset which protects the school against adverse pressures. Here, the percentage of faculty representatives responding in the affirmative was twice as large as that of the deans.

Interviews with Deans

The 10 deans selected for interviews were at medical schools located in four geographic regions, two eastern, two central, two southern, and four western. In response to the questionnaire two deans had indicated preference for current tenure policies, one for abolition of tenure, and the remaining seven for tenure with modifications. Six of the medical schools were publicly supported and four were privately supported institutions. As a group the 10 schools had relatively strong financial bases.

At certain schools university governance had prescribed limits on the creation of additional tenured positions. Deans at the remainder were well aware of the long-term financial implications of further expansion of the tenured faculty. None of the deans seemed to regard current tenure policies and procedures as overly restrictive for the medical school, but most expressed concern about the future. Tenure was accepted as an integral part of academic tradition, with varying degrees of enthusiasm. The deans were not eager to take on the effort of abolishing tenure and believed that within their faculties strong resistance would be mounted against abrogation of tenure. They agreed that tenure was desirable for the core segment of the faculty but, without exception, recognized the need for one or more alternative methods of appointment of senior faculty members who were valued by the school but who either could not be assured of continuing funding or did not meet the academic criteria prescribed for appointment or promotion to tenured rank.

Generally, the nontenured senior faculty members are comprised of three distinct groups: first, the physician at the university hospital with outstanding competence as a teacher and clinician but with little depth in research; second, the laboratory investigator with financial support derived from research or contract funds; and, third, the senior staff member whose salary is supported by an affiliated hospital or program. In private institutions the trend was to appoint nontenured clinicians with a distinguishing title such as "professor of clinical . . ." and to offer appointment for a limited term ranging from one to six years. Publicly supported institutions more often granted nontenured clinicians a professorial title identical to that of other full-time faculty. Senior faculty members engaged almost exclusively in research often were given appointments of indeterminate duration, contingent on continuing funding. In public institutions more than in private, tenure slots tended to be allotted to individuals who played a major role in teaching programs.

Various alternatives to tenure were examined. Shifting to a system of renewable contracts of five or six years duration was considered, but doubt was expressed whether contracts would significantly in-

fluence the rate of retention of faculty members if review of performance were to be left in the hands of faculty committees. Several deans proposed lengthening the probationary period before awarding tenure or restricting tenure to full professors.

The role of tenure system in blocking efforts to terminate or relocate ineffective or incompetent faculty members was discussed. These were, in general, individuals who had been undeservedly awarded tenure during periods of rapid expansion or who had become prematurely obsolescent. Although their number was small, their continued presence on the faculty was a source of irritation. Deans believed that they lacked an effective mechanism to address these situations and predicted that attempts to terminate or transfer a tenured faculty member would evoke faculty opposition. For some, alternative roles could be found, but often no satisfactory solution was available. Early retirement has been considered and occasionally implemented, but financial resources were rarely adequate to make such an arrangement acceptable to the faculty member.

In conclusion, the deans were requested to project institutional responses in the event of a bona fide financial exigency. Without exception they were committed to assign highest priority to retention of tenured faculty members. Each concurred in the following order of retrenchment: termination of, first, temporary staff; second, part-time faculty; third, nontenured faculty; and, only finally, tenured faculty. In the last instance the deans accepted the obligation of transferring tenured faculty personnel to other positions, if possible, or of supporting a period of retraining, for example if the faculty member elected to enter private practice. Certain private medical schools confronted with a financial crisis would reduce student enrollment, but the deans of publicly supported schools affirmed that this alternative would not be acceptable to their governing boards or legislatures.

Financial Exigency

In recognizing that a tenured appointment can be terminated because of a "demonstrably bona fide financial exigency," the AAUP Recommended Institutional Regulations (RIR) on Academic Freedom and Tenure, published in 1968, include procedures for termination "when the intended action is based upon factors beyond the affected individual's direct control" (3). Stimulated by the increasing frequency of faculty dismissals on this premise, AAUP formulated in 1975 a revision of the RIR which proposed, in cases resulting from an assertion of financial exigency, specific procedures for distinguishing between those cases and the cases of formal programmatic or departmental discontinuance not mandated by financial exigency (7).

The revised RIR defines demonstrably bona fide financial exigency as "an imminent financial crisis which threatens the survival of the institution as a whole" and which cannot be alleviated by less drastic means than termination of tenured faculty. In this context Brown (8) has discussed financial exigency as a concept; reviewed legal precedents; commented on the role of the faculty in developing institutional responses to crisis; assessed the impact of "cross-currents," including seniority, age, and affirmative action upon alternative resolutions; and recognized obligations of the institution to nontenured as well as tenured faculty members who are terminated as a consequence of financial exigency. Given a fiscal crisis, he emphasized faculty participation in decisions pertaining to institutional retrenchment and commended prior adoption of an order of retrench-

ment that delineates the responsibility of the faculty in implementing the process for termination.

The deans viewed their institutions as already vulnerable as a result of dwindling revenues from sponsored research and training funds and federal capitation grants and of the erosive effects of inflation. Drastic curtailment of salaried positions, reduction in the support of clinical education programs based at affiliate hospitals, for example, hospitals operated by the Veterans Administration or by municipalities or counties, or a decline in professional fee income from faculty practice plans could bring the school to a state of financial exigency.

The AAUP statement and regulations enhance the economic security afforded by tenure through explicitly restrictive definition of the crisis circumstances when breach of contract is permissible. Furthermore, tenure is often perceived as a binding guaranty that the scale of compensation for tenured ranks will not be lowered. Yet, beset with financial exigency, a dean could propose and the faculty might agree to consider as an alternative to retrenchment the implementation of equitable salary reductions shared among the faculty. The acceptability of such a resolution would be greater in a compelling circumstance where the scope of terminations of nontenured and tenured faculty required to forestall bankruptcy would seriously deplete the integrity of the academic program.

Adaptations of medical schools to programmatic or departmental discontinuance not mandated by financial exigency are less stressful and had occurred uncommonly within the 10 selected medical schools.

Discussion

The debate on tenure in American universities is an old and continuing one. The present study focused on the situation in medical schools and, more narrowly, on an appraisal of tenure of clinical faculties—its advantages and disadvantages, the financial burdens it creates, the utility of modified or alternative systems, and the issue of abolition of tenure.

Medical school faculties are for many reasons large and expensive. In addition to the education of undergraduate students, the faculties are responsible for supervision of equally large programs of graduate training in the broad range of medical specialties. Faculties must have units of a size constituting a "critical mass" in each specialty in order for the programs to thrive. Concomitantly, faculties are heavily occupied in research. Moreover, academic physicians are increasingly engaged in postgraduate education and in programs of recertification and are assuming an expansive role as providers of medical services.

Medical school faculties are diverse. At one end of the spectrum are members of basic science departments, who function much as their counterparts in the parent university and for whom tenure is pivotally important. They comprise a small segment of the total medical school faculty, often 20 percent or less (2). At the opposite end of the spectrum are physicians, performing specialized surgical or diagnostic procedures, who are much like practitioners. For many of them tenure is unnecessary and, in fact, unrewarding. In between are the majority of faculty members, with varying degrees of commitment to teaching, research, and patient care. This group generally accepts tenure as an integral part of the academic structure.

As has been noted, most of the deans and faculty representatives endorsed the tenure system; albeit in some modified form, and recognized its value in the recruitment and retention of able young faculty members. The reason for the latter is clear. The bright young physician

faces a choice between entering practice or remaining in an academic setting. To compete with the inducements of practice, the medical school must provide an environment which offers the young academician not only the opportunity to develop teaching and clinical skills and research interests but also the promise that, if certain standards are met, the academic aspirant will advance into a position of reasonable security. For some individuals deferred entry into practice would not be difficult and might be advantageous. For many others the transition in mid-career would entail a difficult rearrangement in life-style, and this prospect might be a deterrent to the perceptive individual considering an academic career.

Quite apart from security of position, tenure has high symbolic importance. It signifies recognition by peers of unusual achievement and promise and represents the final step, following the long and arduous probation, in acceptance as a permanent member of the medical faculty community.

Relatively few deans viewed protection against adverse pressures as an important consideration in evaluating a tenure system. Faculty members were more worried about this than deans, presumably because they are concerned not only about external forces but also about arbitrary action by department chairmen, deans, or higher administrative officers, particularly when there is a change in leadership.

Three-fourths of the deans cited as an undesirable product of the tenure system the retention of ineffective faculty members. Though the number of such individuals was relatively small, the problem was nonetheless vexing and demoralizing. The incidence was minimized if tenure procedures were rigorous and consideration was given not only to the past accomplishments of the individual but also to the difficult task of forecasting the impact of time and aging upon the performance of the candidate. Moreover, several deans observed that the failure of an individual to function satisfactorily may reflect poor departmental leadership.

High visibility of the clinical teacher probably inhibits retention of incompetent faculty members. The performance of the clinician is constantly subject to scrutiny by undergraduate students, by an even more critical house staff, and by colleagues and department chairmen. His research is subject to peer review. If there is failure to attain high standards, the clinical teacher is uncomfortable and a sensitive chairman will reassign the faculty member to areas of responsibility where he can be effective.

Respondents expressed concern about prospective faculty stagnation. Most individuals acquire tenure at the age of 40 and anticipate 25 additional years as faculty members. Consequently, unless faculty size grows more than is expected, fewer opportunities to award tenure to new faculty members will be available during the ensuing two decades. Decelerating faculty growth will also make it more difficult to balance faculties with appointments of minority group members and women.

Opportunities for young members of the faculty to advance into tenured positions could increase if the turnover of tenured faculty was accelerated. Proposals for pertinent reform were discussed in the interviews with deans. These included: lowering retirement age; encouraging early retirement; shortening the annual term of appointment of senior faculty, for example, from an 11- or 12-month year to a 9-month academic year; transferring tenured faculty to salaried positions in affiliated hospitals; and providing time and support for retraining prior to undertaking a new endeavor or

entering practice. To date, there has not been extensive experience with these approaches, and the issue is unresolved.

Most medical schools do not adhere to traditional tenure policies. Thus, medical faculties include at least two types of full-time appointees: those with continuous tenure and others who do not have a commitment of continuing financial support. The latter individuals hold senior academic rank and may or may not have full faculty privileges but are often highly valued by the medical school. Predictable problems exist in maintaining harmony and unity in this dual faculty structure, notably in preserving, to the extent possible, equity for the nontenured faculty.

The faculties of 9 percent of medical schools are unionized and an additional 11 percent have considered or are considering unionization. With one exception, the unionized faculties are in state-supported schools in the Northeast, and unionization is a relatively recent development. The respondents from these schools reported that: traditional tenure systems may continue as before within a unionized system; criteria for seniority and appointment and review proeess tend to alter and submerge the preexisting tenure procedures; and the administration of tenure policies and procedures becomes more complex and controversial between union and administration. Experience is too limited to permit a well-based prediction on the likelihood that unionization will spread rapidly or on the effect which this will have on existing tenure systems. However, it seems probable that the trend toward unionization will be encouraged as the proportion of senior nontenured faculty increases and if existing tenure systems are curtailed or abolished. Finally, a totally new situation will be created if faculty unions become parts of far larger unions made up primarily of other health-related workers.

The relative importance of the secure (hard) or insecure (soft) financial resources on which individual schools rely for faculty support is variable and changing. Income from practice by individual faculty members or groups or associations within the faculty has become an increasingly significant source of faculty salaries (2). How this revenue is allocated plays a determinant role in the size of the tenured faculty and in the nature of the tenure commitment. When all or a large portion of practice income is retained by the individual who is reimbursed for the service, the amount available for those tenured faculty who are not large income producers will be reduced and the amount which the school can commit as salary to the producer will be smaller. As observed earlier, approximately three-fourths of the schools with GFT faculties guarantee only that part of the salary which is derived from "institutional funds," that is, tenure with a partial salary. When, on the other hand, a substantial proportion of practice income remains for allocation by the school as a whole or by the department, provision can be made to support the full salaries of a considerably larger tenured faculty.

In the majority of medical schools the proportion of tenured faculty is less than 50 percent, but a significant number of schools have awarded tenure to between 50 percent and 75 percent of the faculty. Most of the deans who were interviewed forecast that serious constraints will be encountered when 75 percent of the faculty is tenured but foresee a period for adaptation before restricted growth becomes an acute problem. Clearly, each medical school will be forced sooner or later to fix a ceiling on the size of the tenured faculty or risk compromising institutional solvency.

The major and imminent threat to the tenure system is a financial exigency. In-

solvency could ensue when revenue for support of faculty salaries is reduced to the point where resources are inadequate to meet financial obligations; and, as a result, faculty members would be dismissed. At that point presumably tenured faculty would be terminated last inasmuch as such a policy has both a moral base and legal precedent. The sequence for retrenchment, however, may conflict with the needs of the institution and preclude retention of a faculty composition appropriate for the mission of the medical school.

American medical schools have succeeded well over the past 25 years in recruiting and retaining faculties of high quality. Yet the contributions of tenure policies to these achievements is difficult to assess. The results of this study suggest that the medical schools which have fared best regard the preservation of tenure as important. Presently, little reason and even less support for the abolition of tenure are demonstrable. The collected data, however, provide grounds to justify continuing modification of existing tenure systems and experimentation with other methods of academic appointment which are designed to promote equity, retain the effectiveness of faculty members, assure access to the academic ladder for young persons and members of minority groups and women, and at the same time enable appropriate institutional responses to financial problems.

The value and validity of tenure as a social institution depend upon its capacity to advance the mission of the university and the academic aspirations of the faculty. In recognizing that one is indispensable to the other, tenure is an "embodiment of the postulate that faculty members are not employees of the university, but are the university" (9).

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Tenure in Medical Schools in the 1980s

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Abstract—Tenure in American medical schools is a personnel policy which exists in relation to institutional policies and realities. It is related to the functions of academic institutions and their capacity for carrying out these functions, and it arises from the needs of an open society to sustain critical and innovative roles for its universities, the necessity for universities to support and protect their faculties, the optimization of their capability to react to new opportunities, and the demands of ever shifting social circumstances. The relation between society and its universities and the balance among the various roles of the universities have not been stable in the past and will not be so in the future. Tenure policies will continue to be modified. The leadership of institutions needs to be aware of the fact that the modifications will occur and of what might be termed the plasticity of tenure.

The explosive growth in the size, number, and programs of medical schools of the 1960s and 1970s has ended. Public pronouncements now call for the curtailment of growth if not for a reduction in current levels of academic medical center operations. Recent years have seen at many medical centers a shift in emphasis toward patient care and a variety of service programs. The increasing size and complexity of medical schools and their teaching hospitals have been accompanied by a proliferation of regulations and by a decline of institutional autonomy. The social environment in which medical schools exist and from which they draw their support and much of their direction is constantly changing.

Medical teaching, research, and patient care are labor intensive. Thus, personnel policies are one of the highest priorities for those responsible for the direction of medical schools and teaching hospitals. For the faculty, tenure is the heart of academic personnel policy. In 1977 Spellman and Meiklejohn documented the near ubiquity of tenure in American medical schools (1).

Change in the environment of and support systems for medical schools must impinge upon the policies for selection, advancement, reward, and retention of the medical center's faculty and staff. Many medical schools are aware of these pressures for continuing evolution of their appointments and promotions policies. These concerns have been communicated to the Association of American Medical Colleges (AAMC) through its Management Advancement Program and Management Education Network projects. Such concerns

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stimulated a lengthy study that this paper summarizes (2). The authors' conclusions are that tenure is here to stay; that it is a mutable university policy; that its application has changed and continues to change; and that change is a process over which medical center administrations can and should exert considerable control.

Methods

Reasoning that administrators of medical schools involved in major alterations in their appointments policies would have become well informed about issues surrounding tenure, the authors approached a small but representative sample of these schools. Five schools were visited, and the policies and procedures of three others were reviewed. A total of 62 persons were interviewed at the visited schools. Information gained from these interviews, data drawn from AAMC files on faculties and institutions, and a review of the literature pertinent to the uses of tenure in medical and professional schools constitute the foundation for this paper (3–7).

Three long-established medical schools and two of more recent origin were visited. Four are state-supported; three are large; and two operate their own hospitals. Three have simple and two have complex hospital affiliation networks. Two are heavily research-oriented. Those interviewed included the dean; a sample of department chairmen; the chairman and other persons from the appointments, promotions, and tenure committee or its equivalent; and a few junior people, some tenured and some competing for tenure. Information was collected and recorded on the processes and administrative structures used for promotions and tenure decisions. Forces for changes in appointments, promotions, and tenure practices were identified and discussed, and the consequences of changes in these areas were considered. Similar data were also collected by correspondence from two large private schools and from the University of California system (8, 9).

Results

Spellman and Meiklejohn (1) found that 96 percent of American medical schools have some provisions for tenure. Seventy-six of the 80 sets of medical school bylaws on file at the AAMC contain (or may be presumed to contain in their parent university bylaws) provisions governing appointments, promotions, and tenure. Although the bylaws vary, they delineate what is expected of (*a*) the individual faculty member, (*b*) the department and/or its chairperson, (*c*) the medical school, and (*d*) the parent university or its equivalent. Three of the five visited schools were in the process of changing their bylaws.

Consistently found procedural steps include: (*a*) nomination of the individual at the department level, (*b*) evaluation by an institutional level promotion and tenure committee advising the dean, (*c*) evaluation of the dean's (institutional) recommendations by a university-wide committee or by the president of the university and his staff, and (*d*) action on the president's recommendation by a governing board.

Interinstitutional variation is found in how these steps are handled. Routinely, individuals are responsible for preparing their own supporting papers for promotion. Department chairmen have considerable influence and significant responsibilities in promotion and tenure decisions, but the degree to which chairmen effectively exert their influence varies. This divergence reflects the level of intrainstitutional and extrainstitutional recognition accorded to the chairman, the quality of the chairman's previous nominations, the timing of the action, the ability of the chairman to present the candidate and his contribution to the institution in the best possible light, and the capacity of the

chairman or the department to generate resources to support the nominee.

Tenure and promotions committees are constituted to represent different interests and groups within the faculty. Older members are chosen to preserve awareness of precedents and to lend continuity to decisions through their memories of past actions. Others are chosen for their adherence to high scientific standards or appreciation of clinical skills. Collectively these committees are expected to express the values and attitudes considered central by the institution. These committees may serve as a buffer between the dean and the rest of the institution. Since tenure and promotions committees participate in judgments critical to the future effectiveness of the institution, they are important and may be very influential. As a generalization, the more prestigious schools and faculties tend to have more discriminating and respected promotions committees, and these committees are expected to preserve institutional standards. It appears that committees made up of professors who are not chairmen and for whom extended terms of appointment are permitted are the most influential.

The evaluation of the merits and accomplishments of each individual is the responsibility of the departments and the promotions committee. The dean and his staff are expected to evaluate institutional needs, priorities, and capacities and to weigh competing demands upon available resources. There is a belief that many tenure decisions are pro forma. However, that definitely was not what was found by the authors during site visits. Deliberations were often long and intense. Faculties were very aware of the significance of committee decisions.

At and above the level of the dean's office, decisions about faculty appointments and promotions are related to institutional policies and practices. Governing boards do not seem to be involving themselves in the selection of individual faculty members. Finances, legal issues, even-handed administration from unit to unit, and the promotion of agreed upon standards within the university are the primary considerations at the university or governing board level.

Grievance procedures were written into the bylaws at all the visited schools. Faculty members may and do ask for review, reconsideration, or appeal of adverse tenure or promotions decisions. Provisions for review by faculty and ad hoc groups at both medical school and university levels are common. In addition, faculty members have access to the courts, a recourse rarely used until recent years. At least two of the universities in the sample had recently been involved in legal battles over promotions and/or tenure matters. In both instances, the necessity for legal involvement was considered a failure of university procedures and processes. Society is now so quick to submit issues to litigation that it is important for bylaws to state clearly criteria and processes for promotion and tenure and to delineate the procedures and processes for appeals of such decisions.

MEANING OF TENURE

Tenure can be construed to guarantee title only; title and the right to teach, investigate, and publish results; all of these plus that portion of salary and fringe benefits derived from university funds; all of these plus salaries and benefits from all sources; and these plus associated hospital appointments and privileges. At all the institutions visited, very different impressions were expressed by administrators and by faculty members about what is tenured or guaranteed each faculty member by his institution's faculty bylaws. This was to be expected since written statements of tenure guarantees are unusual. There is broad concurrence that tenure benefits may be

abrogated by resignation, retirement, disability, dereliction of duties, or financial exigency. It is known that abrogation of tenure for the last two reasons will often be contested (4, 5). As another generalization, most administrators operate on the assumption that title, total salary, and fringe benefits derived from university and medical school sources are tenured but that administrative titles and compensation for administrative and/or hospital responsibilities are not.

An issue of current interest is that of job security for the nontenured person of some seniority. How many years must someone serve before he earns from the institution the kinds of obligation implied in tenure in the event that the individual involuntarily leaves the faculty? One concept is that many years of satisfactory service coupled with reduced expectations of other employment do result in de facto if not de jure tenure. In other words, after some unspecified number of years, an individual attains some "equity" in his job.

The assumption that everyone has equivalent access to tenure is not accurate. A department's size, its type, its rate of growth, age of its members, the expectations of the chairman, a change in the chairmanship, and level of funding can and do impinge upon opportunities for the advancement and permanent placement of an individual in an institution. Indeed, such factors are creating many pressures for change. The recent rapid growth of clinical faculties whose support is derived primarily from practice income is a case in point. A second is the large number of grant-supported basic scientists in clinical departments on whom much of the department research may depend. Persons committed to medical center programs in affiliated institutions and funded by these institutions are a third. The willingness of a university to find an avenue for the professional advancement, influence, and security of such faculty members becomes a tangible expression of institutional support for these individuals and their contributions.

QUANTITATIVE PRESSURES

There are quantitative pressures that are forcing changes in faculty appointments and promotions policies. These include the expanded teaching load resulting from the growth in the numbers of medical students, residents, and fellows in the past decade. There has been a dramatic increase in clinical work in actual numbers of patients and inpatient days and in procedures per patient. All of these factors are reflected in the 110 percent growth in full-time clinical faculty members in recent years. Accompanying these changes have been heightened competition for extramural research support, declining resources for research from private philanthropy, the effects of inflation, and the rising cost of increasingly sophisticated equipment. In addition, there has been rapid growth in institutional dependence on income from patient care and a relative decrease in federal research funds (from 46.3 to 25 percent of medical school revenues in the 1968–1978 period). The cash flow in university hospitals increased 300 percent between 1972 and 1978. From 1967 to 1978, revenue from patient fees grew more than 12 times, or from approximately $50 million to more than $600 million, and both of these are conservative estimates. Given this scenario, administrators are faced with the challenge of finding mechanisms for rewarding and retaining those who specialize in patient care and on whose activities their institutions are increasingly dependent (10–13). These changes are occurring in face of increasing resistance from university boards to any increase in the size of the tenured faculty because of slowing institutional growth and rising inflation.

QUALITATIVE PRESSURES

In addition to documented changes in both the volume and mix of academic medical center work, perceptions about changing qualitative or "social forces" emerged from site visits, from the quantitative data, and from the literature. These include the differential in the growth rates of medical schools and of their parent universities; continued societal pressures for changes in institutional medical school/teaching hospital objectives; the sense that universities in general and medical schools as component parts are becoming "tenured in"; a complementary concern that the job security guaranteed by tenure is inversely related to professional productivity, that is, that it promotes institutional deadwood; a lack of clarity in criteria and the procedure used in making appointments for the growing number of medical school faculty members in atypical roles; and rapidly and radically changing attitudes and regulations about retirement.

DISPARATE RATES OF GROWTH

The post-World War II stimulus for growth and the resulting expansion of all levels of postsecondary education in the United States had already begun their decline by 1965 when the explosive growth of medical schools began. An inevitable result of the differences in growth rates between the universities and their medical schools was the conflict described by Clark Kerr (14) in 1972: "I know of no area of higher education where complexities have increased so rapidly and to such a high level of intricacy, where so many changes have been made academically and administratively and where so many new buildings have been built." Medical schools have been pushed by pent-up demand for an increase in the number of physicians, a tidal wave of demand for service resulting from the 1965 Medicare and Medicaid legislation, an exhilarating series of technological advances, fruitful research, and a growing affluence of the public that has made money available for health services. Thus, as the university was developing strategies to contain expansion, its medical school was in a period of rapid growth. The result of this juxtaposition was and is conflict among the various university subdivisions. Any simplistic policy for promotion and tenure became subject to great pressure.

The combination of dramatic economic, social, and demographic changes of the last decade, together with technological advances, has had an impact on medical center tasks (15). Some tasks have been expanded at the expense of others, and centers find themselves deeply involved in problems which heretofore had either been remote or of little interest to most faculty members. These institutions now find themselves attempting to increase the national capacity to conduct biomedical research, to improve the knowledge base and skills of new physicians, to strengthen the training of medical specialists, to maximize the benefits of the high technology services of tertiary care hospitals, and to give higher quality services to those unable to pay for private medical care. Combined, the effects of newer technologies, the greatly increased demand for services, the increasing complexity of tasks, a much larger scale of operations, and very different systems of remuneration and regulation have transformed strikingly the work of medical centers and their faculties.

The medical centers' espousal and development of technology illustrate this point. This has led to the addition of staff members who are expert in the application of technology and has forced on medical centers the role of "court of last resort" for patients requiring these technologies, a situation unique to academic medical centers. Corporations in serious difficulty are not referred to business schools, nor do

law school faculties serve as part-time judges on appellate courts. Thus, societal expectation has led to the addition of persons often highly but narrowly expert. How does one evaluate the academic contribution of a person expert in the use of computerized axial tomography?

At the other end of the scale is the responsibility of faculty members for the direct care of large numbers of Medicare- and Medicaid-supported patients with the most mundane of problems. Such patients tend to see the medical center as "their doctor" and a staff person as their contact (primary physician), a role not sought by many faculty members. The realities of this interrelationship and Medicare-Medicaid regulations and the necessity of the medical centers to recapture some of the cost of the work they do have joined to require the involvement of many clinical faculty members in one-on-one primary care. However, the delivery of first-class primary care is not construed as an important academic activity by classical university promotions committees. Often located in deteriorating urban environments, academic medical centers have by default become the de facto primary care physicians for local populations seeking care in outpatient clinics and emergency rooms. Physicians must be found not only to treat such persons but also to manage and organize their care, to negotiate with appropriate agencies, and to supervise what have become large enterprises. These are not scholarly roles, but they have led to the expansion of faculties. Other social problems that have been "medicalized" and thus are involving the academic medical centers include the attempts to respond to the physical effects of epidemic drug abuse, the increasing numbers of pregnancies in young women, and the needs of elderly people (16).

A completely different pressure creating new roles comes from the necessity to manage what have become very large institutions. Expanding patient populations, house staffs which have doubled and may total 500, a fully salaried faculty in equivalent numbers, total employees numbering up to 5,000, and budgets approaching $150 million per year are not uncommon. The sheer size of these operations requires specialized individuals who are capable of managing them and of dealing with the many regulations governing the building, operations, safety, and employment procedures in the actual facilities in which work takes place. As a result, the faculty "manager" has emerged to join the faculty "scholar."

Expanded medical center responsibilities have also created needs for professionals in such fields as physics, nursing, social work, psychology, biometry, and computer science and people knowledgeable in the use and care of sophisticated instrumentation. Where do such people fit in traditional tenure and promotion systems? How does an institution promote the career of a physicist working with a neutron generator in a department of therapeutic radiology in an affiliated institution removed from the campus? If excluded from tenure track appointments, how are these faculty/staff members assured of access to advancement and a reasonable level of security? Are they to be evaluated by the customary faculty peer review processes or by other methods?

'TENURED UP'

"Tenured up" or "tenured in" occurs when the resources of a department are so obligated that no new appointments can be made. This phenomenon had not occurred in the visited institutions, but some basic science departments did have large percentages of their personnel budgets committed to persons currently holding tenured positions. A high of 69 percent and a low of 32 percent of basic science faculties

were found to be tenured in the authors' small sample of schools. The reasons that high tenure ratios are not a major problem in medical schools are (*a*) that department chairmen are aware of the potential problems this would entail, (*b*) recent rapid growth, (*c*) a relatively young faculty, and (*d*) easy interinstitutional movement. This is a set of circumstances many believe will not apply in the decade ahead.

Intellectual productivity in tenure-heavy departments is thought to be hampered by such factors as: (*a*) too large a proportion of total resources devoted to high salaries; (*b*) investment by senior people of time and effort in extrainstitutional, extradepartmental, national, and personal affairs; (*c*) too few intradepartmental opportunities for scientific self renewal; (*d*) a discouraging environment for younger and talented people seeking advancement. This partial list constitutes a formula for stagnation. Its prevention by a department depends primarily on the careful selection of faculty, keeping salaries low enough for people to be attracted by other offers, insistence on high productivity and interaction with peers, high visibility for the department and its personnel, continuing efforts for a significant role in medical school affairs, moving people to new environments for brief periods, and maintaining a high value for scholarship.

Does tenure, by providing too much security, contribute to stagnation? Clearly the answer is "sometimes." However, individuals interviewed on site visits denied that such stagnation is the fault of the tenure system. The purpose of tenure is to select, protect, and make secure the best, brightest, most creative, and most energetic scholars. It is elitist by definition. It is a system that is designed to further the creative functions of the university. At its best, the university should be a tough-minded place willing to tolerate and support the discomforts that a highly critical, highly selective, and highly competitive group of people engenders. If a department is willing to adhere to high standards, the rewards are high quality faculty members who are stimulated to be productive. Such departments can enjoy a high turnover by sending out good people and by developing a reputation for quality. They can compete successfully for resources precisely because of that reputation. Rewards for the careful selection of people are still high, but the penalties for poor appointments are greater than ever. This is attributed to the lack of new funds to support an additional person, the lack of underutilized space for an additional person, and a slowdown in the expansion of other schools creating berths to which an unproductive but tenured person might be moved.

The fact that the tenure system forces a department to live with a bad choice is seen as one of its greatest strengths. Strict adherence to "up or out" rules forces decisions. Any mitigation of this stringency, regardless of its rationalization, is seen as a violation of one of the fundamental purposes of tenure. This belief is the source of some of the objections which arise when faculties, in their effort to adapt to the changes described in this paper, advocate additional series of appointments or the "non-tenure" permanent appointments to be described later.

DEADWOOD

Tenure was initiated to protect universities in their role as critics of society. If this responsibility is to be carried out, professors require protection from intimidation and recrimination. Over the years this simple but important policy has acquired a series of operating rules that make it difficult to dismiss a tenured faculty member. The implied employment guarantee creates the specter of an institution burdened by a collection of preseniles, preretirees, or

deadwood who are not productive and whose presence blocks the advancement of qualified younger people.

At only one visited school did the academic leaders identify such nonproductive senior faculty personnel as a significant problem in their institution. They attributed their problem to careless selection and appointment procedures in the past. Specifically, decisions had been left largely to departments with very little control at the institution-wide or medical dean's level. Virtually no control had been exercised at the university level. Up or out rules had not been applied. At no other institution did the leadership or faculty feel that low productivity among senior personnel was a significant problem. The reasons for this were largely attributed to the rigor of the selection process, strict adherence to institutional rules, and the role of vigorous competition for faculty appointments.

Individuals selected for tenure are usually over 35. By this time, levels of energy and habits are well enough delineated to allow reasonably accurate projections of contributions the individual is likely to make in the future.

The only protection against deadwood is the exercise of great care and discrimination in initial appointments. Tenure neither ensures a good faculty nor protects against a somnolent one, but the selectivity and vigor with which it is applied have everything to do with the quality of the faculty that emerges.

ALTERNATE TRACKS

The pressures outlined above, especially the growth of tertiary care in teaching hospitals, are severely testing the flexibility and capacity of medical school appointment systems. The problem is by no means new. For years some medical schools have employed a few fully salaried individuals who were not tenured but who were reappointed from year to year indefinitely until retirement. Usually these were clinicians who devoted their energies to a teaching hospital (most often in patient care or bedside teaching) and who had only small research or administrative involvement. However, other examples could be found in persons especially gifted at teaching narrowly defined but important subject matter or in others entirely devoted to their research, often highly technical, and with little interest in the broader affairs of the institution. Usually, but not always, the titles of the clinicians in this category are modified by a descriptor such as "clinical" after their rank and before their field of interest, for example, professor of clinical anesthesiology. The University of California system adds the phrase "in residence," and other universities designate the location of the person's activities, such as "professor of pediatrics at Memorial Hospital."

The use of this kind of nontenure track appointment is on the rise. Two of the visited schools were implementing such appointments; another had already done so; and one had decided to expand its partially salaried faculty rather than to initiate a special series of appointments. One had decided not to expand its use of such appointments. In 1976, in a sample of 41 medical schools, 16 used such appointments, 19 did not, and six were considering their use.* Nontenure track appointments also exist for basic scientists. Individuals in this category tend to be totally committed to research and are almost always supported by extramural funds.

There are objections to one-year renewable full-time nontenure track appointments. Some see it as a retreat from the

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* Personal communication, J. Abrams, M.D., University of Vermont College of Medicine, 1976.

full-time, fully salaried system that is such an integral part of American medical education and assert that such appointments dilute both the loyalty and commitment of an individual to the medical school. Bypassing the stringent evaluations implicit in the tenure system suggests a weakening of commitment to original scholarship. Critics say that such appointments sanction a two-tiered system of first- and second-class citizens. On the other hand, proponents of these nontenure track appointments argue that they suit the realities of the modern tertiary care medical center and are, therefore, a necessary adaptation on the part of the university. Of the people interviewed during this study, those active in clinical practice appeared less concerned about tenure track appointments than those who were more completely involved with only medical school activities. Interestingly, nontenured appointments were not accompanied by higher salaries or different rewards to compensate for the lesser security these positions imply. A striking feature of these nontenure track plans is the insistence written into the regulations governing these appointments that those appointed to the alternate tracks should have achieved distinction in their fields. That this series of appointments shall not be a refuge for those who fail to get tenure is also reflected in the regulations. There is wide variation in how a faculty member may enter this track or move from it. Provisions are often made for entry to the nontenure track de novo or for entry to it from the tenure track. Provisions for a transfer from nontenure to tenure tracks were infrequent.

RETIREMENT

The Age Discrimination in Employment Act of 1977, which extended the mandatory retirement age to 70, was stimulated by many factors, including the increasing number of people surviving and in good health over age 65; the cost of maintaining a large population outside the work force; the changing ratio of people over 65 to those under 65; political and social pressures brought by large numbers of underemployed older people; and the effects and fear of the effects of inflation. This law prohibits the mandatory retirement of tenured college and university personnel prior to age 70 effective July 1, 1982. This change comes at precisely the time when medical school faculties are entering a period of limited growth. Most of the senior faculty members interviewed think that many faculty members will stay on to age 70 and sometimes even later if allowed. One of the universities in the study has seen a recent and dramatic increase in the proportion of people eligible for retirement who are electing to continue their professional activities. The explanation appears to be primarily financial. There is a longer period of earned salary; and the longer a person works and the later he retires, the greater are his chances for his retirement income to keep pace with inflation.

Also important are changing attitudes. People who are physically and mentally active wish to stay involved with their work, their friends, their associates, and their students in familiar surroundings. Thus, the more conservative planning assumption should be that although some faculty members will retire early, most will not (17). If one assumes that the resources needed to support a faculty person include dollars, space, equipment, and opportunity and that these resources are fixed or growing only slowly, the effects of delayed retirement will be in two stages. Initially, resources committed to existing faculty will not be available to support new hirings. This will, in turn, result in a faculty that does not grow and one that is somewhat older with a somewhat higher aver-

age salary cost per person. Eventually a new equilibrium will be reached with the numbers of people joining and leaving the faculty in balance. The planning assumption is that this turnover per 100 faculty members per year may be slower than has been characteristic of medical schools recently because the average faculty member, once appointed, will stay longer.

Another effect on the age of institutional faculties is found in historically different rates of faculty growth. From 1967 to 1977 faculty growth was very rapid. Both before and after this decade it was less so. Thus, there is a relatively small number of faculty members now in their 60s and a large number in their 30s and 40s. This cohort will have an impact on medical school costs during the next 20 to 25 years, a factor with which all medical schools will have to cope. In addition to the concerns about the financial implications of retaining an older and more highly paid faculty, there are the imponderables about the continuing vitality of research programs during a period of limited growth with an aging group of professors. Based on 25 years of faculty data at the Case Western Reserve University School of Medicine, Kutina and colleagues (18) constructed a model which permits projection of the effects of such variables as retirement age, rate of inflation, differential rates of faculty growth, and length of pretenure period on faculty composition and commensurate institutional financial commitments. This management tool, which has now been replicated at several medical schools, is useful in determining the implications of various appointments and promotions policy alternates.

Summary and Conclusion

Tenure is not a practice which exists independently of institutional policies and realities. Tenure is a personnel policy related to the functions of academic institutions and to their capacity for carrying out these functions. Tenure policy is produced by a combination of factors: the need of an open society to sustain the critical and innovative roles of its universities; the necessity for universities to support and protect their faculties; the need to assure the capability of universities to attract and retain gifted, dedicated, and talented people to faculties; the desirability of maintaining a balance between stability and the ability to react appropriately to new stimuli and opportunities; and the demands of ever shifting social circumstances, values, and attitudes. The relation between society and its universities has not been stable in the past and will not be stable in the future. Therefore, tenure policies will continue to be modified. Modifications may include (*a*) changes in the definition of who gets tenure and under what conditions; (*b*) changes in the guarantees implied by tenure, that is, position, function, salary, and/or procedural rights; (*c*) changes in the combination of forces in an institution contributing to such judgments; and (*d*) the development of different kinds of faculty appointments. Since these changes can have direct effects on institutional performance, an institution's leadership needs to be aware of what might be termed the plasticity of tenure.

The 1980s are being seen as a decade of continuing change and pressure for change in academic medical centers during a period of limited or no increase in resources. Although individual faculty members and department chairmen discuss the many opportunities for growth and development in terms of their units and themselves, the limited or no growth forecast appears to be a reality. An inevitable result of the ensuing stabilization will be increasing tension over jobs and security. Both positive and negative results may be invoked.

On one hand, a positive Japanese-like model of increased loyalty to institutions, greater devotion to institutional goals, and more willingness to support common purposes can be envisioned. On the other hand, one can consider the British industrial model of lowered production, increasing confrontation, emphasis on the preservation of the status quo, and an escalation of legal actions. Reality will, of course, contain some elements of each of these models. Whether an institution emerges stable or stagnant will not be determined by a benign or malign environment but by the skill of the people responsible for its direction. One obvious conclusion is that mistakes in personnel selection and direction will become very costly.

Tenure is a faculty matter. This attitude is derived from the classic and jealously guarded right of a university faculty to select its members. Thus, tenure will continue to be managed in collegial style, which implies consensus, committees, time, patience, objections, and criticisms. Despite the somewhat circuitous processes implied, the rewards of having a faculty solidly in support of tenure policies are so great as to justify deep involvement of the faculty in alterations in appointment systems. It must be recognized, however, that the process of changing tenure policies will not be conducted with placid rationality at every step if faculty involvement is prominent.

No matter what its original origins, tenure in American universities came to the fore in the clash between proponents and critics of rampant industrialism. Thus, tenure as we know it has developed as an adaptation of institutions to social pressures exerted on and by them. This evolutionary process is healthy, and it is to be hoped that it will continue. If this is to be the case, persons responsible for medical schools and medical centers must continuously consider the effects of their tenure policies on the futures of their institutions and on the processes by which these policies can best be modulated to serve institutional purposes. In the final analysis, tenure is a manageable process.

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JANET BICKEL, M.A.

The Changing Faces of Promotion and Tenure at U.S. Medical Schools

Abstract—Faced with many potentially divisive questions related to tenure and promotion, leaders at medical schools have lacked an overview of examples of how other medical schools are adapting their faculty policies to reflect changing realities. This article reports results of a survey of U.S. medical school deans and of interviews with faculty affairs administrators regarding areas of change in faculty appointment, promotion, and tenure policies. Examples of adaptations are reported under the following headings: use of tenure; financial guarantees of tenure; criteria for award of tenure; probationary period; post-tenure review; advising faculty; clinician-educator tracks; and recruiting women and minority faculty. Of these, the adaptation entailing the most activity and about which the most information was obtained concerns establishing a clinician-educator track. Numerous examples are provided of schools' evolutions of policies with regard to modifying titles of clinical-educators, defining promotion criteria, monitoring transfer between tracks, and defining contract periods, benefits, and privileges. The primary challenge for medical school administrators is to build sufficient flexibility into their promotion policies to show that the institution values the many different types of faculty needed, and at the same time to provide adequate security to essential faculty. *Acad. Med.* 66(1991):249–256.

U.S. medical school faculties continue to grow. Between 1980 and 1988, the number of full-time preclinical faculty increased 17% to 15,127, and the number of full-time clinical faculty increased almost 50% to 57,193. This expansion occurred while the number of medical students was decreasing, such that nationally there were about 5,000 fewer medical students than faculty members in 1988. And these faculty were joined by almost 10,000 part-time and 127,000 volunteer faculty.[1] However, size presents much less of a challenge than many other features of the present faculty scene.

Academic medical centers are wedded both to a university culture and to the health care industry; in addition to education and research, their missions include the advancement of health care technology and the care of the underserved. The diversity of these missions requires a diverse faculty. This requirement, escalating costs, and financial constraints are exacerbating existing tensions within academic medical centers and between medical schools and their parent universities. In particular, medical schools' increasing reliance on the patient base and income generated by clinical faculty, and the concomitant need to reward these faculty with promotion, clash with the traditional academic ideal of scholarship. Many of the reasons why clinical faculty are important to medical schools do not even appear on the university scale of academic values, e.g., making hospital referrals, supervising residents, and performing clinical trials.

Charged with assuring excellence in the education, patient care, and biomedical research enterprises, deans must continuously consider the effects of their appointment and tenure policies on their institutions. Not only are familiar financial pressures encouraging reexamination of tenure and its guarantees; starting in 1994, there will be no mandatory retirement age for tenured faculty[2] and some deans foresee resulting tie-ups of space and resources.

The literature offers no recent overview of tenure-related policies. In 1976 Spellman and Meiklejohn[3] surveyed medical school deans regarding tenure systems. While 67% of the responding deans rated tenure as an asset in recruiting faculty, 75% viewed tenure as encouraging the retention of ineffective faculty, and half acknowledged that tenure permitted faculty to avoid institutional commitments. In 1980, Smythe and colleagues[4] looked at schools involved in major alterations of their appointment policies and concluded that because the relations between society and its universities will never be stable, tenure policies will continue to be modified. They concluded that these modifications will be managed in collegial style, "which implies consensus, committees, time, patience, objections, and criticisms [because] the rewards of having a faculty solidly in support of tenure policies are so great as to justify deep involvement of the faculty in alterations." In 1983 the Association of American Medical Colleges (AAMC), stimulated by its Group on Business Affairs, surveyed U.S. and Canadian medical school deans regarding faculty appointment practices; the resulting reference guide[5] provides the names of the schools that responded "yes" or "no" to having the various institutional characteristics stated on the questionnaire. Finally, in an oft-cited 1984 paper[6] Petersdorf argued strongly against tenure because of the resources it locks up, the competition among young faculty it can engender, and the potential "disengagement" of older tenured faculty. Since these publications, no overview of tenure or faculty-related policies has been published, and medical school administrators have lacked a means to consider the direction or span of adaptations under way at other medical schools. The present report attempts to provide such an overview.

Method

An informal AAMC survey of faculty affairs deans attending a 1988 AAMC Annual Meeting session aided AAMC staff in refining a list of areas of change in faculty appointment, pro-

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motion, and tenure policies. This formed the basis of a questionnaire sent from the AAMC's president, Robert G. Petersdorf, M.D., to U.S. medical school deans in January 1989. For each of 22 areas, the deans were asked to check whether a policy or procedure (1) had been altered within the past three years or (2) was presently under review. Brief descriptions of the changes and the name of the primary faculty affairs contact(s) at the school were also requested.

After a second mailing to nonresponders in March, a total of 113 (90%) of the questionnaires were returned. Combining schools that had recently altered a policy with those presently reviewing a policy, the most frequently checked areas of change were the following:

- Redefinition of tenure track promotion criteria (88 schools, or 78% of the 113 that responded)
- Promotion criteria for non-tenure tracks (74 schools, or 65%)
- Documentation process for award of tenure (72 schools, or 64%)
- Affirmative action incentives (62 schools, or 55%)
- Advising process for faculty regarding progress toward promotion (59 schools, or 52%)
- Development of a non-tenure track (56 schools, or 50%)

In order to obtain additional background and perspectives regarding these changes, telephone interviews averaging 15 minutes in length were conducted with the dean or faculty affairs designee at 63 of the 113 responding schools; these 63 were most of the schools that had checked three or more items on the survey. Summaries of the interviews were combined with all the written comments from the questionnaires, including the written comments from 28 schools that had not been contacted for an interview. (Twenty-two of the 113 responding schools had not submitted any written comments.) This compendium, summarized in the rest of this article, is organized by subject matter and includes descriptive information on the areas of change in the faculty appointment and promotion policies of 91 schools (72% of all U.S. medical schools).

Results

Two caveats must be stated clearly before proceeding. First, each medical school's faculty promotion and personnel system is the product of its history, its goals, and a variety of environmental factors such that no two schools' policies are strictly comparable. Such common designations as "professor" or "tenure" will have different meanings from school to school depending on the guidelines in place for awarding them. The present study was designed to allow a qualitative overview of policy adaptations under way, not to produce a numerical profile of characteristics of schools' policies and practices. Given the noncomparability of schools' policies, it is unclear whether a study attempting such a profile would yield any more useful an overview than the present study. Second, because of the dynamic interrelationships among policy areas pertaining to faculty, any method of grouping distorts their connectedness. However, the following groupings were chosen for reporting the results of this survey: (1) use of tenure, (2) financial guarantees of tenure, (3) criteria for award of tenure, (4) probationary period, (5) post-tenure review, (6) advising faculty, (7) clinician-educator tracks, and (8) recruiting women and minority faculty.

Use of Tenure

Compiling national data on tenure status is difficult because schools' definitions and reporting practices vary; however, the proportion of full-time faculty with tenure appears to be decreasing. According to data from the AAMC's Faculty Roster System, 41% of faculty for whom tenure-status data were available had tenure in 1985.[7] In 1989, this proportion had decreased to 38%.[8] Another approach is to attempt to look at the number of schools granting tenure. According to results from the 1983 AAMC study,[5] five U.S. schools awarded tenure to basic sciences faculty only and an additional seven had no tenure-appointment system. Results of the present survey show that one of these seven schools (a relatively small and young one) has created a tenure system; but three schools reported a virtual freeze on tenure, and two reported substantial decreases in the numbers of faculty being awarded tenure. Moreover, since the completion of the interviews, additional schools have inquired of AAMC staff regarding any actions other schools are taking to limit the number of tenured faculty and the guarantees accompanying tenure. Another source of evidence here is a 1988 survey of colleges and universities;[9] 93% of the respondents reported some action during the previous three years to reduce the percentage of tenured faculty.

At a number of medical schools, the tenure review process now begins with the determination of the number of tenure slots that can be financially supported. Because of the economic impact of tenure decisions, at Jefferson Medical College of Thomas Jefferson University, the faculty voted in 1987 to leave tenure decisions in the hands of the dean. Another approach is for the dean to negotiate annually the number of available slots with department heads. At another school, chairs confer with the dean before proposing anyone for tenure, and a determination is made as to financial resources; if these are judged to be adequate, the dean appoints an ad hoc committee to examine the candidate and make a recommendation to the standing review committee. At another medical school—ever since 1970 when its parent university placed a freeze on the award of tenure—the dean negotiates each year with the president for tenure slots, department heads nominate individuals for consideration, and a committee of professors reviews the nominees and rank-orders them; the dean discusses this list with the president.

Financial Guarantees

With the elimination of mandatory retirement imminent, medical school deans and business officers are increasingly concerned about what fi-

nancial guarantees accompany tenure. Many schools have never stated their guarantees in writing. In response to the 1983 AAMC survey[5] on faculty policies, 12% of the schools indicated that tenure guaranteed "total salary"; 42%, however, stated "continued appointment at designated rank *without* salary guarantee." The remaining schools noted that some portion of salary was guaranteed, usually limited to that supported with university funds, and usually excluding contributions from faculty practice. At some state schools, tenure financially guarantees only those funds provided through the state-appropriated budget. Conversely, the University of Washington School of Medicine gives tenure only to faculty receiving state support; since this applies to few faculty at that school, it grants "academic tenure" to some faculty, with no monetary guarantees. While most faculty bylaws are silent on the subject of guarantees, the faculty handbook of Northwestern University Medical School states: "A faculty member will be notified in writing by the dean at the time tenure is awarded regarding the level of the base salary. The base salary is usually zero for physician faculty members who are awarded tenure." At the other end of the complexity continuum, last year Dartmouth Medical School approved its Program for Extended Guarantee of Compensation, which assures full salary for the duration of the guarantee. In brief, when an individual is appointed to the rank of associate professor or professor in the tenure track, he or she is granted an Individual Compensation Reserve Account (ICRA) containing 250 base points, each of which is equivalent to 1% of annual compensation. In the event that an individual experiences a shortfall in total compensation from internal or external sources, base points are withdrawn from his or her ICRA.

Criteria for Award of Tenure

Limiting the number of faculty awarded tenure usually involves a fresh look at promotion criteria. A related impetus for examining these criteria is faculty members' need for guidance on what is required. Thus, not surprisingly, virtually all of the 88 schools that checked "redefining tenure track promotion criteria" on the survey were adding specificity to their guidelines.

With regard to determination of research excellence, the data suggest that schools are looking more closely at candidates' accomplishments. In a move begun by Harvard Medical School in conjunction with efforts to bolster research ethics and to combat the charge of trivialization, at least seven schools now either limit the number of publications reviewed for promotion, have eliminated specific numerical requirements, or require fewer publications than previously; a more critical evaluation of publications usually results from these practices. At the University of Texas Southwestern Medical Center, candidates must submit a summary of how their contributions have extended knowledge, and promotion is based on the substantive nature of these contributions rather than on the length of the bibliography. Some schools are broadening their definition of "scholarly activity" beyond clinical or laboratory research. For instance, the Virginia Commonwealth University Medical College of Virginia School of Medicine gives credit for the development of educational materials; additional credit accrues to the author when the materials are used by another institution or society.

Likewise, a substantial number of schools reported working toward the goals of bolstering documentation and reward of faculty members' teaching contributions. A number of years ago Irby[10] described the University of Washington School of Medicine's experience with adding peer review to its faculty evaluation system; recently that university mandated the inclusion of peer review in the faculty evaluation system. A few other schools are also focusing attention on obtaining the evaluation of peers, which significantly enhances the information available about teaching performance. For instance, the Department of Medicine at Ohio State University College of Medicine is piloting a method that includes a three-person team that reviews a faculty member's teaching twice in each teaching category (e.g., lecture). Probably the main difficulty with peer review is its time-intensiveness, but other issues such as observing clinical teaching without intruding arise as well.

At the University of Wisconsin Medical School, when teaching constitutes a major portion of the basis for tenure nomination, the promotions review committee must be notified a year in advance. This committee appoints three faculty to monitor the candidate's teaching skills and scholarly contributions to education. For the evaluation of clinical faculty, a number of schools rely on residents' (sometimes anonymous) evaluation of faculty (e.g., Case Western Reserve School of Medicine; the University of California, Los Angeles, UCLA School of Medicine). The educational database that faculty at the University of Pennsylvania School of Medicine are required to build is probably the most extensive in the country, is more formal than the database required by the other schools within the university, and is credited with improving the quality of education at the school.[11] One recent benefit of that university's evaluation system is that since more teaching is documented, more teaching awards are given, and teaching receives more weight in the promotion process.

Probationary Period

A number of forces have encouraged a lengthening of the probationary period that faculty are allowed between their initial appointment and the tenure decision: (1) grant-writing takes up more time because of intense competition for research funds; (2) faculty have increasing clinical service responsibilities because of the need to generate funds; (3) young clinicians need time to prepare for subspecialty boards; (4) faculty with responsibility for young children cannot simultaneously meet all the requirements for tenure. The American Association of University Professors (AAUP) holds

that lengthening the probationary period beyond the traditional seven-year limit (which actually translates into six years before review) not only weakens the tenure system but results in the retention of unpromising faculty and in department chairs' "using faculty up."[12]

While the debate about the advisability of the seven-year probationary period is likely to continue, many medical schools have lengthened theirs. Clinicians on both tenure and clinician-educator tracks at the University of Pennsylvania School of Medicine have a ten-year probationary period, whereas basic scientists and faculty on the research track have a seven-year one. Recently, basic science chairs attempted to extend this period by one year, but the basic science faculty (heavily influenced by the AAUP) voted against it. A number of years ago, Duke University School of Medicine faculty won the option of requesting a one- to three-year extension of the "accrual period" (i.e., accruing time toward tenure); recently Duke University also lengthened the regular accrual period from seven to eight years. The University of Rochester School of Medicine and Dentistry has taken a slightly different route: associate professors on the tenure track may be considered for unlimited tenure after the first five years or after the second five; if they do not meet the requirements at that point, they may switch to the non-tenure track. The pre-tenure period for all faculty at Case Western Reserve University School of Medicine is nine years from the data of initial appointment as assistant professor; this may be shortened for faculty with prior experience elsewhere. The pre-tenure periods may be extended up to three years for a variety of reasons; a one-year extension is automatically granted to a woman upon request within one year of the birth of a child. Last year, the University of California system added a "clock-stopping" provision that allows childbearing and childrearing leave (which may be granted for a period up to one year) to be excluded from the eight-year probationary period.

A few schools have eliminated the concept of probationary period; for instance, assistant professors may have two-year renewable appointments, and associate professors may have no closing dates on their appointments. Last year, the University of Nebraska College of Medicine eliminated its "up or out" provision, such that faculty can be on the tenure track in untenured status indefinitely; whenever they are able to meet the requirements for tenure, their chair can nominate them. Moving in the other direction, Vanderbilt University School of Medicine replaced its indefinite probationary period with a clearly defined seven-year period, with provisions for a maximum extension of two years for specified exigencies.

Post-tenure Review

Schools have not moved aggressively in instituting post-tenure evaluations. One school with a mandatory comprehensive five-to-seven-year post-tenure review recently surveyed those members of its faculty who have undergone this review; because most faculty reported that it was not helpful, the school is reconsidering this policy. Some schools report that every faculty member is reviewed annually. At one of these, merit pay is tied to the evaluation's results, and 1% or more is subtracted if the evaluation is unsatisfactory. Another school noted that while its review of high-ranked faculty may be fairly casual, if the faculty member has stopped being productive, no raise is given. At another school, when the faculty member becomes unproductive, the chair brings the case up to the executive committee of the committee of chairs; while the person cannot be demoted, he or she can be clinically reassigned. At Bowman Gray School of Medicine of Wake Forest University, at five-year intervals each department chair reports to the dean on the performance of each tenured faculty member. If the performance is judged to be inadequate, the faculty member is notified of specific inadequacies and given a two-year probationary period in which to correct the deficiencies or resign. The University of California system is instituting a plan to allow dismissal of "demonstrably incompetent" tenured faculty. On the constructive side, the University of California, Los Angeles, UCLA School of Medicine recently instituted a committee of senior faculty who will offer assistance to tenured faculty who have become less productive.

Advising Faculty

With the goal of improving the evaluation of faculty, not only are schools adding detail to their promotion guidelines, but many are also working harder at advising their faculties regarding faculty policies. One approach initiated by the Medical Faculty Women's Group at the University of Southern California School of Medicine is publication of a "Survival Manual for New Faculty," which includes descriptions of types of appointments, committees, and evaluation procedures, as well as advice about maintaining one's own personnel file and locating resources. This handbook is now distributed to both new men and new women faculty. The University of California, Los Angeles, UCLA School of Medicine uses a more personalized approach; the reporting mechanism for the mandatory "fourth-year appraisal" has been changed so that faculty are directly informed by the faculty affairs dean about the appraisal (rather than relying on the department chair). The faculty affairs dean also holds an annual general meeting to explain the promotion system and meets individually with many faculty before their fourth-year reviews to help them prepare.

Another approach is to assist faculty in evaluating themselves. A number of departments at the University of Pittsburgh School of Medicine are experimenting with a faculty performance appraisal system. Faculty are given a computer diskette with the appraisal from formatted on it; they can update at any time their research, teaching, administrative, or patient care activities. The division director uses this information to complete an evaluation form, which is

discussed with the faculty member. Each year at Jefferson Medical College of Thomas Jefferson University, faculty submit a plan for the apportionment of their time, and the division chief or chair meets with each faculty member to review his or her plan. A consensus is achieved, and while this stands as the basis for performance review, this system's primary goal is to encourage the faculty to grow.

The Medical College of Georgia School of Medicine is developing a document that will make explicit the chair's responsibilities to assist their faculties in growing and becoming more productive. At another school, whenever a faculty member is denied tenure, the dean reviews with the chair his or her advising responsibilities.

Clinician-educator Tracks

Medical schools' growing reliance on clinicians as educators and on clinical income has spawned a variety of accommodations. Thus it is not surprising that in the course of this study more information was obtained about establishing a clinical education track than about any other policy adaptation. Most schools with traditional tenure systems have instituted some form of alternative recruitment and advancement route for clinicians. In 1986, Jones[13] surveyed medical schools regarding the presence of a "nontenure track for full-time M.D. faculty who are primarily engaged in patient care and teaching." Of the 112 medical schools that grant tenure to clinical faculty, he identified 61 (55%) as having such a track. Information obtained in the course of the present study has revealed that one school was included among those 61 in error; an additional 20 schools have added a clinical track as defined above; and three have added a *tenured* clinician-educator track. Thus it can be estimated that at least 83 schools (74% of 112) have instituted an advancement ladder for faculty with the M.D. degree that gives greater weight to clinical and educational contributions than to research productivity. An additional five schools report actively considering instituting such a ladder; one is considering dismantling theirs.

The difficulty of the birth of these tracks has varied greatly from school to school. In some cases, as with lengthening the probationary period, university approval has been hard to win and has involved a long process of educating university leaders about the importance of clinical service and why most clinical faculty are not as heavily involved in research as are tenure-track faculty. At others, when basic scientists see that keeping excellent clinicians is essential to the health of the hospital and thus to the resources available to the medical school, and when relations between officials of the medical school and university are close, approval has been noncontroversial. At Ohio State University, the University of Pennsylvania, and the University of Michigan, other health professions schools on campus have created clinical tracks modeled after the medical school's.

At most schools that have created a clinical track, the overriding need was for a mechanism whereby the school could retain valuable clinical teachers without bending the tenure guidelines to pieces. Academic physicians are engaged in educating residents as well as students and are increasingly likely to be found in ambulatory-care settings and in highly subspecialized technical fields; they thus "look" less and less like other university or basic science faculty members, necessitating different promotion standards. Given the span of medical schools' missions, if there is only one track, there will be tension among different types of faculty about the promotion criteria. If there are two tracks, the tension will be between the tracks. Neither method eliminates the tension.

A few schools are now considering creating a second clinical track to differentiate between clinicians who do some investigation and those who do none. One school that has such multiple tracks, however, is concluding that too much differentiation can result in keeping marginal faculty.

Just as no two tenure tracks are identical, no two clinician-educator tracks are exactly alike. However, the most controversial questions that arise at the birth of or early in the life of a track can be summarized under five headings:

Titles. Modifying the titles of clinical faculty (e.g., professor "of clinical surgery" or "clinical" professor) on the clinician-educator track has been called "degrading" and an assurance of "second-class citizenship." In replacing its non-tenure clinical track recently with a new "medical center" line, Stanford University School of Medicine chose *not* to use "clinical" in the title in order "to improve the esprit de corps of the faculty and to honor clinician-teachers in a way that is appropriate." Schools at which all full-time faculty at the level of associate professor or above have equivalent titles, regardless of track, appear to find this a satisfactory arrangement (e.g., the University of Pittsburgh School of Medicine, Harvard Medical School). In a different vein, one school added prestige to its clinician-educator track by granting tenure to faculty who gain promotion to the rank of professor on this track. Whether elimination of the clinical prefix or suffix is key to a track's acceptance remains controversial; however, "second class status" probably has less to do with a title than with evaluation methods and benefits and privileges.

Defining promotion criteria and standards. The work of defining promotion standards for a new clinician-educator track, especially regarding teaching contributions (see the earlier section on criteria for award of tenure), often has resulted in standards that are more detailed than those on the books for the equivalent rank on the tenure track. In terms of the process of arriving at criteria, at the University of Missouri—Columbia School of Medicine, the 12 clinical chairs were asked to submit promotion guidelines for the clinical track, and these were combined into one set. Many schools with new tracks are still working out what the promotion criteria should be. Typically, the hierarchy of requisites for tenure is research, teaching, and service; for clinician-educator tracks, this hierarchy

is reversed. Another characteristic of clinical tracks, compared with regular tracks, is that promotion may be based upon excellence in one area without a similar requirement in all areas.

One challenge that arises is translating "service" into an academic criterion and then educating university administrators regarding its importance. In this regard, the Pennsylvania State University College of Medicine has developed two forms: (1) The "Patient Care Activities" form requires candidates to discuss the activities in terms of number and complexity of cases, time commitments, and how the case load of the candidate compares with those of others in that specialty (comparisons between and within specialties are facilitated by the use of a "relative value scale" for major and minor procedures developed by the American Medical Association); (2) the "Service to the University and the Public" form asks candidates to emphasize not only their medical school service but also their teaching, research, and service to the university and community. The University of Pittsburgh School of Medicine also focuses on the role-model component of service.

The creation of clinician-educator tracks highlights the need for reliable peer evaluations of clinical skills. Paul Ramsey[14] has spearheaded the development of such data for use in the physician recertification process. This work may also allow the use of peer ratings of clinical skills as objective data in the promotion of faculty.

Monitoring transfer between tracks. Schools have found that hiring faculty directly onto the clinician-educator track helps to alleviate misperceptions about the track and may enhance its reputation. Ohio State University limits the percentage of College of Medicine faculty who can be on the clinical track to not more than 33% of each department. However, most institutions appear to believe that a cap is not necessary. At Case Western Reserve University School of Medicine, about half of the faculty are on the nontenure track; a faculty committee monitors the track to assure it is not abused. At most medical schools, the promotion and tenure committee (often composed of tenured faculty only) reviews all promotion recommendations. The University of Miami School of Medicine recently found that adding to its committee two faculty from the clinician-educator track and one from its research track helped both the review process and the prestige of these tracks. In most cases it appears that clinical track appointments are not reviewed by the university promotions committee.

Most schools have created or tightened policies that restrict switching between tracks. For instance, faculty on the new clinician-educator track at Temple University School of Medicine may apply for transfer to the presidential, i.e., tenure track (so named because the university president rather than the dean has final approval) during the first two years of their appointments, if there is a position available on the presidential track. Temple faculty wishing to switch from the tenure to the clinical track must apply for transfer no later than the year before they must stand for tenure; they must also meet the criteria for the clinical track, which are much better defined and in some cases more stringent than those for the tenure track. At Oregon Health Sciences University School of Medicine, all nontenured faculty within a department are evaluated for transfer to the tenure track before one is selected. At most schools, once faculty members have transferred to a nontenure track, they cannot return to the tenure track.

Schools that tighten their tenure-track promotion criteria may experience pressure to allow tenure-track faculty to take a "furlough" on the clinical track to garner time to publish, but this practice could alienate basic scientists and other university faculty and ultimately weaken the clinical track. Cornell University Medical College offers another approach: for the first six years, all faculty are "unmodified" assistant professors, and then the decision is made as to track, thus preventing premature placement.

Contract period. Typically, contract periods vary from one to five years, depending on the faculty member's rank and value to the institution, with faculty review occurring in the penultimate year. Another method is to give all clinician-educator faculty three-year contracts. However, some medical schools have run into difficulties with a university practice of limiting contracts for "nonregular" appointments to one year. One such school conducts a yearly review of each faculty member as required by the university but completes a rigorous review every third year. In order to give clinical faculty more security, some departments at schools limited to one-year contracts have extended termination notice periods.

Lengthening contract periods for a sizeable percentage of a school's faculty raises questions regarding the institution's responsibilities to such faculty members: at what point does a faculty member have de facto tenure? If the faculty member challenges termination, can the school defend its review process? Such questions will probably be receiving increasing attention by university counsel as the decade progresses.

Benefits and privileges. Insurance and other benefits and voting privileges are often more important than faculty titles in determining how faculty perceive a faculty ladder. Existing tracks illustrate the gamut of possible arrangements. At Temple University School of Medicine, there are no differences between the clinician-educators and the tenured faculty with regard to benefits and privileges. At the University of Rochester School of Medicine and Dentistry, associate professors and professors on all three tracks have the same benefits with faculty at lower ranks being in another benefit category. On Stanford University School of Medicine's new "medical center" line, faculty will receive most university benefits and be given a fairly low base salary, with annually negotiated additions, such that these faculty have the potential to earn more than tenured faculty. A difficulty for clinical faculty at

the University of Missouri—Kansas City School of Medicine is that, because they are paid through an affiliated hospital rather than through the university, they are considered "nonregular" and therefore not entitled to certain benefits, e.g., they are ineligible for intramural research grants. At the University of Missouri—Columbia School of Medicine, clinical-track faculty cannot serve on the promotion and tenure committee and do not have voting privileges in the university but do have voting privileges in the School of Medicine. Ohio State University College of Medicine found that the appointment of clinical faculty to leadership roles on major committees has helped to improve the status of the clinician-educator track.

Women and Minority Faculty

Because the full-time faculty is still largely men (80%) and white (82%), with proportionately few women or ethnic minorities achieving promotion to the higher academic ranks,[15] deans continue to search for effective affirmative action mechanisms. However, while 62 of the 113 schools responding to the present survey checked "affirmative action incentives" as an area of recent activity, few gave specific examples of this activity. One school established an Office for Minority Enhancement, which includes a program run out of the president's office for providing funds that can be added to salaries to offer minority faculty. A more grassroots approach initiated at another school was to create an Office for Minority Housestaff; this improved morale such that these housestaff are successfully recruiting other minority housestaff.

A number of medical schools reported benefits accruing when the university's affirmative action offer is forthcoming in guiding searches and explaining compliance with guidelines. Alternatively, other stimuli may be needed. One dean appointed a women's advisory group that continuously reviews affirmative action implementation strategies and helps keep the dean's eye on affirmative action goals. Another has an assistant for minority faculty recruitment who works with program and department heads. Another school now requires chairs to review the composition of any search committee and search plan with the dean's office. Related as much to the process of advising faculty as to affirmative action, another medical school's promotion and tenure committee has advisory subcommittees for both women and minorities. In addition, four departmental promotion and tenure committees have subcommittees with members who review with all junior women and minority faculty their dossiers and suggest ways to improve their promotability.

In 1989, Yale University School of Medicine's Task Force on Women Faculty promulgated 13 recommendations related to increasing the numbers of senior women faculty, which the dean strongly supported and the faculty adopted. One of these recommendations is to increase the percentage of Yale's tenured women from 7% to 2% by 1993. Pursuant to this goal is the recent publication of a handbook titled *Faculty Recruitment and Appointment Guide with Emphasis on Increasing the Representation of Women and Minority Group Members.* Other recommendations pertain to developing a comprehensive child care program and encouraging faculty to take parental leave, since the tenure policy allows "clock-stopping," and since part-time faculty can be on the tenure track. The University of Virginia School of Medicine also recently completed a study of the status of women students, housestaff, and faculty; many of the resulting recommendations deal with barriers to advancement of women faculty, and many are meant to improve the environment for men as well as for women.

Discussion

This survey of deans has revealed that over three-fourths of U.S. medical schools have recently made or are in the process of completing changes in their faculty appointment and promotion practices. While the survey and the follow-up interviews did not produce numerical estimates of various features or of changes in faculty policies, the results do provide illustrations of adaptation and allow a few generalizations. It is clear that many schools are examining tenure vis-à-vis financial obligations, adding specificity to promotion and tenure guidelines, allowing extensions of the tenure probationary period, and improving the guidance faculty receive regarding faculty tracks and the promotion process.

The most common stimulus for change has been the need for increased flexibility in retaining and rewarding the mix of faculty necessary to meet institutional needs. In order to retain valued clinicians, most schools have created a clinician-educator track and have employed a variety of strategies to legitimize it. In this work, medical school administrators face challenges in educating university and medical school promotions and tenure committees regarding what constitutes "scholarship" and "professional service" in clinical education and in primary care. Administrators are also having to work harder at educating faculty about the timetables and promotion requirements of the various tracks, and at dealing with questions of equity for medical school faculty who may not meet traditional tenure-track criteria, e.g., faculty with Ph.D.s in clinical departments.

Many of the above-mentioned adaptations bring into question what tenure can mean in a system that has multiple tracks and uncertain financial guarantees. Some medical school faculty are confused about whether tenure is a right; but many university faculty, to whom tenure is essential, are concerned that the meaning of tenure is being worn away by medical schools' "tinkering" with it. Tenure was created as a means of protecting academic freedom; but this goal bears little relation to the meaning medical faculty invest in it today. Given the approaching end of mandatory retirement at age 70 and the high salaries

of senior medical school faculty, more than a few medical school deans may decide it is a luxury they can not afford to offer clinical faculty.

While this survey has provided examples of medical schools' policy *adaptations*, medical school leaders need to think in terms of fashioning a forward-looking *faculty management system*. A systems approach requires strategies for sensing needs, defining problems, attaining consensus on needed changes, and then managing the change process. Piecemeal reforms and short-sighted responses are bound to be ineffective in the present "faculty affairs" environment, which may be characterized as follows:

- Continuing growth in the size of the clinical faculty, most of whom lack knowledge about and responsibility for the general education program[16]
- Increasing numbers of talented young faculty who are unable to establish independent lines of research and whose grant-getting success is declining
- Medical schools' growing dependence on professional fee income and reimbursements from hospitals, together now totalling 48% of medical school revenues[17]
- Increasing complexity of all financial arrangements, with affiliation agreements with hospitals and other health care organizations under continual renegotiation
- Increasingly delicate balance of power among the medical school, hospitals, parent university, and state funding source
- Increasing calls for assessment of educational "outcomes"[18]
- Increasing demographic diversity of the student body, which includes medical students, residents, and fellows, as well as undergraduate, graduate, and other health professions students

Against this volatile backdrop, most deans' lists of short- and long-range faculty management goals may well include examination of the following factors:

- Whether the faculty is in danger of becoming over-tenured
- Whether evaluation mechanisms are perceived as fair by the faculty, are operating efficiently, and allow termination of unproductive faculty
- Whether the faculty reward system (i.e., titles, salaries, privileges) adequately reflects the missions of the institution, especially with regard to medical students' education
- Finding ways to assure faculty access to resources to improve their teaching and research skills
- Finding ways to assure that department chairs give their faculties the leadership and professional guidance they need
- Finding ways to educate university leaders regarding the importance of clinicians' teaching and service contributions
- Finding ways to increase the proportions of women and minority faculty in senior positions

Last fall for the first time the AAMC sponsored a Faculty Affairs Professional Development Seminar, which was attended by over 80 medical school administrators and which included discussion of many of these management tasks. In addition to sponsoring future seminars, the AAMC is also working to improve its ability to serve as a clearinghouse on faculty evaluation and other faculty-related developments and strategies, which this article only begins to address.

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PAPER

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Medical Education in the 1990s—and Beyond: A View from the United States

ABSTRACT

American medical education is under continued study, and reforms are being suggested to improve it. The current paper reviews the standard U.S. medical school curriculum and discusses suggestions for change. Medical education must become more student- and learning-oriented, must place more emphasis on primary care, and must use new settings for education. The paper also examines the reasons that medical schools fail in their education mission.

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In this paper we describe some of the changes occurring in U.S. medical education. The changes are, for the most part, aimed at improving what most would consider already a very good educational system. Many of these changes have already occurred in Europe or are likely to do so soon. Although some may argue that these changes are less relevant to medical education in the developing world, such an argument is unduly pessimistic. Medical education is progressing the world over, and we contend that its rate of progress is as great in the developing as in the developed world.

As individuals from various countries read this paper, we hope they will consider questions such as the following: In countries other than the United States, how does medical education—and the changes being undertaken or proposed—resemble and differ from what we describe? What do the answers imply regarding components of quality in medical education that transcend national boundaries and components that are more country-specific? Given the increasingly widespread recognition that preparation to deliver primary care must be improved, what are the key elements of a quality education in this realm?

In North America in the last decade, medical education has been the subject of a number of comprehensive reviews and targeted foundation programs. The Josiah Macy Foundation, the Pew Charitable Trusts, the W.K. Kellogg Foundation, and the Robert Wood Johnson Foundation have all been engaged in studies of medical education with the aim of improving and changing our academic institutions, their educational programs, and the physicians they produce.[1–4] The consensus of these organizations seems to be that the education we are giving our medical students is dated, arcane, and not in tune with societal needs.

The Association of American Medical Colleges (AAMC) itself has contributed to this steadily growing genre of medical education literature with the 1984 publication of *Physicians for the Twenty-First Century*, the report of the panel on the General Professional Education of the Physician and College Preparation for Medicine (known familiarly as the GPEP report)[5] and with a follow-up report issued in 1992 on assessing the further changes in medical education.[6]

Given the generally held view that the U.S. system of medical education is among the best in the world, the frustration that the U.S. medical education community feels for this constant microscopic examination of medical education is understandable. We feel that medical education need not be equated with the *Titanic*, sinking after it has rammed the iceberg while the band played. Nonetheless, it seems essential for those of us who have been involved in medical education to recognize the need for change in certain key respects, and we are trying to make appropriate changes. Moreover, it is clear that curricular changes are not made easily, particularly when these changes are sweeping. We

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must recognize also that such changes are, by and large, a mandate given the faculty, and that much more so than our student bodies and even our administrations, the faculty is conservative and slow to change.

In this paper we discuss the content of the medical curriculum, strategies for teaching and learning, suggestions for curricular and pedagogic change, educational settings, the student body, and the faculty. These topics should serve as a framework to consider the challenges U.S., and indeed all, medical education faces and to organize an institutional response to these challenges.

The Content of the Medical Curriculum

Let us begin with a review of the curriculum. Although we frequently extol the virtues of diversity in U.S. medical education, most medical schools in the United States follow a traditional curriculum. In general, U.S. medical students now spend their first two years studying mainly anatomy and cell biology, biochemistry and molecular biology, physiology, pharmacology, microbiology, and pathology. These core courses are often enriched by other topics such as medical ethics, biostatistics, medical interviewing, humanities in medicine, and medical sociology.

These first two years of basic science preparation are generally followed by a year of required clinical clerkships. The disciplines of these clerkships generally include internal medicine, pediatrics, psychiatry, obstetrics and gynecology, surgery, and, in many schools, family medicine. The length of these clerkships may range from six to twelve, or even sixteen, weeks. Some schools also have required clinical experiences of shorter duration than the major clerkships. The fourth year of medical school provides additional clinical experiences, generally by means of a mixture of elective and required course work, in disciplines such as radiology, anesthesiology, and the medical and surgical subspecialties.[7]

After receiving the MD degree, new physicians begin an intensive period of hospital-based clinical training, called residency, that lasts from three to seven years. This training prepares them for the practice of a particular medical specialty. This system has served U.S. medical education well by establishing our physicians as among the world's best trained and most scientifically based. Nevertheless, 80 years after the Flexner report, the academic medicine community is trying to define a post-Flexnerian model of medical education that will carry the profession into the next century. The stimuli to such change are several:

- Biomedical knowledge has grown exponentially. In particular, advances in molecular and cell biology have refined the understanding of mechanisms governing health and disease.
- Recent discoveries in biochemistry, immunology, and genetics that explain fundamental biological processes mandate a closer integration of the study of the basic sciences and that of clinical medicine. Such integration can be achieved only through a more interdisciplinary approach to medical education.
- A number of recent studies of medical education emphasize the desirability of making education more student- and learning-oriented rather than faculty- and teaching-oriented. This orientation requires that medical faculties offer educational experiences in which students are active, independent learners and problem-solvers, rather than passive recipients of information.
- Greater attention is being paid to the patient-physician relationship and to giving students the skills and attitudes to make this relationship more meaningful. There is also increased emphasis on the physician's responsibility to work with individual patients and their communities to promote health and prevent disease.
- Whereas heretofore most clinical education has taken place in the teaching hospital, in recent years medical educators have come to recognize that the teaching hospital has significant deficiencies as an educational setting.

Strategies for Teaching and Learning

In response to stimuli for change, the process of medical education, particularly in the undergraduate four years, is under review at most medical schools, and alternative curricula and teaching methodologies are being tried and evaluated. The objective of most of the revisions is to develop the medical student as an adult learner—one who is a self-starter, a problem-solver, and a critical thinker—and to link the content of the course work more closely with the treatment of patients.

In some schools, significant curricular change is taking place. For example, the shortcomings of the didactic lecture as a teaching tool are well known, especially in preparing for a profession whose practitioners must develop the habit of lifelong learning to maintain professional competence. First-year curricula now contain fewer scheduled hours and fewer lecture hours. From 1983 to 1992, the average number of scheduled hours in required first-year courses decreased from 988 hours to 780 hours, and the average number of lecture hours declined from 450 to 370. These reductions represent worthwhile attempts to add learning experiences that are less didactic. In many schools, more emphasis is now placed on tutorials, small group sessions, and independent study.

Lecture hours are not the only place where judicious pruning of the curriculum is in order. Taylor reported that for second-year students at the University of Southern California School of Medicine in 1990–91, the required reading

totaled 11,000 pages, requiring an estimated 1,700-plus hours to complete. Recommended books added more than 7,000 pages and faculty handouts another 4,000-plus pages.[8] This amount is clearly too much. In an accompanying editorial, Kassirer suggested that a better strategy would be to teach students to acquire the skills necessary to search the medical literature for information relevant to clinical problems. He observed, "[W]ith a minimum of training, students can learn how to search efficiently and parsimoniously, and this skill lasts a lifetime."[9]

Several relatively new pedagogic methodologies are receiving increased emphasis in medical schools. One of these is problem-based learning, which allows students to accept responsibility for their own learning. Educational researchers believe that the problem-based learning approach is especially effective in integrating principles from the basic sciences with specific clinical experiences. Student evaluations of this approach have been positive.

Another educational innovation is the use of standardized patients, both real and simulated, to provide standardized clinical learning experiences and to reduce subjectivity in the assessment of students' clinical performance.[10] In a typical evaluation based on standardized patients, students rotate through various examination stations so that all students see the same patients, each of whom has been taught to present his or her case consistently and to evaluate the students' skills in history-taking, physical examination, and interpersonal interaction. The use of standardized patients is of particular interest in the search for evaluation and assessment methodologies that are competency-based, and the Educational Commission for Foreign Medical Graduates is planning to incorporate this technology into its examinations. The multiple-choice examination, long a staple evaluative tool in medical education, is recognized as being of limited use in predicting how well an individual will perform in the practice of clinical medicine. New ways of assessing clinical skills are being studied at many schools to link the process of education more closely with the desired outcome of clinical competence.

Medical schools are also finding new ways to use computers to improve the efficiency of information storage and retrieval, to assist in medical decision making, and to provide educational opportunities. Computers are routinely used for electronic searches of the medical literature, for storage of medical information systems, and for computer-based medical education. Computer simulations have a number of instructional advantages over traditional approaches. These advantages include a greater number and variability of cases to which students are exposed, more control over the complexity of the problems presented at different points in the student's learning curve, the ability to follow diseases over longer periods of time, and the development of standard cases to measure and evaluate students' problem-solving skills.[11]

Suggestions for Change

We now will detail suggestions for change in the medical school curriculum and in the process by which medical knowledge is imparted to students. Six simple points, which echo the GPEP report, would reform the first and second years of medical education. They are: (1) do away with "curricular dense-pack"; (2) eliminate departmental barriers; (3) cut lectures by 50%; (4) promote teaching in small-group sessions; (5) insist on individual or small-group study and research projects; and (6) insist on students' being able to communicate well.

We also need to reorient the clinical years. At a 1988 conference sponsored by the Macy Foundation, the following shortcomings were identified in the present clinical education system:[1] (1) clinical medical education is generally failing to keep abreast of rapid changes in how medical care is organized, delivered, and financed; (2) clinical education has drifted away from being a broad preparation of the undifferentiated physician and is becoming an increasingly fragmented, technically oriented training program for specialists; (3) the current reward system leaves teaching of medical students and concerns for curriculum very low on any list of faculty priorities; (4) schools of medicine are failing in too many instances to produce socially responsible physicians who recognize medicine as a social good, not a commercial commodity; (5) reliance on the results of standardized tests is one factor impeding curricular experimentation and innovation; (6) most medical school faculties are startlingly unaware of research in medical education and of curricular experiments under way at medical schools, and they fail to recognize education as a respectable research discipline; and (7) clinical education, oriented toward individual patients, often fails to address the needs of population groups and the degree to which medical care contributes to the health of the public.

The fourth-year curriculum has been criticized by many in the medical education community, and their criticisms seem to be driven by two main concerns. Many believe that as currently structured the fourth year contributes little to the educational and professional growth of future physicians. Others are concerned with the length of time that medical education and residency consume, and they see the fourth year, already criticized for its lack of educational content, as a convenient target for reducing the overall length of medical training.

There are a number of options for reform of the fourth-year curriculum. First, we could eliminate it and make medical school a three-year experience. Many schools did so dur-

ing the 1970s, when there were governmental incentives for experimental three-year curricula. The changes that occurred in the required curriculum were limited almost exclusively to the preclinical sciences. There was an average total reduction of 700 hours of formal instruction within the traditional six basic science disciplines.[12] The three-year programs flourished briefly, then disappeared for several reasons, not the least of which was the evaporation of the financial incentives. There are many lessons to be learned from this experience, but the lesson is not that medical school cannot be taught in three years. The fourth year could be eliminated, not by lopping off the fourth year as it presently exists, but by restructuring the educational content into a coherent three-year framework.

A second option would be to merge the fourth year into graduate medical education, thereby eliminating a year in the overall period of physician training. Ebert and Ginsberg have espoused this approach.[13] Their proposal is basically sound, but it faces enormous challenges in implementation because it requires merging the first two postgraduate years with the four years of medical school and using year four as the transition year. This approach is being tried as an experiment in a few medical schools and teaching hospitals that can work together as educational consortia, but it has not caught on widely.

A third and less ambitious option would be to use the fourth year as a meaningful rotating internship, a transitional year to graduate medical education. It would be followed by a continuation of graduate medical education at the same institution in the form of further general or specialty training. This approach might entail the loss of the ability to move from institution to institution for different stages of training, a traditional practice in the United States. In a progressively constrained external environment, however, it may be a price we have to pay.

The fourth and final option to consider—restructuring the fourth year—is probably the most useful. There is ample subject matter for a structured fourth year of medical school, and a well-balanced medical education can be achieved by using this year to provide extensive experience in the following areas: primary care and ambulatory care, medical decision making and use of computerized medical information systems, occupational medicine and environmental health hazards, and topics related to the practice of medicine such as cost containment and medical economics, interdisciplinary patient care, and practice management. Although studies in such areas are available in most medical schools as electives, a surprisingly high proportion of U.S. medical students are graduated feeling deficient in these subjects. The fourth year also is an opportune time to schedule learning experiences that integrate basic science and clinical medicine.

In addition to these specific changes in the curriculum, one fundamental and overarching change must take place. We must address the need to educate more physicians to pursue careers in the primary care disciplines of family medicine, general internal medicine, and general pediatrics.

For some time the message from the public and its elected representatives has been clear: More primary care physicians are needed, and the quicker, the better. This message is expressed in many ways: (1) awareness that the increasing use of managed care systems requires a greater dependency on primary care physicians; (2) the concern that the high-technology medicine associated with subspecialists is inappropriately escalating the costs of care; (3) the recognition that basic problems in access to health care persist among a significant portion of our population despite an increased physician supply; (4) the categorization by the Council on Graduate Medical Education of family medicine and general internal medicine as specialties in undersupply;[14] and (5) the growing conviction that individuals should have as their principal contact with the health care system someone who is concerned about their total well-being rather than a physician whose interest and expertise are dominated by one organ system or one major aspect of human biology. Our failure to educate more young physicians for the general practice of medicine is the most significant flaw in the U.S. system of medical education today.

Settings for Medical Education

The German paradigm of firmly grounding medical education in the sciences and the medical school in the university was popularized by the Flexner report[15] and became widely accepted. Although it cannot be denied that the scientific emphasis of this model was a major factor in improving U.S. medical education, a concomitant development also contributed to its success: namely, the integral role played by the immersion of students and graduate trainees in the delivery of patient care. This immersion was made possible by the close affiliation between medical schools and hospitals. The hospital wards became the laboratories for the clinical scientists on medical school faculties, and the existence of a scientific base for clinical departments was accepted within this scholarly framework. Training in outpatient clinics and other ambulatory care sites has generally been considered supplementary to the inpatient experience, and in recent years many such experiences have been elective.

The teaching hospital has been a nurturing environment for clinical education. The concentration of patients has allowed young physicians to see a large number of patients with a wide range of diseases. Similarly, the hospital has offered a heavy concentration of teachers armed with a panoply of consultations in many specialties. In addition,

medical students and housestaff have had peers available in the hospital setting to serve as learning partners. The ancillary resources provided by a professional nursing staff, laboratories, pharmacies, and social services also have contributed to the education of young physicians.

In recent years, however, medical educators have come to recognize that the teaching hospital has significant deficiencies as a setting in which to learn. Thus, they have advocated alternatives, particularly ambulatory care settings, in which to achieve the goals of clinical education. What brought us to realize that this internationally acclaimed model, the teaching hospital, is now a less-than-ideal environment for clinical training?

Above all, in the United States, the environment of the hospital has changed. The patients are sicker, and they are hospitalized for brief periods. Frequently, the patient's workup is performed prior to hospital admission, and much of the patient's recovery takes place after hospital discharge. Thus, it is more difficult to structure a coherent learning situation that enables the student to follow the full progress of a patient and his or her problem.

In addition, new technologies have meant the removal of treatments and procedures from the hospital to other settings. Pressures to control the costs of health care further encourage this movement of treatment modalities away from the hospital. All these trends have led to the realization that a broader and more representative patient population is available outside the hospital than in it. It is time for academic medicine to pay serious attention to the need for a system of clinical education that, while not abandoning its grounding in the teaching hospital, adds a new dimension in ambulatory care education—not only because the current health care system necessitates it, but also because it is imperative for medical education.

The new environment has dictated that we review our teaching efforts in clinical medicine. From looking at various experiments in various academic medical centers, the following conclusions seem evident:

- Teaching in the ambulatory setting is much more difficult than teaching in the inpatient setting.
- We must do a much better job of adapting teaching programs to changes in our inpatient population.
- Ambulatory teaching requires financial subsidy, and to the extent that medical schools control part of their budget, they must earmark funds explicitly for teaching in the ambulatory setting.
- We must be prepared to make some compromises between providing cost-effective service and engaging in ambulatory teaching. There is no reason why every clinic must be a teaching clinic, or why every patient in every clinic must be a teaching patient. On the other hand, ambulatory teaching need not be restricted to indigent patients.
- We need a small but dedicated set of faculty members to organize, supervise, and involve themselves in ambulatory teaching.

Identifying settings in which expanded educational experiences in ambulatory care might be offered is challenging. Such settings might include offices of physicians in private solo or group practice, health maintenance organizations, skilled and nonskilled nursing facilities, hospices, day care facilities for special populations, outpatient clinics, ambulatory surgery centers, and freestanding emergency facilities. The modus operandi in these locations differs radically from the classical inpatient exposure that has been in vogue for nearly 100 years.

Beyond identifying potential settings for ambulatory education and devising the means for affiliation with medical schools, academe must enlist the participation and cooperation of the community physicians responsible for managing patient care in these settings. It will be no easy task, and its success is by no means assured. Many communities already experience town-gown problems, and these problems can be exacerbated as the academic medical center is perceived as moving into new domains. Resistance on the part of practitioners may occur not only because of economic competition, but also because the practitioners are concerned about how the new educational construct will affect their patients and the quality of care they receive. The "arrogance factor" that is so much of the academic profile must be mitigated to ensure success in these new teaching settings.

Effect on the Student Body

We must face the fact that the U.S. medical education system has in fact, if not by design, been guilty of stifling intellectual growth and exploration. All too often a career in medicine is launched in the rigid premedical educational environment that prevails in colleges and universities. Students become study machines, characterized as hypercompetitive and narrow-minded at best, and greedy and dishonest at worst. They are thought to be interested only in courses they believe will help ensure their admission to medical school. Students in college should be broadening their educational background, exploring various disciplines, and broadening their minds to new intellectual horizons. Instead, we hear too often of students who will not consider an intellectually challenging course for fear of getting a poor grade and hurting their chances of admission to medical school.

Potential applicants dismiss as lip service the medical schools' expressed desire to encourage application by students with undergraduate studies in the arts and humanities.

Three-quarters of all applicants and matriculants have earned bachelor's degrees in the sciences. The AAMC's Medical College Admission Test (MCAT), used by nearly every medical school as one evaluation criterion for entrance, was substantially revised for the 1991 administrations with the objective of encouraging students interested in medicine to pursue broad undergraduate study in the social sciences and humanities. The new test emphasizes critical thinking, logical reasoning, problem-solving, and communication skills. The most radical feature of the new MCAT is the inclusion of a graded essay component, in which all examinees prepare an essay on a uniform subject, under standard conditions. The most recent MCAT administration was quite successful in providing a range of scores that will help medical schools to discriminate among applicants.

Faculty Development

We now venture a brief look at the ultimate part of the medical education equation, the faculty. Nearly every recent study of medical education has one or more recommendations emphasizing the importance of teaching medical students. When queried, most schools indicate that faculty members' teaching of medical students and educational accomplishments are major factors in promotion and tenure decisions. They admit, however, that teaching does not generate revenue or publications, which places it at competitive disadvantage with research and patient care in evaluations for promotion and tenure. No matter what official changes might be made in favor of teaching, many faculty members insist that traditional research accomplishments are the principal factor in academic advancement. This opinion reflects the university ethos that is deeply ingrained in our institutional culture and strongly reinforced by how we have traditionally paid and promoted faculty. The recognition that medical schools require active clinician-educators has not been an easy sell to many universities. We need to encourage the development of a national consensus that achievements in education should be more important criteria for promotion and tenure.

Reasons That Medical Schools Often Fail in Their Educational Mission

Last, we must ask why medical schools often fail in their educational mission. Factors include the following:

- *Excessive emphasis on research.* We do not want to be misunderstood on this point. The discovery of new knowledge by medical faculties is one of the reasons for their existence, but it is not the only reason. Because the reward system favors the achiever in the laboratory—or at least the producer of multiple papers—teaching and sometimes patient care take a back seat to research.
- *Excessive emphasis on training graduate students, housestaff, and fellows.* The emphasis of basic science faculties on producing PhDs and educating postdoctoral fellows is well known. Similarly, faculty members in clinical departments spend much more time with housestaff and fellows than with medical students.
- *Departmental barriers.* These barriers often interfere with the teaching of modern medical science, leading to the demoralization of the students, who are locked into a departmentally rigidified curriculum.
- *Misguided academic personnel policies.* These policies include the university's failure to reward strong clinician-teachers, its tendency to bestow academic accolades only on its researchers, and, most important, its inability to recognize that a modern medical school needs good clinician-teachers as well as good investigators.
- *Excessive emphasis on practice.* The modern medical school needs a system with two platoons: researcher-teachers and clinician-teachers. What is worrisome is that we seem to be spawning a generation of clinician-nonteachers. If that were to happen, then the environment of academic practice would be no different from that in the community.
- *Excessive expectations of faculty.* A corollary of the previous two points is that universities expect their medical faculty members to remain triple-threat academicians—great in teaching, research, and patient care. It cannot be done. These demands yield a faculty of hurried, albeit well-paid, individuals who are running from clinic to laboratory to conference room, always behind, always late, always reacting, and rarely thinking. Moreover, among the thoughts for which faculty members have little time are those concerning medical students and their education.
- *An outdated and excessively permissive curriculum.* The curriculum in most medical schools goes from one extreme to the other—highly structured and crowded early on, yet in the fourth year so permissive as to be virtually useless.
- *Disregard for societal needs.* Our educational missions must be tied to the needs of the communities we serve. We must orient our curricula and our schools to the education of the generalist physician. If medicine is not willing to meet this critical health care need of our society, we may find the responsibility for primary care seized by—or given to—other health professionals.

How might we achieve some of the needed reforms? Crucial to their implementation is more centralized control of the curriculum to achieve better outlined educational objectives. The education of future physicians should be an institutional, not a departmental, function. A centralized educational unit would have recognized responsibility and

authority to develop the basic curriculum. Along with it would go improvements in methods of clinical teaching.

Although a number of medical schools report that they have moved to implement such a centralized responsibility, few have been able to establish a defined budget for the education of medical students. Schools report that the major constraint to establishing a central administrative structure with the authority to plan and manage their medical education programs is the unwillingness of the faculty to relinquish what is viewed as a departmental right to determine independently the knowledge and skills in their respective disciplines that medical students should acquire. Faculty members defend this privilege even while acknowledging that medical students' education is not a principal priority.

Conclusion

We have come full circle; we began with curriculum and we end with curriculum. Of all the variables, it has changed the least but must change the most. We are right to pride ourselves on the excellence of medical education, but we must acknowledge the need for change if we are to maintain and improve its quality.

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Faculty Appointment and Tenure Policies in Medical Schools: A 1997 Status Report

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Abstract

The authors present recent data on changes under way in and the current status of faculty appointment and tenure policies in U.S. medical schools. The data are drawn from a survey conducted by the Association of American Medical Colleges in 1997, to which deans at all 125 U.S. allopathic medical schools responded, supplemented by follow-up telephone and electronic mail inquiries. Faculty evaluation systems and faculty compensation systems top the list of areas in which medical schools are most frequently making policy changes, with approximately half of the schools involved in each area. Changes in evaluation systems reflect an increasing emphasis on post-tenure review. Changes in compensation systems are characterized by the division of pay into separate components, each with its own financial guarantees and with the level of compensation tied specifically to measures of individual and group productivity. Other policy changes include introducing new faculty tracks and career pathways, redefining or clarifying the portion of salary or compensation that is defined by tenure, lengthening the pre-tenure probationary period, and modifying the link between promotion and tenure. Of the 125 medical schools in the United States, only five do not award tenure, while another six effectively limit eligibility for tenure to basic science faculty. These numbers are unchanged from those reported in 1994. Only two schools indicated that eliminating tenure or ceasing to make tenure-eligible appointments was being considered, and neither reported that a policy change was imminent. Current data on the status of tenure guarantees, tenure probationary periods, other tenure eligibility criteria, and special clinical tracks are provided. Nearly three fourths of the medical schools in the United States now have a separate and distinct faculty track for full-time clinical faculty whose primary responsibilities are in patient care and teaching. The vast majority of these tracks do not permit faculty to be tenured, but 71% require evidence of scholarship for promotion. The authors conclude that faculty personnel policies in medical schools are likely to continue to evolve, consistent with a growing insinuation of the corporate culture into academia.

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Since 1994, when we last published a comprehensive summary of faculty appointment and tenure policies for medical schools in the United States and Canada,[1] institutional discussions about policies governing the faculty employment relationship have continued apace. Two conferences sponsored by the Association of American Medical Colleges (AAMC) have served as national forums for these discussions. The first, held in Tysons Corner, Virginia, in February 1996, brought together nearly 250 faculty, medical school, and university leaders to hear how schools were clarifying or redefining the tenure guarantee, modifying faculty compensation policies, and developing alternative career pathways particularly for clinical faculty.[2] A follow-up meeting, held in Leesburg, Virginia, nearly a year later, focused on the attendant legal issues.[3] Both conferences bore witness to the salience of the issues and the intensity of the discussion about them.

Medical schools are reexamining their faculty employment policies for a number of reasons. Fears about the consequences of ending age-based, mandatory retirement, a more uncertain fiscal environment with changes in the health care marketplace and greater competition for research grant support, and demands by state legislatures and boards of regents for greater accountability are among the major factors. However, reexamination of the faculty employment relationship is not confined to academic medicine. The broader higher education community has been engaged in its own discussion of the relevance of tenure and accompanying issues, as witnessed by the spate of stories and articles that now regularly fill the pages of *The Chronicle of Higher Education*.[4–6] The American Association for Higher Education (AAHE) is leading this discussion through its New Pathways project, a program of "policy studies and special forums designed to deepen

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the emerging national discussion about tenure and cast it in broader terms."[7]

Some of the papers that have emerged from the New Pathways project promote the view that medical schools are the vanguard of change, particularly with respect to their development of alternative faculty tracks and career pathways.[8,9] However, not all are pleased with the direction medical schools are taking. In 1995, the American Association of University Professors (AAUP) convened a task force to look at the relevance of its faculty policy guidelines for medical school faculty. The result was a thoughtful paper that laid out a middle-ground position between those calling for an outright rebuke of medical school practices and those who believed that traditional AAUP policies should not apply to medical schools.[10]

In its report, the AAUP task force acknowledged that the structure and financing of medical schools, with their heavy investment in and dependence on revenues from clinical services, were unique. They had spawned faculty appointments that "were not foreseen by, and in any case not intended to fall within the ambit of, the 1940 Statement of Principles on Academic Freedom and Tenure."[11] Yet, the task force insisted that for those appointments that resemble a traditional academic appointment, the burden was on medical schools to justify their placement of faculty on non–tenure-eligible tracks. The task force conceded that preserving academic freedom did not require that medical schools guarantee tenured clinical faculty their total compensation, but argued that they should provide "an assured minimum salary adequate to the maintenance of support at a level appropriate to faculty members in the basic sciences." Finally, the task force acknowledged the possibility that medical schools may legitimately allow clinical faculty (and that clinical faculty may benefit from) extended pre-tenure probationary periods, but it did not find persuasive arguments for exempting basic science faculty from the traditional seven-year, "up-or-out" system that the AAUP has long defended.

In this report, we present data on the status in 1997 of medical school policies on faculty appointments and tenure, including data on alternative tracks for full-time clinical faculty whose primary responsibilities are in teaching and patient care. We also describe the areas in which medical schools are making or contemplating changes in policies and characterize the direction of those changes. While information was collected from both U.S. and Canadian schools, this report is limited to data from accredited allopathic medical schools in the United States.

Method

On March 31, 1997, we mailed an eight-page questionnaire, entitled "Faculty Appointment, Tenure, and Career Tracks: 1997 Survey of Medical School Policies," accompanied by a cover memorandum from the AAMC's president, Jordan J. Cohen, MD, to the dean of each accredited allopathic medical school in the United States and Canada, a total of 141 schools. The memo instructed the deans to complete the survey or to have it completed by a designated staff member with expertise in the institution's policies governing faculty appointment and tenure. Deans were asked to return completed surveys to the AAMC by April 18.

We contacted 52 non-responding institutions by electronic mail on April 25, 1997, to remind them to complete and return their questionnaires. As of May 12, we had not received responses from 29 schools. Those schools received a follow-up letter, along with another copy of the questionnaire. Finally, we contacted the remaining non-respondents by telephone to encourage them to return the completed questionnaires. By August 1997, we had received completed questionnaires from all 125 accredited allopathic U.S. medical schools, and had decided to limit our study to that group.

We checked the responses for internal consistency, that is, the absence of contradictions between the answers to different questions. Where discrepancies were found, we contacted the respondent by electronic mail or telephone to resolve them. The first author (RFJ) also engaged selected respondents in a series of telephone interviews to seek elaboration on some of the faculty policy changes recently introduced at their schools.

Results

Faculty evaluation and faculty compensation systems top the list of areas in which the U.S. medical schools reported that they were most frequently making policy changes (Table 1). Half of the schools surveyed had recently initiated or revised, or were considering initiating or revising, systems for faculty evaluation, including the evaluation of tenured faculty. Nearly the same percentage had been working on changing the structure of faculty compensation systems.

Other areas of activity included the introduction of new faculty tracks and career pathways, accomplished by 26% of the schools, with another 15% considering it. While 11% of schools had recently redefined or clarified the portion of salary and compensation that was guaranteed by tenure, another 29% were working on this issue. Lengthening the pre-tenure probationary period and modifying the link between promotion and tenure (one that requires that promotion to a specific rank be tied to the award of tenure) were two other policy areas under review. Despite all these changes, eliminating tenure or even ceasing to make new tenure-eligible appointments appear not to have been options seriously considered by the medical schools. We further discuss these changes below.

Tenure Policies

The number of medical schools with tenure systems remained the same as

Table 1

Changes in Faculty Personnel Policies, U.S. Medical Schools, 1997

Policy Question	Change Made in Past 3 Years		Change under Active Consideration		No Change Made or Contemplated	
	No. Schools	%	No. Schools	%	No. Schools	%
Eliminate tenure system or cease making tenure appointments	0	0	2	2	123	98
Redefine tenure salary guarantee	14	11	36	29	75	60
Modify faculty compensation structure	30	24	32	26	63	50
Lengthen pre-tenure probationary period	15	12	21	17	89	71
Modify link between promotion and tenure	8	6	12	10	105	84
Introduce new faculty track	32	26	19	15	74	59
Initiate/revise periodic evaluation of tenured faculty	27	22	35	28	63	50
Initiate/revise periodic evaluation of all faculty	32	26	30	24	63	50

when the last study was conducted in 1994. Of the 125 accredited allopathic medical schools in the United States, only five reported not awarding tenure, while another six effectively limited eligibility for tenure to basic science faculty.* Only two schools indicated that eliminating tenure or ceasing to make tenure-eligible appointments was under active consideration, and subsequent follow-up to these schools did not find that a policy change was imminent at either. Whatever else medical schools may be doing about tenure, they are not abandoning the system wholesale.

Table 2

Guarantees of Tenure, U.S. Medical Schools, 1997

Guarantees of Tenure	Basic Sciences Faculty		Clinical Sciences Faculty	
	No. Schools	%	No. Schools	%
Financial guarantee				
No financial guarantee	18	15	20	18
Some financial guarantee	98	81	88	77
Both, depending on type of faculty	2	2	6	5
Other	2	2	0	0
TOTAL	120	100	114	100
Nature of financial guarantee				
Total salary	30	29	9	10
University/state funds	28	28	30	32
Base component	19	19	30	32
Fixed dollar amount	3	3	3	3
Internal standard	11	11	9	10
External standard	4	4	6	6
Other	7	7	7	7
TOTAL	102	100	94	100

Tenure guarantees. The vast majority of schools reported that they defined tenure to provide not just a continuing appointment but also a financial guarantee. How the schools defined that financial guarantee varied. For basic science faculty, 29% of the schools that associated tenure with a financial guarantee defined it as "total salary/compensation regardless of sources of funding" (Table 2). Another 28% of schools guaranteed that portion of salary/compensation that was derived from university or state funds, while 19% guaranteed a "base salary," variously defined. A small number of schools defined the salary guarantee as

*The medical schools without a tenure system are Mayo Medical School, Morehouse School of Medicine, Ponce School of Medicine, Universidad Central del Caribe School of Medicine, and Boston University School of Medicine (Boston University ceased making tenure appointments in the 1970s). Schools that effectively limit the award of tenure to basic science faculty are Loma Linda University School of Medicine, Tufts University School of Medicine, Northeastern Ohio Universities College of Medicine, the University of Missouri–Kansas City School of Medicine, Wright State University School of Medicine, and Brown University School of Medicine. In the case of the schools at the University of Missouri–Kansas City and Wright State University, basic science faculty receive tenure through the university, not the medical school. While Texas A&M University Health Science Center College of Medicine, Dartmouth Medical School, and the University of Minnesota–Duluth School of Medicine are not on this list, each grants tenure to only the small number of clinicians who are on the medical school payroll.

equal to an internally or externally referenced standard. The average salary (by rank) of an institution's basic science faculty was a popular internal reference standard; some percentile on the *AAMC Report on Medical School Faculty Salaries*[12] was a popular external reference standard.

These various formulations may yield nearly identical results. Base salary or salary derived from university or state funds may be equivalent to the totality of salary/compensation for many basic science faculty. The average salary of a basic science faculty member by rank may not differ much from the salary obtained by an individual holding that rank. Thus, we conclude that, where tenure provides a financial guarantee for basic science faculty, that guarantee very often covers their total salary or a figure close to it.

Exceptions to this include the University of Colorado School of Medicine and the University of Vermont College of Medicine, both of which recently redefined the guarantees for newly tenured faculty. Colorado now guarantees to all newly tenured faculty compensation equivalent to 70% of the average salary of the school's basic science faculty members by rank. Vermont now links the tenure guarantee for basic science faculty members to 60% of the average salary of basic science faculty reported in the AAMC faculty salary report.[12] The University of Southern California School of Medicine recently declared by administrative action that tenure guarantees no more than salary for a nine-month appointment, but the matter remains to be resolved in litigation.[13]

The situation is different for clinical faculty; the part of compensation associated with practice earnings is typically exempted from the tenure guarantee. Only nine schools indicated that tenure guaranteed the total salary/compensation of clinical faculty, regardless of sources of funding. (Follow-up interviews with officials at several of these schools indicated that the guarantees were a consequence of the way salaries were constructed—folding in expected practice earnings in a single salary figure negotiated prospectively. These schools were among those actively considering clarification or redefinition of the tenure guarantee.) The remaining schools defined the tenure guarantee for clinical faculty in a way similar to those for basic science faculty, as university or state funds, or as a "base salary" (in each case, 32%). The difference is that these formulations typically excluded practice earnings and rarely were equivalent to total compensation. The use of internally and externally referenced standards also applied to 10% and 6% of schools, respectively. Again, the average salary levels of basic science faculty were a common reference point.

Pre-tenure probationary period and tenure eligibility. Lengthened pre-tenure probationary periods, beyond the traditional six- to seven-year period endorsed by the AAUP, have long been observed in medical schools and, according to the data shown in Table 1, are becoming more frequent. In the present study, 34% of the medical schools allowed basic science faculty eight years or more before they were required to be reviewed for tenure; 42% of schools allowed this for clinical faculty (Table 3). These figures include schools for which the probationary periods were "indefinite." Even where the more traditional guidelines apply, medical schools liberally employ "clock-stopping" options that allow the period effectively to be extended.[1]

The vast majority of schools (76%) reported that they required a faculty member to achieve the rank of "associate professor" in order to be tenured; a small group of schools (4%) reserved tenure for those reaching the rank of "full professor" (Table 4). Nearly half of the schools (45%), with some possible exceptions, linked the promotion to a specific rank with the award of tenure for those in a tenure-eligible track, that is, the promotion and the award of tenure were simultaneous actions. Most often, the rank linked to tenure was that of "associate professor" (Table 4).

Table 3

Tenure Probationary Periods, U.S. Medical Schools, 1997*

	Basic Sciences Faculty		Clinical Sciences Faculty	
Probationary Period	No. Schools	%	No. Schools	%
7 years or less	77	66	65	59
8 years	10	9	10	9
9 years	10	9	11	10
10 years	8	7	7	6
11 years	2	2	2	2
More than 11 years	0	0	1	1
Indefinite—no fixed maximum	9	8	15	14
TOTAL	116	100	111	100

*Percentages do not add to 100% because of rounding

Special Clinical Tracks

Nearly three fourths of the medical schools in the United States now have a separate and distinct faculty track for full-time clinical faculty whose primary responsibilities are in patient care and teaching (Table 5). These tracks are in addition to, and define a career pathway distinct from, tracks that accommodate the clinical investigator, whose activity

Table 4

Links between Tenure and Promotion to Rank, U.S. Medical Schools, 1997*

	Schools	
	No.	%
Minimum rank for tenure		
Professor	5	4
Associate professor	90	76
Assistant professor	19	16
Instructor	2	2
Other	2	2
TOTAL	118	100
Link between promotion and tenure		
With promotion to professor	5	4
With promotion to associate professor	47	39
With promotion to assistant professor	2	2
No link	65	55
TOTAL	119	100

*Percentages do not add to 100% because of rounding.

profile includes a significant research component and more clearly matches the traditional criteria for promotion and tenure. Clinical tracks facilitate the promotion of faculty who provide valuable support to the clinical service and teaching missions. According to these criteria, the majority of schools have one such alternate track, but 30 schools have two alternate tracks that meet this definition, and two schools have three.

The development of separate tracks for clinical faculty engaged primarily in patient care and teaching has been a signature of faculty appointment systems in medical schools. One of the first published references to such tracks was by Parris and Stemmler, in a description of the clinician–educator track developed at the University of Pennsylvania School of Medicine.[14] Beyond the commonality afforded by differentiation from a clinical investigator pathway, clinical tracks in medical schools take on various forms. The tracks are designated by a host of labels, "clinical," "clinical educator," "clinical scholar," "clinical pathway," etc. The vast majority (81%) do not permit faculty to be tenured (Table 5). Indeed, a prime motivation for developing such tracks is to provide for clinical faculty appointments without the financial obligations associated with tenure. However, the prohibition is not absolute. Presumably, the concern that such tracks not be viewed as having "second-class" status induces some schools to make them eligible for tenure.

While, by definition, promotion in these tracks does not require faculty to conduct and publish original research (usually in a select list of peer-reviewed journals), 71% of the tracks do entail the faculty member's providing evidence of "scholarship" for promotion reviews (Table 5). The form this evidence takes derives from the broadened definition of scholarship popularized by Boyer[15] and recently extended by Rice.[16] Jacobs,[17] Schneeweiss et al.[18] and Evans[19] have each written about an expanded definition of scholarship from the medical school perspective, and Beasley et al.[20] have reported on methods and criteria that exemplify it, which are used by schools in the promotion of clinician–educators. Among the activities listed by schools as providing evidence of scholarship, the most frequent mentions were of publication of case reports, book chapters, and reviews; development of learning tools (software, CD-ROM, etc.); curriculum development activities; formal evaluations of teaching performance; speeches and presentations to professional groups; and development of model clinical service programs.

More than a third of the clinical tracks allow faculty to use unmodified titles (Table 5). Of those that require modified titles, the primary usage is divided between a clinical suffix, for example, "professor of *clinical* medicine," and a clinical prefix, for example, "*clinical* professor of medicine." The use of the clinical prefix often blurs the distinction between full-time clinical-track faculty and part-time or volunteer faculty.

For those clinical tracks that do not include the possibility of gaining tenure, the employment relationship is governed by both annual and multi-year agreements (appointment letters or contracts). Nearly half of the schools now provide multi-year contracts for at least some of these faculty (Table 5). The lengths of multi-year contracts vary, generally between two to six years, and, according to comments of many of the respondents, tend to be at the discretion of the department chair.

Finally, other than not having eligibility for tenure, faculty in clinical tracks with few exceptions appear to enjoy all the rights and privileges associated with tenured appointments. The most frequent exceptions mentioned were "eligibility for sabbatical leave" and "membership and voting privileges in faculty senate."

Faculty Compensation Policies

Nearly half of the schools surveyed had modified or were considering modifying the structures of their faculty compensation systems. The survey form did not gather information about the current structure of faculty compensation systems, but follow-up interviews with selected respondents, by telephone and electronic mail, revealed that many of these changes were aimed at similar objectives, such as (1) to divide compen-

Table 5

Policies Governing Special Clinical Tracks

Clinical Track Characteristics	No.	%
Number of tracks		
None	34	27
One	59	48
Two	30	24
Three	2	2
TOTAL SCHOOLS	125	100
Name of track		
Clinician–educator	25	20
Clinician–scholar	9	7
Clinical	37	30
Clinician pathway	2	2
Clinical service	2	2
Medical school	3	2
Teacher–clinician	4	3
Other	43	34
TOTAL TRACKS	125	100
Tenure-eligible		
Yes	24	19
No	101	81
TOTAL TRACKS†	125	100
Title modifications		
Unmodified	42	34
Modified–clinical suffix	36	29
Modified–clinical prefix	32	26
Modified–location	3	2
Modified–other	12	10
TOTAL TRACKS†	125	100
Requirement for scholarship		
Yes	89	71
No	36	29
TOTAL TRACKS†	125	100
Employment agreements		
Annual appointment letters	36	29
Annual contracts	28	22
Multi-year contracts	22	18
Annual and multi-year agreements	34	27
Other	5	4
TOTAL TRACKS†	125	100

*Percentages do not add to 100% because of rounding.
†By coincidence, the number of tracks in each category of the table was 125, the same as the number of schools.

sation, at least conceptually if not operationally, into various components; (2) to associate each component with differing levels of institutional financial guarantees; and (3) to link the compensation awarded through certain components to measures of individual and group productivity. Some schools reported that the various components of compensation were associated with differing faculty roles (academic, administrative, service, etc.). Medical schools seemed to be more clearly than in the past defining what pay was for, making explicit how the faculty member shared risk with the division, department, and school for the success of their endeavors, and creating a framework in which pay could be reduced in the face of diminished productivity.[21]

While the data indicate that 24% of the schools had recently changed their compensation structures, our follow-up interviews revealed that many of these were still "works-in-progress." In some cases, a framework had been constructed but implementation of the plan was being handled at the department level. Examples of schools that have recently modified faculty compensation structures include the University of Iowa College of Medicine, which, countering tradition, moved from a straight salary arrangement for all faculty to a two-part salary structure consisting of an "academic" component and a "service" component. The latter can vary up or down according to criteria set by the department chair. Similarly, Stanford University School of Medicine has implemented a two-component structure, where the base component defines the financial guarantee of tenure or, in the case of non-tenured "medical-center-line" faculty, the guarantee associated with the contract term. Penn State University College of Medicine has divided compensation into academic and clinical service components, with the latter to be paid by the newly formed Penn State–Geisinger Health System. The academic component of compensation, paid by the school of medicine, itself consists of three parts, two of which are directly related to academic productivity.

New, individualized versions of three-component compensation plans are being implemented at Yale University School of Medicine, Washington University School of Medicine, the University of Oklahoma College of Medicine, the Medical College of Wisconsin, and the University of Wisconsin Medical School, among others. A three-part salary construction (x-y-z plan) has not been uncommon for clinical faculty in medical schools. Tradi-

tionally, the "x" component represented a base salary, the "y" component a supplement for clinical earnings, and the "z" component, bonus or incentive payments. The change evident in newly developed plans is that "y" and "z" components are being developed to provide incentives for productivity and quality not only in clinical practice but also in teaching and research.

Finally, the University of North Carolina at Chapel Hill School of Medicine provides an example of a salary plan for faculty clinicians based on four components (a-b-c-d). The first three-components (a-b-c) together constitute the negotiated salary based on performance in prior years. The fourth component (d) provides for special individual incentive pay beyond this amount. The innovation in the Chapel Hill plan is that the "c" component, representing 15% of every faculty member's negotiated salary, is withheld and paid quarterly, contingent on the faculty member's department's meeting certain prescribed performance objectives. The remaining 85% of the salary is guaranteed for the year. This is subdivided into "a" and "b" components with "a" equivalent to the average salary of all university faculty at the faculty member's particular rank. This sets a salary "floor" in future negotiations.

Plans with incentives are being developed also with basic science faculty in mind, but we found few schools that had yet made much progress in altering basic science faculty compensation structures. Dartmouth has had an "extended guarantee-of-compensation plan" for faculty as an alternative to tenure for many years. It divides salary into components linked to different activities, and functions effectively as a rolling contract. The University of Vermont College of Medicine, in limiting the guarantee of tenure for basic science faculty, has developed rules that specify how the non-guaranteed component of salary can vary in accord with performance. The development of multi-part, incentive compensation systems for basic science faculty may be hindered by concerns that they might reduce the amount of salary recovery from grants funded by the National Institutes of Health. If those issues were resolved, more schools might initiate compensation plans for basic science faculty that resemble those developed for clinical faculty.

Faculty Evaluation and Post-Tenure Review

The number of schools that reported having recently implemented or that were considering systems of post-tenure review should not seem a surprise. Reports from higher education indicate a growing number of colleges and universities that have instituted procedures during the last decade for the periodic evaluation of tenured faculty.[22,23]

The value of post-tenure review has been debated for some time, with opponents generally arguing in line with a 1983 AAUP statement that it "would bring scant benefit, would incur unacceptable costs, not only in money and time but in a dampening of creativity and of collegial relationships and would threaten academic freedom."[24] Its resurgence is due in part to the actions of legislators and boards of regents who, in seeking greater accountability for publicly financed education, have mandated that state institutions develop plans. Mandated post-tenure review procedures for public institutions are being implemented or at least being discussed in 28 states.[20] Perhaps in response to changing public sentiment, the AAUP has drafted a new statement for discussion. While still expressing reservations about the value of such reviews, the statement appears to concede the inevitability of these procedures and focuses on how to make them consistent with other AAUP principles.[25]

Post-tenure review can take a variety of forms, depending on (1) whether the primary purpose is summative (leading to a bottom-line assessment with consequences) or formative (used for the purpose of fostering faculty growth and development), (2) whether the review applies to all faculty on a prescribed cycle (periodic review) or select faculty identified by another "triggering" review, and (3) the cycle length of periodic reviews (e.g., one, three, or five years). The University of New Mexico School of Medicine has developed a procedure for annual reviews, the outcome of which can trigger a more extensive review with consequences. Periodic reviews linked to salary and step increases have long been part of the University of California system. Post-tenure reviews at five-year intervals are now being introduced at medical schools in Texas and Wisconsin, among others, in response to guidelines established by their state systems.

Not all the interest in post-tenure review is at public medical schools. Wake Forest University School of Medicine (formerly Bowman Gray), a private medical school, has for many years conducted reviews, primarily summative and consequential, of tenured faculty on a five-year cycle. Emory University School of Medicine has recently developed a plan for periodic review of tenured faculty with both summative and formative features.

Georgetown University School of Medicine requires an annual review of all faculty by department chairs and division chiefs, primarily for formative purposes. Northeastern Ohio Universities and the University of Cincinnati are examples of public medical schools that have adopted this format. This type of review ensures that a conversation takes place annually between each faculty member and his or her chair or chief. The purpose of these meetings is to negotiate for the coming year responsibilities and duties, the amounts of time to be devoted to various activities, goals, and objectives, and the resources required. The formal record of the results of these meetings forms the basis for the following year's review, and is intended to ensure continued faculty growth and development.

Conclusion

Medical schools continue to modify faculty employment policies and procedures in line with new management imperatives. The center of activity is in the areas of faculty evaluation and compensation systems. Internally and externally generated demands for greater accountability and the perceived need to stimulate greater faculty productivity in response to a more uncertain fiscal climate appear to be fueling these changes. Lingering concern about the consequences of ending mandatory, age-based retirement is probably a factor as well.

Medical schools do not appear to be abandoning tenure, although they are more clearly defining and limiting the financial guarantees associated with it and are introducing alternative faculty tracks, particularly for clinical faculty. They are also continuing to introduce other policy modifications, e.g., extended probationary periods, that provide greater management flexibility.

We expect these changes to continue. Medical schools are the vanguard of a large-scale policy experiment regarding the faculty employment relationship, the outcomes of which should be of great interest to the higher education community as a whole. Underlying the current preoccupation with tenure and the faculty employment relationship is the growing insinuation of a "corporate culture" into academia, with demands for accountability, productivity, and the bottom line, and its clash with the academic culture, which values faculty autonomy, consensus decision making, and intellectual pursuits without immediate obvious return. The large-scale involvement of medical schools in biomedical research and health care delivery, and the resulting thin capitalization of annual expenses from traditional "hard-money" sources, such as tuition, state appropriations, and endowment income, increase the stakes for medical schools.[26] As a result, as Cohen observes, "the clash of these cultures [within academic medicine] is reaching deafening proportions."[27] Cohen further advises that "if medical schools are to succeed, they must avoid the Scylla of an ivory-tower disregard of new competitive realities and the Charybdis of a corporate sellout of academic values." Time will tell whether, through the further evolution and implementation of faculty employment policies, they manage to accomplish this.

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CASE STUDY

Defining Scholarship at the Uniformed Services University of the Health Sciences School of Medicine: A Study in Cultures

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ABSTRACT

Medical schools' long-awaited recognition of the varied contributions of their faculty has caused active dialogue and debate. The discourse centers on the best approach for incorporating a broader definition of scholarship, including professional service, into the traditional promotion and tenure processes. At the School of Medicine of the Uniformed Services University of the Health Sciences (USUHS), the majority of the clinical faculty also serve as active-duty uniformed medical officers, and the subject of how to appropriately recognize their varied contributions has long been contended. Concerns have been raised from all constituent groups that broadening the definition of scholarship at the USUHS has the potential to lower the standards of the academy and thus devalue faculty positions. The USUHS has viewed this challenge as a study in the integration of cultures. Institutional cultures include those of the academy, the military, government, basic science, and clinical science, and all the resulting permutations. A nine-year review of scholarship, promotion, and tenure at the USUHS has resulted in a document that supports the diverse missions of the university and appropriately rewards the accomplishments of its faculty. The dialogue continues, as the new document is subject to continuing review and ongoing critical analysis.

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The ongoing transition in the definition of scholarship and its application within the Uniformed Services University of the Health Sciences School of Medicine (USUHS) began in 1991 and is first and foremost a study in the influence of culture. Cultures in our institution include those of the academy, the military, government, basic science, clinical science, and all the resulting permutations. The interface between the military and academic communities catalyzed a redefinition of scholarship at the USUHS.

The USUHS was established in 1972 with a clearly defined mission to train uniformed medical officers. A uniformed medical officer simultaneously serves two professions: the medical profession and the military profession. The preponderance of USUHS students enters one of the three military services, with a small number serving in the Public Health Service. Similarly, the vast majority (>95%) of our clinical faculty are active-duty military medical officers. As such, they occupy a unique position within American medicine. They serve in the traditional roles of practitioners but in addition have a multitude of other responsibilities unique to the uniformed community. They are called upon to design and adapt health care delivery systems and provide care in a number of different environments, from shipboard to jungle, from conflict to humanitarian missions, and in the traditional hospital and clinic settings. As a part of their normal responsibilities they serve as educators at the undergraduate and graduate levels while participating in "operational medicine" activities and providing health care to the various communities they serve. In these varying roles and positions, our faculty accomplish substantial work that in the past was viewed as simply "service," or work that was "just part of the job," much in the same way that teaching has traditionally been considered a task that

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comes with the position of academic physician but that is not a "true" area of scholarship. The concept that these activities of USUHS faculty were somehow "scholarly" was neither widely nor strongly supported. In reassessing these activities in an expanded context of scholarship, the university was forced to consider what our values really were and how our support and reward systems reflected these values.

The dissatisfaction on the part of our clinical faculty in terms of recognition was most clearly manifested in complaints about our academic titles. Initially, in the original Appointment, Promotion and Tenure Instruction (implemented in 1981), our clinical faculty were classified as "volunteers," similar to the local private-practice clinical faculty who support teaching activities in most academic medical centers. In addition, the School of Medicine modified academic titles, predominately in the clinical departments. For example, both "*clinical* professor of . . ." and "professor of clinical . . ." titles were applied, and they served to differentiate faculty in terms of both time committed to university educational activities and the extent of research productivity. Although the university provided guidelines, departments were not consistent in how they applied them, and this led to increasing difficulty when faculty were evaluated for promotion. The Committee on Appointment, Promotion, and Tenure (CAPT) would routinely reject promotion proposals for clinical faculty that involved the use of an unmodified title. In retrospect, promotion criteria for all faculty were relatively inflexible, with "research and teaching" accomplishments considered to be the primary, if not the sole, basis for promotion. Essentially there was no clear definition of scholarship. This resulted in limited numbers of promotions for the clinical faculty and lent credence to the general consensus among this group that their role in the mission of the School of Medicine was not appreciated. The issue of modified titles was the most frequently quoted example of a "town vs gown" mentality.

Re-examining the Promotion and Tenure Processes

In our first attempt to rework the appointment and promotion process we abandoned the volunteer classification as a clear acknowledgement of the intrinsic importance of our clinical faculty to the teaching and professional role-modeling missions of the school by our clinical faculty. Following three years of proposals, review, and debate, in 1994 a new Appointment, Promotion, and Tenure Instruction provided additional guidance and criteria for assessing scholarly accomplishment and established a clinician–educator pathway within the tenure-ineligible track (federal policy prevents our uniformed faculty, as they are active-duty service members, from being in the tenure track; however, they are entitled to the same level of academic due process as their civilian colleagues). It was apparent soon after the Instruction was issued and implemented that it did not successfully define scholarship or what scholarly "value" was to be placed on the broad range of faculty activities. It also did not address the frequently expressed concerns and frustrations of junior faculty within the basic science departments, who were directed to be highly competitive in research while simultaneously assigned substantial teaching responsibilities. Teaching was seen as not being appropriately rewarded, and this commonly-held opinion precluded some faculty from pursuing interests in the educational process. It was primarily for these reasons that we undertook a complete re-evaluation of what we would consider a scholarly accomplishment and the appropriate institutional recognition for such scholarship. A key element that allowed the School of Medicine to pursue this objective was the selection of a new dean who was dedicated to addressing these issues and moving the process forward. It was during this period of time that the office of associate dean for faculty affairs was established to coordinate and facilitate this and related faculty initiatives.

Early in the process, we were influenced by Boyer's definitions of the scholarship of discovery, integration, teaching, and application.[1] The division of scholarship into these four categories was meant not to separate them but simply to allow each to be examined in terms of its components. The criteria we have embraced for a scholarly accomplishment are designed to be applied universally without regard to the forum in which the activity occurs or its subject. Acceptance of that principle allows for a breakdown of the boundaries imposed by an individual's membership within a particular culture. We hold that we have a faculty composed of individuals who perform scholarly acts. It is only through a shared understanding and acceptance of what defines such acts that our faculty can move toward becoming a collegial community of scholars.

The defining elements of scholarship were determined to be innovation, originality, creativity, and peer recognition, including dissemination, acceptance, and impact. These attributes could be examined in the context of the work presented for review. For example, in recognition that much of the written materials that are prepared in federal service do not necessarily carry the name of the author but rather attribute the material to the institution, agency, or group, it was necessary to investigate the concept of "publication equivalents." These disseminated materials had to meet the stringent criteria established for work published in the more familiar "peer-reviewed journal." The criterion of true peer recognition and review, in association with the necessity for dissemination, was considered to be essential. For our purpose, the peers of

the faculty candidate are the community of scholars and professionals in the discipline, field of study, or activity of which the candidate is a member or participant. This provides the range of input necessary from the various groups represented by our faculty, but it requires that we seek to enlarge the faculty community's knowledge of the range of activities in which its members are engaged. This knowledge is essential if the accomplishments of each faculty member are to be appropriately appreciated and weighted.

Implementing Boyer's Model

After a five-year series of discussions and various modifications and revisions, a faculty consensus was reached and the following definitions were accepted as policy for the school of medicine. The *scholarship of discovery* was defined as original, disciplined research that expands or challenges current knowledge. It encompasses the pursuit of phenomena and observations, which results in the generation of new knowledge. The knowledge provided by the scholarship of discovery is assimilated and interpreted through the scholarship of integration and is shared through the scholarship of teaching and of application.

The *scholarship of integration* combines and connects various disciplines through the process of creative synthesis or analysis and seeks to interpret, draw together, and bring new insight to bear on original research. It provides meaning to isolated facts, and illuminates data by putting them in perspective and fitting them into larger intellectual patterns. It requires innovative thinking that integrates knowledge from various fields, bringing different perspectives to bear on central themes.

The *scholarship of teaching* communicates understanding. It challenges, extends, and transforms the knowledge of discovery into something students can comprehend. The scholarly enterprise of teaching includes the creative development of innovative pedagogic practices and course materials, and aims to encourage independent learning and critical thinking. Scholarly teaching requires enthusiastic, intellectually engaged faculty who are well informed about the latest advances in their disciplines.

The *scholarship of application* refers to the responsible implementation of knowledge gained from the other three forms of scholarship. Application is a scholarly engagement with society, building bridges between theory and practice by applying knowledge to practical problems. It encompasses professional service, including clinical activities. The activity of application is dynamically related to the other kinds of scholarship; it is directly tied to one's special field of knowledge and can itself give rise to new intellectual understandings.

Most faculty clearly understand the meanings of the scholarship of discovery and the scholarship of integration, as their primary focus is research. On our campus interdisciplinary programs in neuroscience, molecular biology, and emerging infectious diseases provide working examples of discovery combined with integration. It is the incorporation of other faculty accomplishments into the remaining areas of scholarship that continues to be the greatest challenge. Many faculty have voiced the belief that teaching and application (professional service) are not as rigorous in their academic demands. As a result, some faculty believe that including these areas in the promotion process will allow some individuals who are not productive in the laboratory to attain academic ranks that in the past were reserved for the successful researcher who also taught. This has challenged us to carefully examine how we will apply our criteria and conduct our evaluations. We have attempted to make it crystal clear that our renewed emphasis on recognizing the scholarly components of teaching is in no way a repudiation of the importance of the scholarship of discovery and its research foundation. The criteria for promotion for an individual whose primary focus is in teaching and educational research requires the same attention to detail and critical analysis expected in other areas of research. We continue to strive to establish a system that will accurately assess the quality of the various components of teaching, including students' performance and the teacher's contributions to peers.

We evaluate professional service activities, including clinical activities, on the basis of the professional expertise required and the extent of peer recognition. As such, many of these activities are considered evidence of the scholarship of application. In the area of service, both the community served and the level of discipline-specific expertise required were determined to be the main criteria for differentiating between professional service (a peer-recognition activity with scholarly components) and institutional citizenship (the reasonable responsibility of any faculty or institutional member). This division allowed the use of the criteria for the scholarship of application (and, in some cases, of the scholarship of teaching) to be applied to these areas of faculty activity. Professional service to the uniformed services or other federal departments and agencies, and involvement in professional, educational, scientific, or community organizations at the local, state, national, or international level are considered by the CAPT and evaluated for their scholarly value.

The evaluation of the scholarly components of clinical activities, including the innovative and thoughtful application of knowledge and experience, serves as a good example of the use of our expanded definition of scholarship. We contend that an additional component in this educational setting is the teaching by example of the personal characteristics of honesty, compassion, dedication to patient welfare, and sen-

sitivity to the human aspects of medical care. These attributes as documented by peer evaluation are considered an essential component in appointment and promotion reviews of health care professionals who deliver patient care and teach in the clinical environment. The USUHS recognizes that the transmission of clinical knowledge, skills, and professional attitudes requires that the clinical teacher have an ongoing involvement in patient care to assure that the teaching is relevant to actual practice. Expertise in this area also requires that the clinical teacher keep abreast of advances in relevant basic science and be able to communicate this new knowledge to students and explain its relevance to the clinical setting.

An excellent example of the type of activity that combines different areas of scholarship in a nontraditional academic environment was a recent "operational medicine" exercise. To provide a realistic training experience for the crew and medical staff of a U.S. Navy hospital ship intended for humanitarian missions, a number of our faculty wrote a series of clinical scenarios, trained a cadre of simulated patients, developed pre- and post-exercise criteria for the evaluation of crew and patient performances, developed instruments to obtain input from practitioners and patients, and, after evaluating the data, provided an educational report. The results were provided to the command authority, shared with participating medical personnel, and maintained to serve as a basis for additional educational research activities within the School of Medicine. Here were integration, application, and teaching in a real-world environment. The information learned from this experience continues to benefit the general community; in addition, since many members of the ship's medical staff are faculty members, the lessions they learned will in turn benefit our students and other faculty. This activity was not simply service or "line of duty" work—it meets all our criteria for scholarly work.

Establishing New Promotion and Reward Criteria

It was clear from the outset that to reassure faculty whose academic careers had been dictated by the "traditional" system of requirements, accomplishments, and rewards, it was essential to establish a clear definition of a "scholarly work" based on defensible criteria. A recurrently voiced fear is that any redefinition of the "traditional" criteria will serve to lower our academic standards and thus reflect poorly on the USUHS and its faculty. This opinion continues to be the major impediment to universal faculty acceptance of the ongoing evolution—or, as some of our faculty see it, the ongoing *revolution*—in the definition of scholarship. This response is not unique to our campus, and its historical basis is well described by Rice in his working paper, *Making a Place for the New American Scholar*.[2] The task for the promoters of cultural change is to somehow facilitate openness to new ideas and concepts—the same type of openness that allows for the free exchange and critical analysis of ideas that is the foundation of academic thought and processes. (This task was brilliantly captured in a cartoon characterization of the famous Sir Isaac Newton apple legend. In the drawing, a world globe is shown falling from a tree and striking a smiling human figure on the head; the caption reads "Open your mind and say Ah.")

Using the new definitions and criteria, a diverse faculty committee examined the common types of faculty accomplishments that could be considered by the CAPT. From that review, a nonexhaustive list of examples was generated to guide faculty candidates, department chairs, and the CAPT. Once these new criteria were generally accepted, a reassessment of the academic title system became the main priority. It was decided that the "clinical" modifier would be removed from use. To accomplish this without losing the basic rationale for its existence, and to prevent a reduction in the level of accomplishment required for each academic rank, a new clinician–investigator pathway was developed and the promotion criteria for the clinician–educator pathway were enhanced. However, many were reluctant to accept this change. Criticism came not only from the basic science constituency but also from clinicians who had invested a significant portion of their careers in bench and clinical research and who saw the removal of the "clinical" modifier as a move to diminish the value of their titles. It is interesting that some faculty appeared to believe that they would be judged outside our institution mainly on the basis of the academic titles they attained rather than on the accomplishments that earned the titles. Our institution, and I assume all others, evaluate candidates based on what they bring to the desired position. How will they meet the mission and expectations of the USUHS? Our new criteria of scholarship encourage our current and prospective faculty members to bring all their cards to the table and be judged accordingly. It was discussed and acknowledged that some faculty who would have been promoted within a modified titling system will now remain for longer, if not indefinite, periods at the assistant professor level. However, the basic intent throughout the process has been to maintain high academic standards while giving serious consideration to the amount of time and effort each faculty member spends in university-related activities.

A Work in Progress

Educating our faculty about the meaning of our definitions of scholarship and their implementation continues to be of the highest priority. We have undertaken a major effort to visit clinical

sites, meet with departments, provide information via our Web-based faculty handbook, and offer consultation to faculty and chairs alike. The initial implementation stage uncovered a number of issues that have emphasized that this is a "work in progress." Issues and questions continue to be raised as we deal with both the substance and the interpretation of the changes. Examples of these concerns included the absolute value of external funding and its source as criteria for promotion, criteria for the evaluation of teaching contributions, and the various manifestations of peer recognition. Our response has included some minor revisions to the documents and, more important, the development of a comprehensive plan to study the various components of teaching and its evaluation.

The commitment of the university and the School of Medicine to not asking a faculty member to do something without providing the means for accomplishing the task has led to a new appreciation of the need for professional development. We see professional development as a broader concept than faculty development. Individuals are more prone to accept the advantage of "development" programs if they see them as opportunities to enhance their personal professional growth and not simply as additional tasks. The programs we anticipate creating will be based on combining the professional aspirations of our faculty with the missions of our university. This is a direct result of our broadening of the definitions of scholarship, because these definitions now encompass a range of activities that in the past would have been less valued within the academic arena. To change a behavior and the culture that encourages it requires that clear benefits must be seen. Redesigning titles, mandating criteria, and establishing numerous academic tracks and pathways are not the methods that will encourage persistent movement and growth. Linking the ability of an individual to do what that individual sees as being in his or her best professional interest and the missions of the academy enhances both. Recognition of the variety of scholarly activities further enhances the faculty, for it allows for continual professional growth. Our faculty, like many others, has members that evolve through a series of stages in their careers. Diversity in scholarship allows faculty to undergo the types of changes in interests and motivation that are both natural and essential for individual renewal, professional satisfaction, and productivity. We accept that unexpected events, particularly for our uniformed faculty, may move them throughout their careers into positions that in the traditional academy would not be considered conducive to scholarly work. However, within those positions there are usually opportunities to apply the one or more of the skills that distinguish a scholarly accomplishment. It is our belief that by recognizing these activities we will encourage our faculty to bring back the knowledge and experience they gain and, through the activities of teaching and application, enhance the university community as a whole.

Debate on our campus continues, and old beliefs die slowly and painfully. The faculty assembly through our faculty senate continues to provide a forum to discuss these matters. We encourage ongoing dialogue as a means for enhancing understanding. Involvement in and service to the larger community—the people of the United States—has always been at the foundation of the USUHS mission. We believe that we have developed and implemented a system based on an enhanced appreciation and recognition of scholarship that will better enable us to fulfill that commitment.

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Tenure Policies in U.S. and Canadian Medical Schools

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Abstract: This report presents data on tenure policies in U.S. and Canadian medical schools. The data are drawn from the findings of a larger survey of faculty appointment and tenure policies, which was mailed to each medical school dean in December 1993. The deans were asked to complete the questionnaire themselves or direct it to a staff member knowledgeable about faculty personnel policies. Non-responding institutions were sent a follow-up letter two months later. The response rate for the written survey was 96%: 137 of a possible 142 schools responded, with the remaining five schools participating in an abbreviated telephone survey. Of the 142 U.S. and Canadian medical schools, 136 (96%) have tenure systems, although nine of these schools limit the award of tenure to basic science faculty. Over three-fourths of the schools that have tenure systems define tenure to include some kind of financial guarantee. Rarely does this financial guarantee cover total salary/compensation; typically it is restricted to a "base" or university component of salary. Twenty percent of the schools have fixed pre-tenure probationary periods for clinical faculty that are longer than seven years; another 11% report having either no fixed pre-tenure probationary period or one that is unlimited. In the last five years, 10% of medical schools have terminated a tenured faculty member "for cause." Data are also examined concerning policies governing the extension of the pre-tenure probationary period, the rank at which tenure is usually granted, consequences of a negative tenure decision, caps on tenure positions, vacated tenure positions, and tenure arrangements for VA faculty and PhD faculty in clinical departments. The report shows that medical schools have adapted tenure policies to allow themselves flexibility in meeting their academic and clinical missions. The forces driving schools to fashion unique faculty appointment arrangements are not dissipating. Tenure is likely to continue in the academic medical center of the future but to play a diminished role. *Acad. Med.* 69(1994):772–778.

Since 1915, when the American Association of University Professors (AAUP) issued its "Declaration of Principles: Academic Freedom and Tenure"[1] (updated in 1940),[2] tenure has been an enduring topic of controversy in higher education,[3] including academic medicine.[4–6] There, the controversy has been especially strong because of the distinct way in which academic medical centers have evolved in the latter half of the twentieth century.

Medical school faculties during this period have grown enormously and become increasingly differentiated in roles and responsibilities.[7] Their growth began mainly as a response to a mandate to increase training capacity. More recently, it has been driven by an opportunistic expansion of the research and clinical enterprises, to a level much beyond that required to support medical education. In addition, medical school faculty are now engaged in a wide array of activities: medical student, resident/fellow, and continuing education, basic science and clinical investigation, medical informatics, health services research, patient care, public health and population medicine, and school and community service. The creation of academic career pathways and an academic reward system that recognizes the various and diverse contributions of faculty in this enlarged enterprise has proved a formidable undertaking.

Defining the purpose, meaning, and guarantees of tenure in this system adds to the difficulty. Much of this enlarged academic medical enterprise now rests on a tenuous financial base of medical service income and federal research grants and contracts, which account for more than two-thirds of medical school revenues.[7] For better or worse, institutional structures for medical education have evolved differently than those for other areas of higher education, including other forms of professional education, such as law, business, and engineering. For some time, medical school administrators have questioned the fit of traditional academic practices such as tenure to their system.

In this report, we present data on tenure policies of U.S. and Canadian medical schools. The data are drawn from a larger AAMC survey of medical school faculty appointment and tenure policies conducted in the academic year 1993–94. These data can be compared with the results of four previous national studies of medical school faculty tenure marking the last two decades. In 1977 Spellman and Meiklejohn reported the results of a study of tenure policies at 106 U.S. medical schools, along with the opinions of deans and faculty on the advantages and disadvantages of those policies for clinical faculties.[8] In 1982 Smythe and Jones reviewed the policies of eight medical schools (visiting five of them) in an in-depth study of tenure in academic medicine.[9] In 1983 the AAMC published comprehensive data on medical school faculty appointment and tenure policies, from a study cosponsored by the AAMC's Council of Deans and Group on Business Affairs.[10] Finally, in 1991 Bickel reviewed the major areas of change in promotion and tenure policies, from a written and telephone interview survey.[11]

In addition to tenure policies, the 1993–94 AAMC survey gathered information on medical school faculty appointment tracks, including special "clinical" tracks, and procedures regarding faculty offer letters and appointment notices. Reports on these areas are forthcoming.

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METHOD

The questionnaire "Faculty Appointment and Tenure—AAMC Survey of Medical School Policies and Procedures" was first mailed to each medical school dean in the United States and Canada on December 16, 1993, accompanied by a cover memorandum from Robert G. Petersdorf, MD, then the AAMC president. The deans were asked to complete the questionnaire themselves or direct it to a staff member knowledgeable about faculty personnel policies. They were encouraged to include with the returned questionnaires a copy of the most recently updated faculty bylaws or other institutional documents that specified faculty appointment and tenure policies.

We sent non-responding institutions a follow-up letter on February 14, 1994, and made subsequent telephone calls encouraging schools to respond. By May 16, 1994, 137 of the 142 schools (96%) had returned questionnaires. We then contacted the remaining five schools to participate in an abbreviated version of the survey by phone.

Returned questionnaires were reviewed for internal consistency, that is, an absence of apparent contradictions between the answers to different questions. Inconsistencies were checked against information available from faculty bylaws documents that many schools provided. When an apparent inconsistency was not resolved through this means, it was resolved through direct contact with the person who had filled out the questionnaire. A total of 15 responding schools were called for this reason.

RESULTS

The 137 schools that returned questionnaires constitute virtually the entire population of accredited medical schools in the United States and Canada. All of the remaining five schools participated in the abbreviated telephone survey. The areas addressed in this report cover tenure systems; tenure definitions and guarantees; tenure probationary periods; the linking of promotion and tenure; consequences of tenure decisions; policies restricting or limiting tenure appointments; eligibility for tenure of Department of Veterans Affairs (VA) faculty and PhDs in clinical departments; and termination of tenure appointments.

Tenure Systems and Tenured Faculty

Tenure systems remain entrenched in U.S. and Canadian medical schools. Of the 142 schools in this population, 136 (96%) had tenure systems, although nine of these schools limited awards of tenure to basic science faculty.* This near-ubiquity of tenure systems in 1993 matches that found by Spellman and Meiklejohn in 1977 and by the AAMC in 1983.[8,10]

While tenure systems endure in academic medicine, the granting of tenure by medical schools has changed significantly. In 1983, 77% of the 9,971 full-time basic science faculty listed on the AAMC Faculty Roster System (FRS) held appointments in a tenure stream, that is, they were either tenured or on track (Figure 1). A decade later in 1993, the total number of full-time basic science faculty had grown by 29%, with 72% of the faculty tenured or on track. In 1983 and 1993 identical percentages were tenured. These modest differences contrast with significant changes in the population of full-time clinical faculty over this period. In 1983, 30,856 clinical faculty were listed on the FRS, with 59% in tenure streams: 33% tenured and another 26% on tenure tracks. By 1993, the number of clinical faculty listed on the FRS had nearly doubled, to 58,607. Only 47% were in tenure streams: 26% with tenure and 21% on track.

Non–tenure-eligible clinical faculty appointments have been facilitated by the emergence of special full-time "clinical" tracks. These tracks vary in emphasis and nomenclature, e.g., educator–clinician, clinician–educator, clinical teacher, clinical scholar, clinical emphasis, but they share one characteristic: a de-emphasis on traditional research requirements in promotion decisions, although *scholarship*, in the sense defined by Boyer, is often required.[12] Bickel estimates that 83 medical schools in the United States alone have clinical tracks that meet this criterion.[11] An updated count and a fuller description of these tracks are reserved for a forthcoming report.

Tenure Definition and Guarantees

In the classic formulation of tenure by the AAUP, tenure is described as a means to certain ends, namely, "freedom of teaching and research and of extramural activities" and "a sufficient degree of economic security to make the profession attractive to men and women of ability."[2] Tenure is essentially a characteristic of a faculty appointment. Tenure appointments are distinguished from term appointments. A tenure appointment is one "of indefinite term," "without stated term," or "continuous in tenure." It guarantees a faculty member the opportunity for continued service to the institution, *subject to certain conditions*. Beyond that, commonality in the meaning of tenure at U.S. and Canadian medical schools ends. Operationally and legally, tenure is ultimately defined by myriad institutionally specific agreements between institutions and faculty members. These agreements specify two important features of tenure as it is understood within those institutions: the specific conditions under which a tenured appointment may end (discussed later in this report) and the existence and extent of financial support guaranteed as part of any continued appointment.

Whether and to what extent financial support was guaranteed by a tenured appointment was addressed in a series

*The six schools with no tenure system are Morehouse, Boston University, Mayo, Wright State University, Universidad Central del Caribe, and Ponce. Schools limiting tenure to basic science faculty are Loma Linda, Tufts University, University of Missouri–Kansas City, Northeastern Ohio Universities, Brown University, University of Ottawa, University of Toronto, University of Western Ontario, and Laval University.

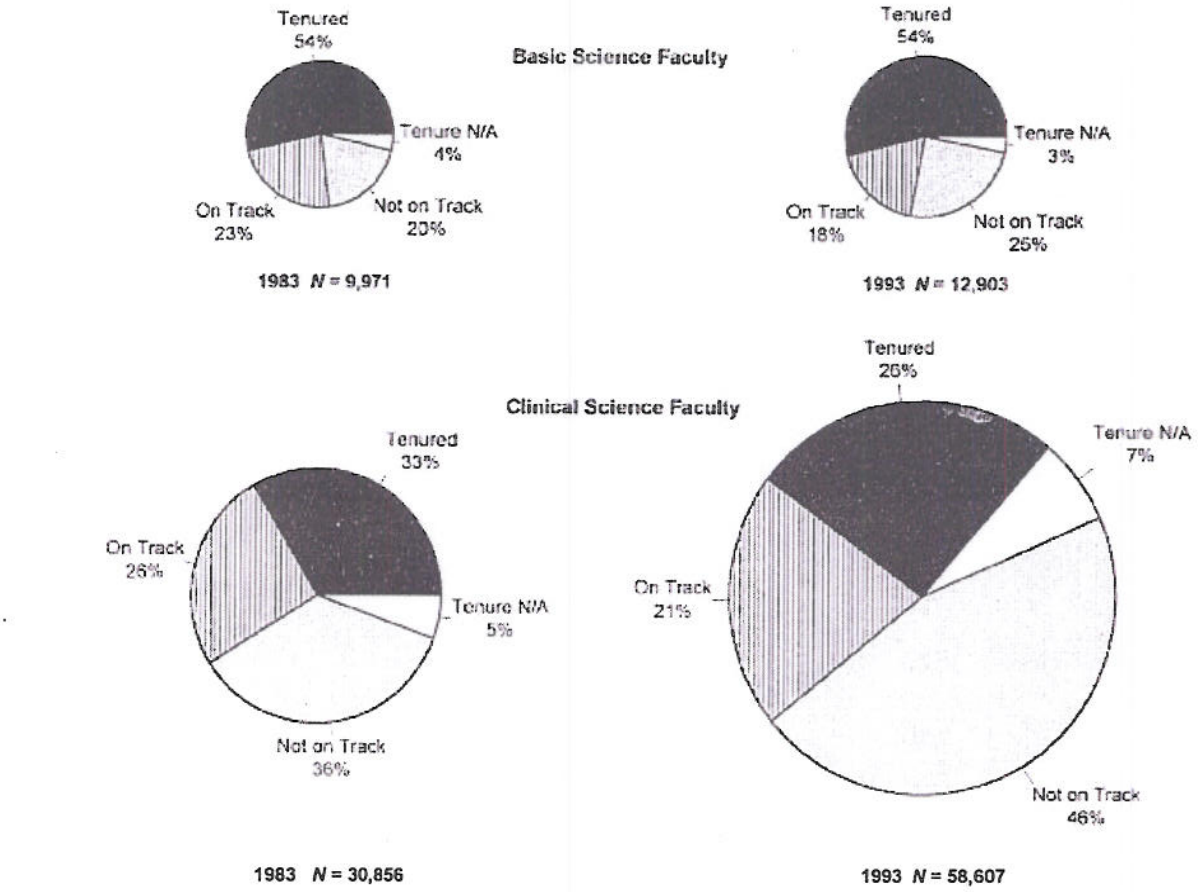

Figure. 1. **Tenure status of the basic science and clinical science faculty for 1983 and 1993 in U.S. and Canadian medical schools. These data are from the AAMC Faculty Roster System, which lists data on 95% of all the U.S. and Canadian medical school faculty reported to the Liaison Committee on Medical Education.**

of questions on the survey. The responses indicated that at 23 schools (17%), tenure guarantees were limited to a continuing appointment, without any financial guarantee ("tenure of title"). The majority of schools (69%) defined tenure to uniformly include a financial guarantee. Twelve schools (9%) awarded both types of tenure, while at the remaining six schools, the policy on tenure guarantees was not clearly defined.

The extent of financial guarantees associated with tenure was addressed in two further questions. The school deans were asked to describe the financial guarantee and also to indicate sources of faculty compensation that were specifically excluded from the guarantee, including supplements for administrative service, clinical income, and research grant and contract income. The issue was addressed in both these ways to avoid misinterpretation due to the diverse ways in which faculty are paid. A summary of the diversity of financial guarantees derived from answers to these questions is shown in Table 1.

Nine schools reported that the financial guarantee of tenure extended to the faculty member's total salary/compensation without any indicated exclusion except supplements for administrative duties and the bonus/incentive portions of clinical income (the latter two income sources were commonly excluded from financial guarantees). However, four of these schools granted tenure to basic science faculty only. All the other schools that had clearly defined policies limited the financial guarantees of tenure to a component of salary that effectively excluded clinical income and might have excluded income derived from research grants.

The schools stated these restrictions in various ways. The majority of the schools (55%) simply defined the financial guarantee in terms of (1) the component of salary from university/state funds, or (2) a "base salary" otherwise defined. For 18% of the schools, the financial guarantee was defined as total salary/compensation excluding clinical income (eight schools) or clinical and research grant income

Table 1

Financial Guarantees Associated with Tenure in U.S. and Canadian Medical Schools

Financial Guarantee*	No. Schools	% Schools§
Total (or average by rank and discipline) salary/compenstion—no exclusions†	9‡	9
Total (or average by rank and discipline) salary/compensation—with exclusions	19	18
Clinical income excluded	(8)	(8)
Clinical and research grant income excluded	(11)	(10)
Portion of salary/compensation	57	55
Derived from university/state funds	(34)	(33)
"Base" salary otherwise determined	(23)	(22)
Different guarantees: total salary for basic science faculty; limited or no financial guarantee for clinical faculty	7	7
Other	5	5
Financial guarantee not defined	6	6
Total (with financial guarantee)	103	100

*Several of the guarantees listed may be functionally equivalent (e.g., "base" salary and total salary excluding clinical or research/grant income). They are listed here in the ways described by the respondents.

†Exceptions are salary supplements for administrative service (e.g., department chairmanship) and bonus/incentive portions of clinical income.

‡Includes four schools that tenure basic science faculty only.

§Percentages are rounded.

(11 schools). Seven percent of the schools guaranteed total salary for basic science faculty, but had very limited or no financial guarantee for clinical faculty. While acknowledging that tenure was associated with a financial guarantee, 6% of the schools indicated that the extent of the financial guarantee was not clearly defined.

The tenure guarantees reported by the schools in this survey differed markedly and unexpectedly from those reported by the schools surveyed in 1983.[10] At that time, 41% of the respondents indicated that tenure guaranteed no more than a continued appointment at a designated rank—without salary guarantee. The differences may be partly explained by the fact that in 1983, tenure guarantees for 29% of schools were classified as "other." Many of these schools reported no clear policy on the issue at that time. Thus, in 1994, we found more schools with defined policies that tied financial guarantees to the award of tenure, but the guarantees were limited, particularly for clinical faculty.

Probationary Periods, Tenure and Rank, and Consequences of Tenure Decisions

AAUP guidelines call for newly appointed faculty members to be placed in a probationary status for a period not to exceed seven years. Usually the award of tenure is expected to coincide with promotion from assistant to associate professor. Those denied tenure are expected to be given one-year terminal appointments. For various reasons, some medical schools have found this structure problematic. The six years prior to tenure review may be an inadequate period for basic science faculty to establish themselves as independent investigators, especially given the competition for research funding. Clinical faculty may be even further disadvantaged. Their demonstration of promise as clinician–investigators may be hampered by the time required for care of patients, both to maintain clinical skills and to support medical school programs. Many at the time are also preparing for one or more specialty board certifications. For these reasons and others, medical schools have increasingly adapted their tenure processes to better meet the needs of faculty and their institutions.

One adaptation is to lengthen the pre-tenure probationary period. Seventy-three percent of the schools maintained probationary periods for basic science faculty of seven years or less, consistent with AAUP guidelines (Table 2). The percentage was slightly less for clinical science faculty. Eleven percent of the schools had no fixed maximum period by which basic science or clinical science faculty must present themselves for tenure review. The remaining schools had maximum probationary periods that extended from eight to eleven years. There appeared to have been little change in these policies from those of 1983.[10]

Another adaptation, for medical schools with fixed maximum probationary periods, is to extend some flexibility to faculty through various "clock-stopping" or "clock-extending" arrangements. For example, 75% of schools in this category allowed probationary faculty to remain on the tenure track but to have their probationary "clock" stopped for various approved reasons (Table 3). The most frequently approved reasons by far were pregnancy and family/parental leave, but other reasons were offered, such as personal illness, educational leave, administrative load, etc. At many schools these requests appeared to be considered on a case-

Table 2

Maximum Lengths of Pre-tenure Probationary Periods in U.S. and Canadian Medical Schools

Maximum Length	Basic Science Faculty		Clinical Science Faculty	
	No. Schools	% Schools*	No. Schools	% Schools*
7 years or less	97	73	86	69
8 years	9	7	8	7
9 years	7	5	9	7
10 years	4	3	6	5
11 years	1	1	1	1
No fixed period, or unlimited period	15	11	14	11
TOTAL	133	100	124	100

*Percentages are rounded.

by-case basis.

Newly appointed faculty can gain an extended pre-tenure period for the building of a tenure-worthy portfolio by initially taking a non–tenure-track appointment, with later transfer to a tenure-eligible track. The vast majority (86%) of the schools that had fixed maximum probationary periods allowed this (Table 3). A more complicated strategy to extend time for those initially appointed to a tenure-eligible track would be to transfer to a non-tenure track for a period of time, with eventual transfer back to the tenure-eligible track. This appears to be discouraged, since fewer than half of the schools allowed faculty that kind of track-transfer option (Table 3).

The failure of a faculty member to gain tenure at the end of a fixed probationary period may represent a loss to the medical school as well as to the individual. Some of these faculty members remain significant contributors to the missions of their medical schools, particularly clinical faculty who provide valuable patient care and teaching services. Of those medical schools that required faculty to be reviewed for tenure after fixed maximum probationary periods, 57% maintained strict up-or-out systems, with the remainder permitting at least some faculty to be continued on a renewable appointment basis. Some schools went further by allowing faculty to reapply for tenure in the future.

Schools without a fixed maximum probationary period may have strict guidelines for time-in-rank, requiring faculty to be promoted within a given period or face dismissal. But this appeared to be uncoupled from the tenure decisions. The minimum rank at which one could be tenured was most commonly "associate professor" (54% of schools), but more than a third of the schools (34%) allowed an "assistant professor" to be tenured. Three schools reserved tenure for faculty who held the "full professor" title. The linking of promotion and tenure in the classic sense (tenure is automatically awarded with promotion to associate professor) was found in only 35% of schools.

Caps on Tenure Positions and Policies on Vacated Positions

Most of the responding medical schools (82%) neither limited the number of tenure-eligible positions nor limited the number of faculty who could be awarded tenure. The re-

Table 3

Presence in U.S. and Canadian Medical Schools of Policies Allowing Effective Lengthening of the Pre-tenure Probationary Periods*

Policy	Allowed		Not Allowed		Policy Not Defined	
	No.	%†	No.	%†	No.	%†
Tenure-track faculty can have their "clock stopped" but can remain "on-track"	87	75	27	23	2	2
Faculty can be initially appointed to a non-tenure earning track, with later transfer to a tenure-eligible track	100	86	14	12	2	2
Faculty on a tenure-eligible track can transfer to a non-tenure earning track, then transfer back to the tenure track	55	47	58	50	4	3

*For schools that have fixed pre-tenure probationary periods.
†Percentages are rounded.

mainder included nine schools that limited the number of tenure-eligible positions; three schools, the number of tenured faculty; and 12 schools, both. With a few exceptions, those limiting tenured positions, tenured faculty, or both were public medical schools, with limitations set by state authority. However, several schools indicated that limits were set in negotiation with university officials.

When a tenured position in a medical school was vacated for whatever reason, the policies of the schools dictated generally that the position be retained within the same department (51%), as either a tenure-eligible or an open position. Another 29% of the respondents required only that the position remain in the school of medicine. Rarely (two schools) did such a position revert to an open position within the university.

Tenure for VA Faculty and PhDs in Clinical Departments

At medical schools that have VA affiliates, 57% allowed a faculty member with a full-time VA appointment to be appointed to a tenure-eligible series; 62% allowed it for a faculty member with a part-time VA appointment. However, because several schools commented that it was rarely done, the prevalence of these practices is in question. Also, the limitations on tenure guarantees, particularly financial guarantees, apply. Tenure guarantees are in many cases limited to salary support from university or state sources. As several respondents indicated, the award of tenure to VA faculty would impose only a very small or non-existent financial obligation on the school.

Medical schools have increasingly appointed PhD faculty to appointments in clinical departments. Whether these appointments could be to tenure-eligible positions was the subject of a further question. Nearly all schools (95%) allowed this. However, as with VA faculty appointments, several respondents commented that in practice it was rarely done.

Termination of Tenured Faculty Appointment

The conditions under which the medical schools reserved the right to terminate a tenured appointment were gleaned from review of the official, institutional definitions of tenure that had been adopted by 81% of the responding schools. The language in these various formulations differed, but generally reduced to the following justifications: death; voluntary resignation or retirement; and involuntary termination for cause, medical incapacity, financial exigency, and discontinuance of program or academic unit. Involuntary terminations based on age are now prohibited by the 1986 Amendments to the Age Discrimination in Employment Act (ADEA).

The involuntary termination of a tenured faculty member for reasons cited above is appropriately an infrequent event, but it occurs. Respondents from 13 medical schools (10%) reported that in the last five years, they had terminated tenured faculty appointments "for cause." Twelve schools had terminated one faculty member each; one school, two faculty members. Two other schools reported that involuntary terminations of tenured faculty members "for cause" were in process. Descriptions of the "causes" volunteered by the schools included "misconduct in science," "sexual harassment," "disregard for university code of conduct," "interference with departmental functioning," and "total lack of effort." Data on these terminations "for cause" probably underestimate medical school experience in addressing cases of inadequate performance by tenured faculty. Respondents from four schools indicated that they had negotiated settlements with tenured faculty that permitted them to resign rather than face a review process. Undoubtedly, other schools have done the same.

The questionnaire did not prompt respondents to report cases of involuntary termination for reasons of "medical incapacity," and no such case was volunteered. Two other bases for involuntary termination, recognized by the AAUP, are "financial exigency" and "program close or reduction." The former is defined as "an imminent financial crisis which threatens the survival of the institution as a whole and which cannot be alleviated by less drastic means."[13] The latter refers to "formal discontinuance of a program or department of instruction. . . . based essentially upon educational considerations, as determined primarily by the faculty as a whole or an appropriate committee thereof."[13] Two medical schools reported the termination of a total of four tenured faculty appointments for reasons of financial exigency and another four schools reported a total of 13 terminated tenure appointments that were based on the closing of medical school programs.

CONCLUSION

The picture of tenure revealed in this summary of institutional policies portrays academic medicine working to adapt the concept to institutional realities. Tenure's often-predicted demise does not appear imminent. Indeed, the remarkable characteristic of tenure is its endurance. But what Spellman and Meiklejohn observed 17 years ago is still true today, that "[t]enure in American medical schools is under progressively intensive scrutiny."[8] Tenure as a concept and practice in academic medicine is evolving.

Part of this evolution is to define more precisely, but in a limited way, the financial guarantees of the tenure commitment. More schools now appear to acknowledge a financial commitment, but given the far-flung nature of faculty activities and sources of funding, the schools want to tie it more clearly to a university base of support. Medical schools have also implemented exceptions to university policies on various rules surrounding tenure, such as length of probationary period and up-or-out provisions, to allow themselves flexibility in meeting their academic and clinical missions. It is also unmistakable that medical schools are developing alternatives to tenure tracks, particularly for clinical faculty, to accommodate patient care and clinical teaching needs.

The forces driving medical schools to fashion unique fac-

ulty appointment arrangements are not dissipating; quite the opposite. Academic medical institutions are in the process of a fundamental restructuring as a consequence of changes in health care delivery and reimbursement, with certain implications for faculty appointment policies. One scenario holds that the clinical enterprise surrounding the academic medical center will grow even larger. Academic medical centers will develop integrated health delivery systems, which will necessitate expanded linkages with community primary care physicians.[14] Many of these community physicians may assume larger roles in the teaching program.

Another scenario is that the medical school will downsize, to a much smaller core faculty linked to a larger, independent health care system that will provide clinical experiences and clinical teaching. Under such a scenario, the core medical school faculty may become much more like its counterparts in other areas of higher education, and traditional tenure arrangements may be more applicable to this group. In either case, tenure is likely to continue but to play a diminished role in the academic medical center of the future.

The authors gratefully acknowledge Dr. Brooke Whiting, director, Faculty Roster System, AAMC, for her contributions to this project.

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The Present and Future of Appointment, Tenure, and Compensation Policies for Medical School Clinical Faculty

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Outline

- ABSTRACT
- DELINEATION OF CLINICAL FACULTY

ABSTRACT

The authors present data and information about appointment, tenure, and compensation policies to describe how medical schools are redefining the terms under which they relate to their full-time clinical faculties. First, the authors

ROLES: CLINICIANS AND RESEARCHERS
- CLINICAL FACULTY APPOINTMENT AND TENURE: POLICY AND PRACTICE
  - Trends in Tenure-eligible Clinical Faculty Appointments
  - The Tenure Guarantee
  - Payroll/Employment Arrangements and the Tenure Guarantee
- FACULTY COMPENSATION
  - Elements of New Faculty Compensation Plans
  - Continuing Problems and Issues
- CONCLUSIONS
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note the increasing differentiation of clinical faculty members into two groups, researchers and clinicians. The present-day competitive realities of both research and clinical enterprises have prompted this change and the principles of mission-based management are reinforcing it. Second, they document the long-term tendency of schools to appoint new clinical faculty members to contract-term (as opposed to tenure) appointments, as special non-tenure-eligible tracks for clinically oriented faculty proliferate. Third, they report on the policies of schools to limit the financial guarantees provided to clinical faculty members who are awarded tenure. For schools that have yet to address this issue, they discuss the various employment and pay arrangements that inform or confuse the question. Fourth, they describe historic problems with clinical faculty compensation arrangements and illustrate, with examples from ten schools, the characteristics of recently implemented performance- and risk-based compensation plans.

While these trends in institutional policies and practices may initially concern faculty advocate groups, the authors argue that they may serve the long-term interests of those groups. The terms of relationships between medical schools and their clinical faculties are tied closely to the specifics of organizational structure, which are currently undergoing review and change. The challenge all schools face is to define these terms in ways that allow them to continue to attract high-quality clinical faculty while avoiding an insupportable financial liability.

In a previous report,[1] we described the status of and changes under way in personnel policies governing medical school faculty in U.S. allopathic medical schools. While the data revealed that no medical school had eliminated tenure, many schools were considering, if not already implementing, changes to the tenure salary guarantee, the length of the pre-tenure probationary period, faculty tracks, faculty compensation structures, and faculty evaluation, including post-tenure review.

The motivation of medical school leaders to reexamine and change the way in which faculty are appointed, evaluated, tenured (or not), and paid is easily understood. While medical school revenues continue to grow, the schools are operating in a less certain economic environment.[2] The financial health of many is tied closely to the fortunes of their teaching hospital partners, which are being buffeted by changes in health care financing and reductions in Medicare funding from the Balanced Budget Act of 1997.[3] The health care market is also having a direct impact on income from faculty physicians' fees, part of which supports medical school academic programs. Some schools are seeing actual declines in faculty practice income, after years of growth.[4,5] Others are maintaining these revenues, but purportedly at the cost of increased faculty time in the clinic, and diversion from academic endeavors. To be sure, research support available to medical schools, through the National Institutes of Health (NIH) and other research sponsors, is growing at an unprecedented rate.[6] However, the ability of schools to take advantage of this external funding boom is dependent on their sound management of institutional resources to meet infrastructure-support and cost-sharing demands.

The financial underpinnings of medical schools have always rested on a thin layer of hard-money support: tuition, state appropriations, and endowment income. Together, these three sources constituted only 20% of the revenues of public medical schools in 1998-99, and as little as 8% of those of private medical schools.[7] The bulk of the remainder, 74% for public schools and 84% for private schools, derives from faculty practice, hospital, and grant and contract revenue. Korn has written persuasively of the fragility of this financial support structure and of the difficulties of sustaining the historic levels of growth enjoyed by academic medicine.[8] Yet, the institutional commitments inherent in traditional faculty appointment, tenure, and compensation structures have often failed to reflect these risks.

In this report, we present data on and discuss trends in clinical faculty appointment, tenure, and compensation policies.

(The issues with regard to the basic science faculty have nuances that merit a separate discussion). We believe that medical schools are redefining the conditions under which they relate to their clinical faculties—indeed, that they have been engaged in this redefinition for many years. Its hallmarks are (1) an increasing differentiation of faculty roles and a separation of cal faculties largely into two groups, clinicians and researchers; (2) a movement to contract-term, as opposed to tenure, appointments; (3) the establishment of limited tenure guarantees for those clinical faculty who are awarded tenure; and (4) the introduction of compensation structures that are more performance- and risk-based. These changes are occurring against the backdrop of a more fundamental reexamination and restructuring of medical school-clinical enterprise relationships, the full description of which is beyond the scope of this article.9

The data and information that support our thesis come from several sources: (1) the 1999 online Faculty Personnel Policies Survey conducted by the Association of American Medical Colleges (AAMC), to which all but two schools responded; (2) the AAMC Faculty Roster System (FRS), a continuously updated database on the characteristics of fulltime U.S. medical school faculty; (3) institutional documents describing new faculty compensation arrangements, and (4) informal telephone interviews and discussions with faculty affairs deans and principal business officers within the past two years.

DELINEATION OF CLINICAL FACULTY ROLES: CLINICIANS AND RESEARCHERS

Medical schools have led the way in higher education in designing multiple career pathways to accommodate the diverse roles and responsibilities of their faculty members. The quintessential example is the clinical faculty member primarily engaged in patient care who has some teaching responsibilities but is not expected to make original contributions in research. Nearly all medical schools have such faculty on their full-time rolls, and 91 schools have created separate faculty tracks to accommodate them.1 Various descriptions of these tracks have appeared in the literature.10,11,12,13 Problems continue with the promotion of faculty on these tracks,14 but their inclusion in faculty ranks appears to have taken hold.

The number of schools with clinical tracks has increased from the 61 we counted in 1986.15 These tracks began to appear years before. With the advent of Medicare and Medicaid in the mid-sixties, medical schools began to see the benefits of hiring more clinically oriented faculty and organizing the billing for their services. This growth of the clinical enterprise also ostensibly helped to expand sites for and fund new opportunities in teaching and research. Clinical tracks facilitated these changes by providing an academic "home" and formal career pathway for these faculty.

Through the development of clinical tracks, medical schools also began to acknowledge the rarity, if not end, of the "triple-threat" clinical faculty member. The current realities of both research and clinical enterprises now make it unlikely that a clinical faculty member can excel in all three missions of teaching, research, and patient care. Patient care that is of high quality, is satisfying to patients, and makes efficient use of resources demands nearly full-time attention of the physician to the clinical mission. Remaining competitive for NIH and other external research funding requires a similarly focused commitment. Thus, we see the increasing separation of clinical faculty members largely into two groups, clinicians and researchers, with clinical teaching responsibilities distributed broadly among them.

Few clinical faculty, even those identified as clinician-educators, can now point to education as a primary or even major activity. Clinical education has become a byproduct of other medical school missions. Educators have long been concerned about the effect of this model on the quality of clinical education and are calling for a renewed recognition of teaching.16 Schools are developing teaching-focused clinical venues (for example, the Shapiro Institute at Beth Israel-Deaconess Medical Center), and teaching-focused subgroups of clinical faculties (for example, the Academy of Medical Educators at the University of California, San Francisco). Thus, a third, albeit small, distinct group of faculty may emerge with a major focus on the clinical teaching program.

As schools implement principles of mission-based management, the sharp demarcation of clinical faculty roles is likely to become further embedded.17 Mission-based management requires that schools track the allocated effort of each faculty member by mission and relate it to measures of activity or productivity in that mission. It reveals faculty effort that is not optimally deployed, and provides the basis for redirection of that effort for the benefit of the faculty member, the department, and the school. A fertile area for redirecting faculty effort appears to be the unsponsored research of clinical faculty.18 Some of this effort, to be sure, represents a strategic investment: helping a promising researcher become competitive for NIH funding. Some is a luxury that institutions are discovering they simply can no longer afford. Having some unt of protected time for scholarly pursuits is part of all faculty job descriptions. However, bifurcation of most of the ical faculty into researchers (at least 60-70% effort in research) and clinicians (at least 75-80% effort in patient care) seems only a matter of time and institutional resolve.

CLINICAL FACULTY APPOINTMENT AND TENURE: POLICY AND PRACTICE

The evolution and delineation of roles discussed above confronts directly the question of institutional commitments and obligations to clinical faculty. On its face, U.S. medical schools do not appear to be abandoning tenure. Only five of these do not offer tenure: Ponce School of Medicine, the Universidad Central del Caribe School of Medicine, More-house School of Medicine, Mayo Medical School, and Boston University School of Medicine. This list is unchanged from the last two surveys we conducted in 1994 19 and 1997.1 Boston University is the only one of these institutions that previously granted tenure. However, that practice ended in the late 1970s.

Wright State University School of Medicine and the University of Missouri—Kansas City School of Medicine might also be included in this group. Neither offers tenure *through the medical school*, although both have basic science faculty members who are appointed by and eligible for tenure through other university departments. Five other medical schools limit tenure eligibility generally to basic science faculty: Brown University School of Medicine, Loma Linda University School of Medicine, Northeastern Ohio Universities College of Medicine (NEOUCOM), Tufts University School of Medicine, and Louisiana State University in New Orleans. As we discuss below, the peculiarities of organizational structures and employment relationships dictate the policies at some of these schools.

All other medical schools, as a matter of policy, offer tenure to at least some of their clinical faculty members. However, the problem tenure may create for institutional management hinges on the answers to two questions. Are medical schools continuing to make tenure widely available to clinical faculty? And when medical schools do grant tenure to a clinical faculty member, what is their financial commitment to that individual?

Trends in Tenure-eligible Clinical Faculty Appointments

Of the special tracks that medical schools have established for clinical faculty members primarily engaged in patient care and teaching, approximately 80% are tenure-ineligible.1 Most of the expansion of clinical faculties during the last several decades has been through appointments to these tenure-ineligible tracks. The result is a dramatic redistribution of clinical faculty by tenure status, illustrated in Figure 1.

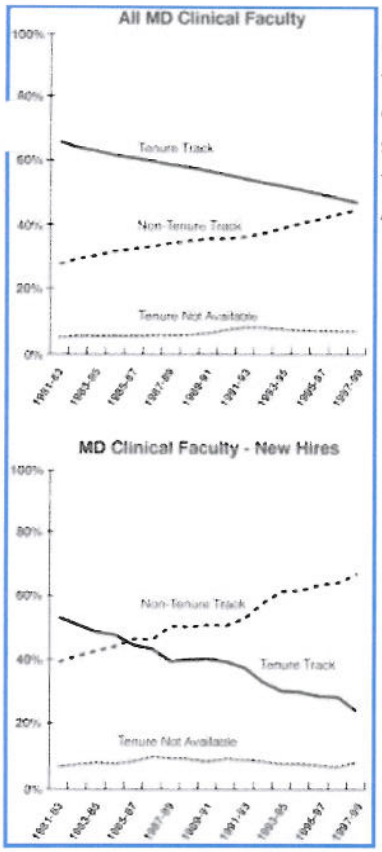

Figure 1. Percentage distributions of MD clinical faculty by tenure-track status for all faculty (top panel) and new hires (bottom panel), from 1981-1983 to 1997-1999. The data are about those at the rank of assistant professor and above only, and are from sequential, overlapping three-year time periods. "Tenure not available" refers to faculty at schools that do not grant tenure to clinical faculty. *Source*: Association of American Medical Colleges Faculty Roster System.

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During the period 1981-1983, an average of 68% of all clinical faculty at the assistant professor level and above were in tenure tracks, either tenured or tenure-eligible (Figure 1, top panel). By 1997-99, this figure had declined to 46%. Figure 1's bottom panel shows that changing new-hire practices have been driving this decline. In the period 1981-1983, 57% of all new hires (assistant professor and above) were appointed to tenure-eligible tracks. During the period 1997-1999, this figure dropped to 24%.

This period corresponds to a time of rapid growth in the number of clinical faculty. Thus, even with this significant decline in proportion, the number of MD clinical faculty on tenure tracks gradually rose during the period (Figure 2). Within the most recent decade, the number of non-tenure-track faculty increased at an accelerated pace, while the number of tenure-track faculty appears to have been leveling off. We conclude that appointments to non-tenure-eligible faculty tracks are now driving any continuing growth of clinical faculties.

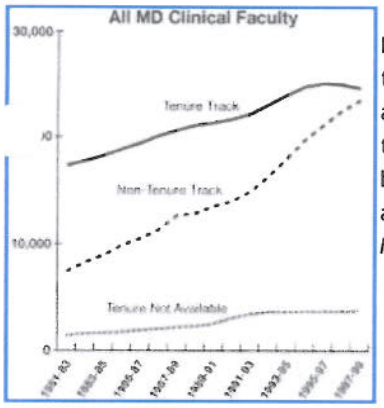

Figure 2. Numbers of MD clinical faculty by tenure-track status, all faculty, 1981-1983 to 1997-1999. The data are about only those at the rank of assistant professor and above for which tenure information was available, and are from sequential, overlapping three-year time periods. Data for most recent years may be slightly underestimated because of a reporting time lag for new hires. "Tenure not available" refers to faculty at schools that do not grant tenure to clinical faculty. *Source*: Association of American Medical Colleges Faculty Roster System.

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Whether or not the redistribution of clinical faculty by tenure status has stabilized is not yet clear. It depends on the future growth of full-time clinical faculties as well as changing appointment practices. Some medical schools, like the University of Connecticut School of Medicine, have de facto ended tenure-track appointments for new clinical faculty, even while institutional policy allows such appointments.[20] Other schools may sharply reduce the size of their tenured clinical faculties by following Georgetown University School of Medicine's recent lead in severing their employment relationships with clinically active faculty.[21] With new hires being less and less frequently appointed into tenure tracks, and the large proportion of current tenure-track clinical faculty approaching retirement age, the proportion, if not the number, of clinical faculty members on tenure tracks may continue to decline in the coming years.

The Tenure Guarantee

Even in those cases where tenure is offered, institutional liability varies, depending upon what tenure guarantees. In simple terms, tenure refers to the characteristic of a faculty appointment that distinguishes it from a term appointment. A re appointment is one "without term," or "of indefinite term." It guarantees the faculty member a continuing appointment, subject to certain conditions. The American Association of University Professors (AAUP) ties the purpose of tenure to two objectives: academic freedom ("freedom of teaching and research and of extramural activities") and economic security ("a sufficient degree of economic security to make the profession attractive to men and women of ability").[22] In an excellent historical and legal review of tenure issues for academic medicine, White suggests that the link between tenure and academic freedom is "venerable and well established," but that the link between tenure and economic security is "more tenuous."[23] The latter issue is at the heart of the problem for medical schools.

The guarantees associated with tenure for clinical faculty members vary considerably among medical schools, according to the most recent AAMC data (Table 1). First, 32 schools assert that tenure provides for a continuing appointment but "without any specific financial guarantee." In some cases, such as that of Northwestern University Medical School, which recently successfully defended its policy in an Illinois trial court and through appeal,[24,25] this assertion reflects a clearly stated and defined contract: the award of tenure is not associated with any particular level of salary, or salary at all. In other cases, the definition of tenure in the faculty bylaws is simply absent language with respect to a financial guarantee and may reflect an issue still unresolved.

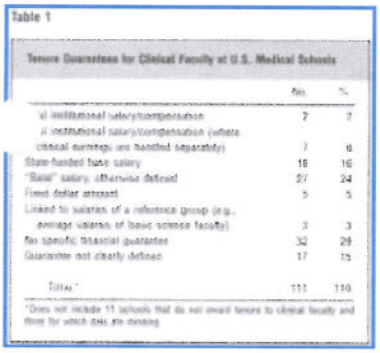

Table 1. Tenure Guarantees for Clinical Faculty at U.S. Medical Schools

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Of the schools that offer financial guarantees with tenure, few assert that they guarantee clinical faculty "total institutional salary/compensation" when clinical practice earnings are factored into that compensation. The Johns Hopkins University School of Medicine and the Finch University of the Health Sciences/Chicago Medical School (Finch) are the exceptions. Johns Hopkins's response to this question is qualified by a provision in its faculty handbook that allows a salary reduction of up to 20% for any faculty member, "[w]hen in the judgment of the Dean and the Department Director the individual's professional activities (clinical, research, teaching or administrative) indicate that such a salary reduction would be appropriate."26 Finch has only a small number of tenured clinical faculty. The remaining schools define the financial guarantee for a tenured clinical faculty member as something less than full compensation, for example, salary exclusive of clinical earnings, which are handled separately; a state-funded portion of salary; a "base salary" otherwise defined; etc. Many of these schools have always had clearly defined policies that limit the tenure guarantee. Other schools, for example the University of Pittsburgh School of Medicine,27 have recently clarified policies to address the problem of an unspecified and potentially large liability. Still others have redefined the tenure guarantee as part of a restructuring of faculty compensation, described below. In these last cases, the institution has to determine its contractual obligations to previously tenured faculty.

:oll/Employment Arrangements and the Tenure Guarantee

Administrators at 17 schools acknowledged that tenure guarantees for clinical faculty were "not well defined." In such cases, the critical question is whether any part or all of the contribution to salary that derives from clinical earnings should be included in the tenure guarantee. Payroll and employment arrangements may help to clarify this issue. Our recent survey found that at 45 schools, full-time clinical faculty members who were active in medical practice were employed solely by the medical schools and received one paycheck, which compensated them for activities in all missions (Table 2). These situations potentially are most rife for tenure interpretation disputes. Another 19 medical schools also provided just one check to clinical faculty members, but both the medical school and a separate practice group or health system employed them and contributed to their pay. Conversely, at 11 schools, the medical school remained the single employer (the practice plan was a unit of the school), but provided separate paychecks to clinical faculty members for their academic and clinical activities.

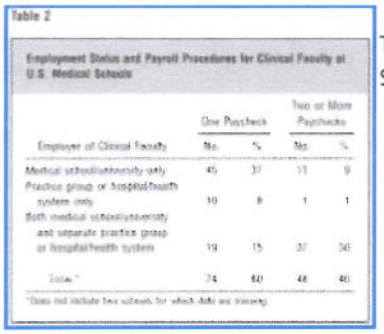

Table 2. Employment Status and Payroll Procedures for Clinical Faculty at U.S. Medical Schools

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At the 37 medical schools where there are dual employers and two (or more) paychecks for clinically active faculty, a limited financial obligation may be most clear. Here, the medical school contribution to salary is clearly delineated, with the presumption, absent any contravening statement, that the tenure guarantee does not exceed that contribution.

Eleven schools observed an arrangement whereby clinical faculty active in medical practice had full-time academic appointments at a medical school but were not employed by those schools. Such schools included Tufts University School of Medicine, Brown University School of Medicine, and NEOUCOM, none of which offers tenure to clinical faculty. Dartmouth and Texas A&M are organized in this way as well. At Dartmouth, the majority of full-time clinical faculty are employed by the Dartmouth-Hitchcock Medical Center, and at Texas A&M, by the Scott and White Memorial Hospital and Clinic. Both institutions offer tenure to clinical faculty, but only to the relatively small group that the school employs.

Two medical schools in Washington, DC, are moving toward this model as a result of recent restructurings. Georgetown University School of Medicine divested itself of its hospital and faculty clinical practice through a partnership agreement with MedStar. Clinical faculty at Georgetown active in medical practice recently became employees of the nonprofit health care organization, which is based in Columbia, Maryland. Tenured clinical faculty were offered a "buyout" of their tenure commitment.28 The George Washington University School of Medicine and Health Sciences also recently restructured its faculty practice plan from an administrative unit of the school to a separate, nonprofit, physician-directed corporation affiliated with the school. George Washington has pledged to respect the rights of tenure for existing clinical faculty, but those whose support depends on clinical practice earnings became employees of the new corporation as of July 1, 2000.29 It is questionable whether Georgetown or George Washington will grant tenure to new clinical faculty hires, at least insofar as that tenure is associated with a financial guarantee.

However the ambiguities about the meaning of tenure at the local school level are resolved, the national data reported here do not provide empirical support for the assertion that tenure protects the total compensation of clinical faculty. There is little conceptual support for this assertion as well. Even a 1996 AAUP task force on tenure in medical schools has acknowledged that "certain kinds of [faculty] appointments were not foreseen by, and in any case not intended to fall within the ambit of the 1940 *Statement*.... Their [clinical faculty members'] relationship to the institution... is therefore fundamentally unlike that of full-time teachers and investigators...."30 The report goes on to say that tenured faculty "should be guaranteed an assured minimum salary adequate to the maintenance of support at a level appropriate to faculty members in the basic sciences, on a formula to be determined by the administration and board of trustees after consultation with a representative body of the faculty." While the AAUP never formally adopted the task force's statement, it provides a balanced and real-world view of the nature of clinical faculty appointments and the limits of institutional obligation.

FACULTY COMPENSATION

Redefining and limiting the tenure guarantee is merely one, albeit an important, element of medical school efforts to restructure compensation plans for clinical faculty. The problems that have led schools to change existing compensation plans can be described as follows.

Large within-school variation in compensation arrangements. Medical school clinical departments historically have had relatively wide latitude in developing compensation arrangements for their faculties. That tradition has been supported by the plethora of organizational arrangements for practice activities and corresponding multiple employment relationships for clinical faculty. While the differing cultures of clinical departments, among each other and from basic science departments, may demand some individualization of plans, the variation has been so great at some schools as to belie the existence of any common framework. As schools have moved toward more centralized practice arrangements, a loosely federated group of departments if not a true multispecialty group practice, so too has there been the push for a common framework for compensation.

Lack of a clearly defined, consistent, and fiscally responsible tenure guarantee. As we have discussed, many schools have been reexamining the financial guarantees made to faculty members who receive tenure. Some of these schools are struggling with guarantees that are not clearly defined or are difficult to identify from compensation arrangements that vary considerably among departments. Other schools have acknowledged guarantees that are not supportable by adequate bases of stable funding.

Failure to link salary to performance. The salaries of clinical faculty have generally been linked to the patient care revenues they generate. However, when performance in nonclinical areas is considered, the differentials in pay increases may

be relatively small. In addition, individual faculty members' pay may not be well tied to group performance, so those individuals tend to have little financial stake in the success of the department or the institution.

Inability to reduce compensation when warranted. A meaningful link of compensation to performance requires that medical schools be able to reduce faculty salaries from one year to the next, when warranted. Except in those cases where the earnings from clinical services are treated separately and at risk, existing compensation frameworks may not give medical schools much ability to reduce salaries. Thus, schools are hesitant to give large increases in pay, even when performances or changes in market factors demand them, because they see themselves as unable to take these increases back when performance deteriorates or market conditions change.

Difficulty in recruiting because of failure to allow for market differentials. In a few cases, existing compensation plans may impede recruiting by not allowing schools to pay market rates for clinical faculty in certain specialties. This may be particularly problematic for state institutions that have various regulations and requirements around compensation.

Elements of New Faculty Compensation Plans

We outline in Table 3 the structures of clinical faculty compensation plans (some cover basic science faculty as well) introduced at ten medical schools—three private and seven public—since 1996. They illustrate, in our opinion, the general direction for clinical faculty compensation plans.

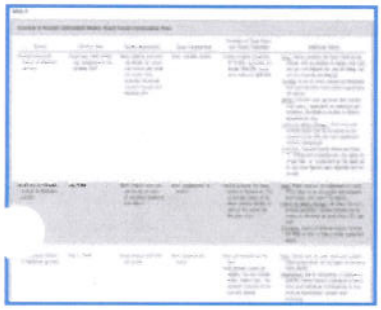

Table 3. Examples of Recently Implemented Medical School Faculty Compensation Plans

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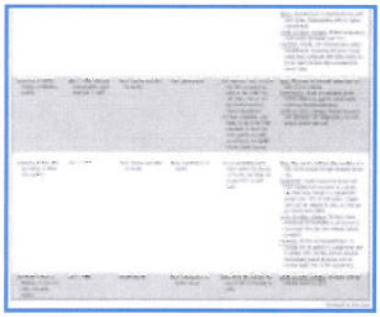

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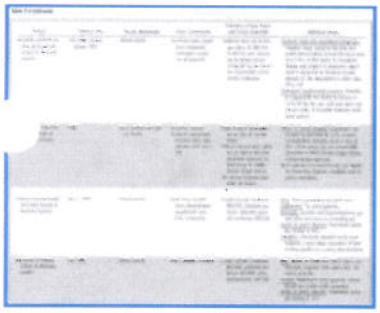

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These new plans have three to four basic components that are remarkably similar in concept. The first is a fixed and guaranteed (for that year) "base" component; the second, a variable, supplemental component; and the third, if applicable, a bonus/incentive component. A few schools include a separately labeled component to capture special, time-limited stipends for administrative service. We discuss each of these in turn.

Fixed-base component. The fixed-base component is that customarily linked to the tenure guarantee, although some schools that we examined (UNC-Chapel Hill, Penn State) do not associate tenure with a financial guarantee. There are several approaches to setting the level of the base: (1) a salary figure fixed by rank (Stanford, Yale, Virginia Commonwealth, Virginia); (2) a salary figure linked to the average salary by rank of basic science faculty (Colorado); (3) a salary figure linked to the average regional or national salaries of medical school faculty (Florida, Penn State); (4) a salary figure linked to the average salary of university faculty campus-wide (North Carolina, East Carolina); and (5) a fixed percentage of total salary (New Mexico).

Most of these approaches preserve the principle that base pay is equivalent for basic science and clinical faculty, varying only by rank. They imply an association between base pay and the core academic duties of teaching, research, and tutional service, which is independent of specialty or discipline. Most also preserve a level of financial guarantee for tenured clinical faculty that is not greater than that accorded to basic science faculty and, in some cases, may actually be less.

Variable, supplemental component. A variable, supplemental component in new clinical faculty compensation plans has several purposes. First and foremost, it allows medical schools to provide for differences in total compensation because of market factors, even while maintaining base pay that is the same for all faculty members at a given rank. While the fixed-base component may recognize the equal values of teaching, research, and institutional service provided by all faculty regardless of discipline, a variable pay component provides for the reality that schools have to pay faculty in certain disciplines more than they pay faculty in others. This is most clearly evident in the pay differences between basic scientists and clinicians, but it also is seen in the pay differences among clinicians in different specialties.

The variable, supplemental component also allows pay to be directly tied to faculty performance. Pay raises (and reductions) from year to year are realized by changing the variable pay components, even while base pay may remain the same or increase. While the variable component of pay is not guaranteed from year to year, most schools have recognized the need to set limits on how much it may be allowed to vary. These limits generally range from 10 to 20%, and are applied in both directions. Alternatively, the variable, supplemental component may be guaranteed for more than one year, but, after that time, could be reduced by more than 20%.

Bonus/incentive component. The bonus/incentive component to faculty compensation is not new. Schools generally give departments discretion, within broad guidelines, about whether to offer bonus/incentive payments and how to determine them. While schools have historically provided bonus/incentive pay to reward exceptional clinical productivity, they can use it to reward exceptional performances in other mission areas. The obstacle to doing so is the general perception that performance data in teaching and research are not comparable to those provided by clinical billings or relative-value unit asures of faculty clinical work produced by most billing systems.

Administrative stipends. Faculty members who serve as section heads, as department chairs, or in other administrative

roles may receive supplemental pay components tied to these administrative responsibilities, as is the case, for example, at Virginia Commonwealth University School of Medicine. The objective in doing so is not only to recognize such service but also to have a basis for reducing pay accordingly when the faculty member steps down from the responsibility.

A common framework in these plans provides for them to be "institutional," links each faculty member's pay to all others, and ensures that the plans comply with state and federal requirements. However, if a plan is too prescribed and detailed, it will fail to recognize the differing cultures of the individual departments and will likely impede recruiting. Schools have preserved departmental autonomy by allowing departments to set and implement evaluation criteria and processes for judging performance and linking a portion of compensation to them. They have also allowed departments to decide whether, and in what form, they should provide for bonus/incentive pay.

Continuing Problems and Issues

When a new compensation plan incorporates a tenure guarantee that is less than that offered previously, its introduction creates an obvious problem: what to do with the existing tenured faculty. Except under circumstances previously defined, institutions must honor their contractual obligations to tenure faculty. The problem is in understanding what these obligations are. When guarantees have been well defined, schools have tended to "grandfather" previously tenured faculty. The existing level of financial guarantee is honored but "frozen," until such time as the new tenure guarantee, through increases and adjustments, comes up to or exceeds that level. Stanford, Colorado, Yale, and New Mexico have dealt with the transition problem in this way. One drawback is that departments have to live with a dual-class reward system: a group of newer faculty working under a performance-based system and a second group of previously tenured faculty enjoying more generous guarantees that are independent of performance. Other schools (including those not represented in Table 3), where the tenure guarantees have not been clearly defined, have used the opportunity of a restructured compensation plan to state the university's position with regard to its obligations under tenure.

Another problem is that the creation of a performance-based compensation framework that allows for differentiation of pay increases and decreases does not guarantee that department chairs will use it to manage their faculties. Historically, the academic culture has discouraged sharp differentiation in pay and pay increases in the interest of promoting collegiality. This practice reaches its purest expression in other areas of higher education where pay is primarily a function of faculty rank and s of service. Given the growing recognition that the economic viability of medical schools rests on faculty productivity, it is doubtful that schools will continue to allow productivity and pay not to be tightly linked. Still, these cultural concerns appear to have been at least one factor in the decision by Johns Hopkins not to follow through on a new compensation plan that was two years in the planning.[31,32]

A third major problem is that information support systems within many departments are not sufficiently robust to support the hard decisions that performance-linked and risk-based compensation requires. Most clinical department chairs can look toward financial (e.g., billings) and non-financial (e.g., resource-based relative value units) measures that are easily derived from billing systems to judge performance within the clinical mission.[33] Productivity measurement is less mature in the educational and research areas.[34,35] In our experience, schools have looked to changes in the compensation plan as the key to improving productivity. However, without a decision-support system in place, the plan's principles often cannot be fully enacted.

Finally, schools that seek to reward high-performing faculty with bonuses and incentives find themselves constrained when faculty members so described are located in departments with deficits and without the funds to do so. Such faculty members may be key to having prevented a worsened financial state for those departments. Solving this problem requires a cross-departmental mechanism to reward such faculty. Instituting such a mechanism requires that departments recognize their interdependence and their stakes in the financial health of the institution as a whole.

CONCLUSIONS

We have posited and illustrated several trends in policies and practices governing appointment, tenure, and compensation of medical school clinical faculty. We believe that schools are increasingly differentiating two primary clinical faculty roles, researchers and clinicians, with members of both groups each contributing a small amount of time to teaching. Tenure eligibility is being preserved primarily for researchers and may extend to a small group of specialists that emerge to ' ⁴ educational programs. The proportion of clinical faculty appointed to tenure-eligible tracks is likely to continue to ease, to a plateau not yet discernible. Medical schools are defining explicitly and conservatively the financial guarantees they provide to those clinical faculty to whom they do offer tenure. They are tying faculty compensation more closely to

productivity across all missions. Their ability to reduce pay from year to year when warranted is increasing.

While these trends may initially concern faculty advocate groups such as the AAUP, we believe these groups may ıtually see their benefits. The changes will allow medical schools to preserve tenure for the small group of medical school clinical faculty who most resemble in their activities their university colleagues, those most heavily involved in teaching and research. After all, the primary argument for tenure has been the protection of academic freedom. To the extent to which academic freedom issues have involved medical school faculty, they have mainly dealt with the research mission.[36,37,38] In addition, many if not most medical schools may be expected to provide tenured clinical faculty financial guarantees that are consistent with the AAUP task force's recommendation.[28]

Finally, the terms of the relationships between medical schools and their clinical faculties are tied closely to the specifics of organizational structure: how medical schools are configured with faculty practice organizations, hospitals, and health systems. To the extent to which medical schools change these configurations, they will need to reexamine the terms of their relationships with clinical faculty. The continuing challenge of all schools is to define these terms in ways that allow them to continue to attract high-quality clinical faculty while avoiding an insupportable financial liability.

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The Continued Evolution of Faculty Appointment and Tenure Policies at U.S. Medical Schools

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Abstract

For the past several decades, financial uncertainty, changes in health care delivery and reimbursement, and changing workforce needs have prompted medical schools to continually refine their appointment and tenure policies. Studies during the past 30 years have examined the nature of these faculty appointment and tenure policies in U.S. medical schools, and in this article the authors present data from a 2005 survey on faculty personnel policies to

- Prevalence of Tenure Systems and the Tenure Track
- Relationship between Tenure and Guaranteed Salary
- Flexibility in Tenure Policies
  - Probationary periods.
  - Tenure clock-stopping and part-time tenure policies.
  - New faculty tracks.
- Emerging Tenure Policies
  - Emphasis on interdisciplinary team science
  - Expanded definition of scholarship
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extend this analysis.

For both basic science and clinical faculty in U.S. medical schools, the authors describe tenure systems, trends in the number and percentage of full-time faculty on tenure-eligible tracks, the financial guarantee of tenure, and probationary period lengths. They review the status of flexible policies and highlight two current faculty policy changes that many institutions have made or are actively contemplating: the recognition of interdisciplinary and team science, and a broadening view of scholarship.

Results show that although tenure systems remain well established in medical schools, the proportion of faculty on tenured or tenure-eligible tracks has continued to decline over time. Changes in the financial guarantee associated with tenure have transformed the fundamental concept of tenure at many medical schools, and the percentage of schools that have lengthened the probationary period for tenure-track faculty has steadily increased during the past 25 years. Tenure-clock-stopping policies and part-time tenure policies continue to exist at medical schools, though results indicate low faculty use of the policies, suggesting a disconnect between policy and practice.

For three decades, studies have examined the nature of faculty appointment, tenure, and promotion policies in U.S. medical schools.[1-8] Reviewed longitudinally, these reports reveal two prominent reasons for the continued evolution of faculty appointment policies: (1) to respond to the uncertainties of the financial model in which medical schools operate, and (2) to acknowledge the different needs, responsibilities, and expectations of various faculty members.

For many years an incongruity existed between the tenuousness of U.S. medical schools' financing and the stability of institutional commitments to faculty. As others have described, medical schools have operated with a financial model of uncertainty and volatility.[9] In contrast, medical faculty employment arrangements typically modeled the stability and security of policies promoted by the American Association of University Professors, in which tenure was designed to protect academic freedom and bring "a sufficient degree of economic security to make the profession attractive to men and women of ability."[10] For many years, tenure typically was thought to guarantee the full salary of medical faculty, and the ability of a medical school to reduce salaries or eliminate positions was considered to be extremely constrained. Over time, however, medical schools have been forced to align their faculty employment policies and practices with the economic realities of their environments.

Changes in faculty work responsibilities and preferences have also contributed to the continued evolution in faculty appointment and tenure policies. The difficulty of establishing research careers in an era of increased competition for grants and greater work pressures to fulfill patient care responsibilities has prompted a reconsideration of probationary period length; expanding definitions of scholarship have led to new faculty promotion pathways; and the changing composition of the faculty itself has prompted institutional flexibility. For example, the proportion of female medical school faculty members has continually increased,[11] and a younger generation of both male and female faculty has demanded policies that accommodate a more balanced work and family life.[12-13]

In this article, we present data from 2005 that extend the aforementioned themes. We describe tenure systems, trends in the number and percentage of full-time faculty on tenure-eligible tracks, the financial guarantee of tenure, and probationary periods for both clinical and basic science faculty in U.S medical schools. We then briefly review the status of flexible policies, including clock-stopping policies, part-time tenure options, and track choices. Finally, we highlight two current faculty policy changes that many institutions have made or are actively contemplating: the recognition of interdisciplinary and team science and a broadening view of scholarship.

The data in this article come primarily from responses to the 2005 Faculty Personnel Policies Survey, a survey conducted by the Association of American Medical Colleges (AAMC) of the 125 U.S. medical schools accredited by the Liaison Committee of Medical Education. Administered triennially since 1994, the survey instrument consists of questions about policies and procedures related to appointment, promotion, tenure, and compensation structures for medical school faculty. Deans or designated staff members with expertise in an institution's policies governing faculty appointment, tenure, and compensation completed the survey instrument, which received a 100% overall response rate. We supplemented survey responses with data from the AAMC Faculty Roster database— a national database that tracks characteristics of more than 95% of all full-time U.S. medical school faculty—and from institutional policy documents, bylaws, and faculty handbooks.

Prevalence of Tenure Systems and the Tenure Track

As previously reported, tenure systems remain well established in U.S. medical schools.[1,3,5,6] In 2005, only six of the 125 U.S. medical schools did not offer tenure: Boston University School of Medicine, Mayo Medical School, Morehouse School of Medicine, Ponce School of Medicine, Universidad Central del Caribe School of Medicine, and Wright State University School of Medicine. Six additional schools generally limit tenure eligibility to basic science faculty: Brown Medical School, Loma Linda University School of Medicine, Northeastern Ohio Universities College of Medicine, Tufts University School of Medicine, University of Missouri-Kansas City School of Medicine, and Sanford School of Medicine of the University of South Dakota.* Except for the inclusion of the University of South Dakota, this list has remained unchanged since the last comprehensive report published in 1997.[6]

Although tenure systems remain common, the proportion of faculty on tenured or tenure-eligible tracks has changed significantly over time, especially for clinical faculty. In 1985, 57% of full-time MD faculty in clinical departments were either tenured or on the tenure track, but in 2004, this percentage decreased to 42% (Figure 1, top panel). Yet, an important, and sometimes overlooked, component of this analysis is that the number of tenured and tenure-eligible MD clinical faculty increased by 50% during the same period: from 14,026 in 1985 to 21,921 in 2004 (Figure 1, bottom panel). In other words, there were far more, not fewer, tenured and tenure-track clinical faculty at U.S. medical schools in 2005 than ever before. Yet, the *percentage* of tenure-eligible clinical faculty declined even while the absolute numbers increased, because the number of nontenure-track clinical MDs grew even faster: from 8,612 in 1985 to 27,207 in 2004 (an increase of over 315%). During these two decades, as medical schools expanded their clinical enterprises, they most commonly populated their faculty ranks with nontenure-track MD practitioners whose primary responsibility was patient care.[6] In the period from 1985 to 1995, although tenured and tenure-track clinical MDs increased at an average rate of 4% per year, they were still eclipsed by nontenure-track MDs, which realized a sizable growth rate of 8% per year (Figure 2). From 1996 to 2002, the growth in tenure-eligible clinical MD faculty decreased to an average rate of 1% per year.

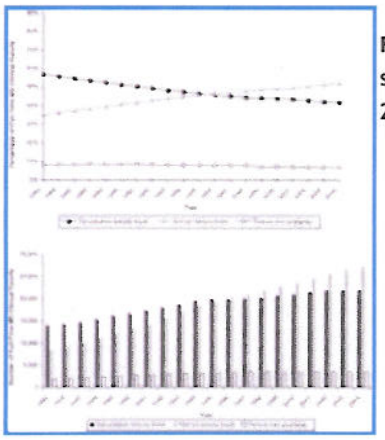

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Figure 1 Tenure status for full-time MD faculty in clinical departments at U.S. medical schools, in percentages (top panel) and in absolute numbers (bottom panel), 1985-2004. *Source:* AAMC Faculty Roster database.

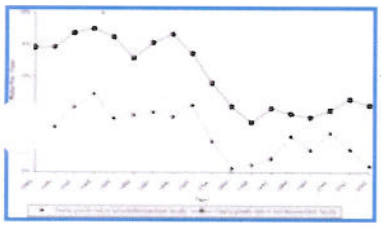

Figure 2 Annual growth rates in the number of tenure-track and nontenure-track MD faculty in clinical departments at U.S. medical schools, 1985–2002. *Source:* AAMC Faculty Roster database.

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Although the steady decline in the overall percentage of tenure-eligible MD clinical faculty is certainly noteworthy, it would be difficult to conclude that tenure is in jeopardy of disappearing for these faculty, at least in absolute terms. New MD faculty in clinical departments, however, are increasingly appointed to nontenure-eligible positions, thus influencing the overall trends in tenure status. In 1985, 41% of newly hired full-time clinical MD faculty were on tenure-eligible tracks, but in 2004, that percentage declined to 28% (Figure 3).

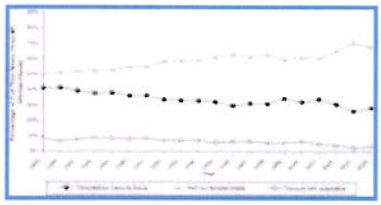

Figure 3 Tenure status for full-time newly hired MD faculty in clinical departments at U.S. medical schools, in percentages, 1985–2004. (Newly hired faculty are those at the rank of assistant professor and above hired in the previous year.) *Source:* AAMC Faculty Roster database.

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As previously reported,[8] there has also been an increased use of nontenure-eligible appointments for basic scientists during the past two decades, although the change is much less dramatic than for clinical MD faculty. In 1985, 83% of PhD basic science faculty were either tenured or on the tenure track; in 2004, this percentage had declined to 76% (Figure 4). During this time, the overall number of PhD basic science faculty steadily increased from 8,726 in 1985 to 12,553 in 2005. Unlike the trends for clinical faculty, the patterns of tenure status for basic science faculty are consistent with those for all faculty in higher education: 78% of all full-time faculty at four-year U.S. colleges and universities were tenured or on the tenure track in fall 2003.[14] Despite the decrease in tenure-eligible appointments, the majority of basic science PhD faculty continue to have traditional academic appointments.

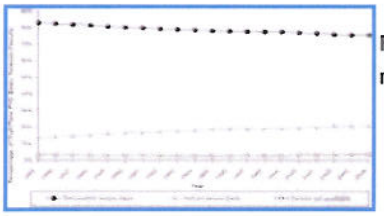

Figure 4 Tenure status for full-time PhD faculty in basic science departments at U.S. medical schools, in percentages, 1985–2004. *Source:* AAMC Faculty Roster database.

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Although tenured positions in both basic science and clinical departments serve as mechanisms to attract and retain exceptional faculty by providing stability and security, they remain more common in basic science departments for several ons: first, the growth in the biomedical research enterprise in medical schools notwithstanding, basic science departments have not realized the same levels of explosive growth in faculty positions as have clinical departments. Second, basic scientists' salaries, on average, are far lower than their clinical counterparts. To the extent that the push for nontenure-track

appointments is rooted in institutional fear of having to support full salaries regardless of the productivity of individual tenured faculty members, that fear would be much greater with highly paid clinical subspecialists than with basic science bench researchers. Finally, we assert that the culture in basic science departments, on average, is more akin to the 'tional academic ethos in other university divisions than to the health care-driven environments of clinical departments. In other words, it is our supposition that basic science faculty have held onto the notion that tenure matters to a greater extent than have clinical faculty.

Similar to the pattern seen for clinical MD faculty, a large part of the decreasing percentage of tenure-eligible positions for PhD basic scientists is driven by new faculty hires. For newly hired full-time PhD basic science faculty, 68% were on tenure-eligible tracks in 1985 compared with 51% in 2004 (Figure 5). Previous research has suggested that medical schools have increased the use of nontenure tracks, as they have hired more junior research faculty whose positions are funded completely on grant funds to afford flexibility in terminating such appointments if that grant money ends.8

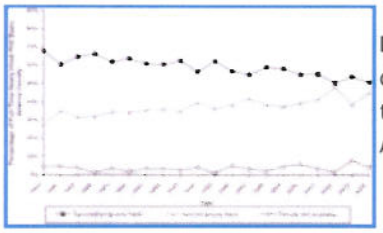

Figure 5 Tenure status for full-time newly hired PhD faculty in basic science departments at U.S. medical schools, in percent, 1985-2004. (Newly hired faculty are those at the rank of assistant professor and above, hired in the previous year.)*Source:* AAMC Faculty Roster database.

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Relationship between Tenure and Guaranteed Salary

Historically, tenure has been linked to the economic security of faculty members.10 The modern concept of tenure, ever, especially for medical school faculty, does not necessarily encompass this concept.15 Of the 113 medical schools that offered tenure to clinical faculty in 2005, 56 (50%) had a financial guarantee associated with tenure, whereas 43 (38%) had none (Table 1). Of those 56 schools with a tenure guarantee, only three asserted that they guaranteed total institutional salary, and all three were considering a revision or clarification of what portion of compensation was guaranteed by tenure. The majority of institutions with a specific tenure financial guarantee for clinical faculty defined the guarantee as base salary, whether it was the state-funded portion of salary or was otherwise defined. Similar patterns exist with basic science faculty. Of the 119 medical schools that offer tenure to basic science faculty, 62 (52%) noted that tenure had a specific financial guarantee, and 42 (35%) had no financial guarantee associated with tenure. Of those with a tenure guarantee for basic scientists, only eight schools (13%) guaranteed total institutional salary.

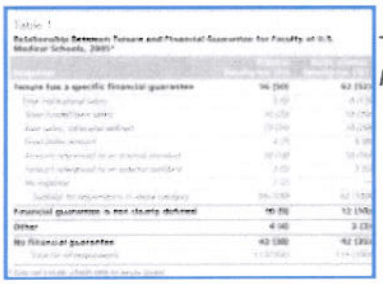

Table 1 **Relationship Between Tenure and Financial Guarantee for Faculty at U.S. Medical Schools, 2005**

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These relationships continue to change: 12 schools (10%) revised or clarified their tenure guarantee policies between 2002 and 2005, and another 17 schools (14%) were actively considering such changes in 2005. Medical schools also continued to

resolve unclear policies in this area: the percentage of schools indicating that their tenure financial guarantee for basic science faculty was not clearly defined declined from 20% in 2002 8 to 10% in 2005.

The changes in the financial guarantee associated with tenure during the last several decades have transformed the fundamental concept of tenure at many medical schools. At more than 40 institutions where tenure does not guarantee any level of salary support, the meaning of tenure is no longer clear. Does tenure protect job security or academic freedom if a tenured faculty member's salary could effectively be reduced to zero? Many medical schools may have reached the point at which the difference between tenured and nontenured faculty appointments is more symbolic than substantive, more important for prestige than for job protection.

It also seems that enough medical schools have altered tenure policies that academic medicine has reached a tipping point in the fundamental faculty reward structure. Historically, that structure guaranteed job security and stability and protected time for scholarly pursuits in exchange for lower salaries than those found in industry and other sectors. Limited financial remuneration was not as important as the benefits of tenure and other intrinsic rewards. 16 That traditional reward structure for a majority of faculty in academic medicine is now an anachronism, replaced with a contract—implicit or explicit—that aligns risk with reward, where guaranteed salary through tenure has been diminished or has vanished, and contingency-based (i.e., bonus and incentive) pay structures are common, certainly for clinical faculty and now, too, for basic science faculty. As a case in point, in 2004, 78% of medical school clinical faculty and 59% percent of basic science faculty were eligible for bonus pay, and 52% of clinical faculty and 20% of basic science faculty received bonus pay (AAMC Faculty Salary Survey, unpublished data, 2005).

Flexibility in Tenure Policies

To meet the needs of medical school faculty who are facing increased pressures to develop research agendas, attract funding, fulfill patient care responsibilities, contribute to the educational mission, and balance work and family demands, institutional policies increasingly permit flexibility for tenure-track faculty. These strategies include lengthening the pretenure probationary period, offering clock-stopping policies, and creating new appointment tracks.

Probationary periods.

The percentage of medical schools that have lengthened the probationary period for tenure-track faculty beyond the traditional six- to seven-year period endorsed by the American Association of University Professors (AAUP) has steadily increased since 1983 (Table 2). In that year, of those medical schools with fixed probationary length, 74% (70/95) had probationary periods of seven or fewer years for their clinical faculty; by 2005, 57% (61/107) of schools did. Similar trends exist for basic science faculty: in 1983, 74% of schools (73/99) had probationary periods of seven or fewer years for basic science faculty; in 2005, 61% (69/114) of schools did. Many of these changes have occurred recently: 10 schools (8%) noted that they lengthened their pretenure probationary period for basic science faculty between 2002 and 2005, and another 11 (9%) were actively considering a change in 2005. Eleven schools (9%) made a change in probationary period length for clinical faculty between 2002 and 2005, and another nine (7%) were actively considering a change in 2005. These policy revisions typically reflect the difficulty for faculty to become established within the traditional time frame because of increasing demands on their time as they also try to maintain a balance of work and family. 17

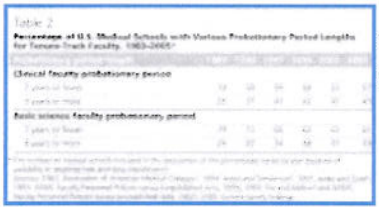

Table 2 **Percentage of U.S. Medical Schools with Various Probationary Period Lengths for Tenure-Track Faculty, 1983-2005**

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re clock-stopping and part-time tenure policies.

Another institutional strategy that purports to offer flexibility to tenure-track faculty is tenure-clock-stopping policies.

These policies, which allow faculty on a tenure-eligible track to extend the probationary period, were available at 82 (69%) medical schools in 2005. These policies could be used for child care (at 87% [71/82] of the institutions with such policies), care for sick family members (84% [69/82]), and for a medical disability (84% [69/82]), among other reasons. Yet, critics have d that these policies fail to offer flexibility for tenure-track faculty because they are rarely used.[18-19] Our data support this point. Of the 82 medical schools with tenure-clock-stopping policies in 2005, 57 were able to provide recent statistics about the use of these policies by their faculty members. At these 57 institutions, an average of only 1.0 men and 1.5 women at each institution used these policies each year in 2003-2004 and 2004-2005.

Medical schools and research universities continue to wrestle with how to translate flexible policies into practice. As our data indicate, few medical school faculty actually use policies to extend probationary periods. Innovative ideas taken from the higher education sector are, therefore, now being considered. In 2005, for example, Princeton University began to automatically grant an extra probationary year to all faculty with a new child rather than making faculty members specifically request the extension.[20] The purpose of the automatic extension was to remove the stigma associated with the request. Medical schools might consider similar policy revisions to increase the use of such flexible policies.

Some institutions also have policies that allow faculty to work less than full-time while remaining on a tenure-eligible track. Such policies were available at 37 (31%) medical schools offering tenure in 2005. Here, too, a disconnect exists between having policies on the books and faculty members' use of the policies. Of the 37 medical schools with part- time tenure policies, 23 were able to provide recent data on the number of tenure-track faculty who worked less than full-time. At these institutions, an average of 4.1 men and 4.3 women at each institution used the policy each year in 2003-2004 and 2004-2005.

New faculty tracks.

During the past 25 years, medical schools have introduced various faculty appointment tracks or pathways to accommodate the differing work arrangements of clinical and research faculty. These types of policy changes have continued in the last few years. Twenty-seven institutions (22%) reported that they introduced a new faculty track or career pathway between 2002 and 2005. Many of these new tracks are based on well-established models. For example, several schools instituted nontenure-eligible research tracks for faculty who are affiliated with independent research centers or programs or are engaged in research support activities but do little teaching. The Feinberg School of Medicine at Northwestern University created its research track to "[permit] appointment of scholars to the faculty on a nontenure basis in order to participate in and cooperate with the research efforts of faculty with tenure-track appointments." For clinical faculty, clinical educator tracks have frequently been added for faculty who are engaged primarily in patient care. The University of Virginia School of Medicine created a tenure-eligible track for faculty who spend approximately 80% of their time "devoted to patient care and/or teaching [and] 20% of time devoted to scholarly activities with research focused in the area of medical education."

A different type of faculty track has also emerged recently. The University of Iowa Carver College of Medicine, University of New Mexico School of Medicine, East Tennessee State University Quillen College of Medicine, and West Virginia University School of Medicine have introduced an "undeclared," or "flex," track for new faculty, in which faculty do not have to choose a tenure-eligible or nontenure track at the initial point of their hiring. This option has been designed for several reasons. In some cases, the parent university has not permitted the medical school to extend the traditional probationary period. An undeclared track effectively accomplishes that goal. Also, this type of track is designed to give basic science faculty time to garner R-01 grants as well as clinical faculty time to establish their clinical practice before turning to research. Officials at the University of New Mexico, for example, report that most clinicians without previous research training opt for a nontenure-track clinical educator track if forced to choose on initial appointment. With the undeclared track, however, clinicians can establish a clinical practice and then focus more attention after 2 to 3 years to developing a research program. Without the pressure to address all parts of their career at the same time, a greater number of clinicians, they hope, will ultimately choose a tenure track (Susan Scott, MD, senior associate dean for academic affairs, University of New Mexico School of Medicine, written communication, October 2005).

Emerging Tenure Policies

Two trends in promotion and tenure policies have emerged in the last few years as particularly important at large bers of U.S. medical schools, and we anticipate these issues to continue to be at the forefront of policy discussions in ming years: first, institutional recognition of interdisciplinary and team science in the tenure and promotion process, and second, the evolving notions of educational scholarship.

Emphasis on interdisciplinary team science

Many medical schools recently have incorporated or are discussing the recognition of interdisciplinary team science in the ire and promotion process. Historically, medical schools have emphasized individual faculty work in their structure, ough promotion and tenure guidelines, and in their culture. As biomedical research increasingly becomes interdisciplinary, however, scientific process often demands collaboration with teams of researchers from diverse fields, creating a difficult situation for some faculty—they may wish to engage in interdisciplinary research, but their institutional policies and practices serve as roadblocks for the recognition of such work in the promotion and tenure process.

Some medical schools have begun to modify their policies to address the need for greater collaborative and team-based research. Between 2002 and 2005, 15 medical schools (12%) revised their tenure and promotion guidelines to include an emphasis on interdisciplinary team science, and another 24 (19%) were actively considering such a change. For example, Vanderbilt University School of Medicine has included recognition of collaboration in its criteria for promotion and tenure; at the time this article was written, the language had not been added to its promotion and tenure guidelines, but it had received endorsement of the executive faculty:

Vanderbilt recognizes the critical importance of collaboration ("team science") in research and scholarly activity and that the contributions of middle authors in multiauthored publications are often seminal and of the highest quality. When the research and/or scholarship is pursued in a collaborative fashion and results in multiauthored publications, the specific contributions of the candidate must be clear and significant. The candidate's role can be described via the Critical Reference Form that must be included in the promotion dossier. In addition, the Chair, the manuscript's senior author, and external correspondents can make an assessment of the quality and impact of a middle author's contribution. (Steven Gabbe, MD, dean, Vanderbilt University School of Medicine, written communication, June 2006.)

Michigan State University College of Human Medicine also has incorporated the notion of collaborative work in their definition of scholarly activity contained in their promotion and tenure guidelines:

To advance in rank in any of the faculty appointment systems, all MSU-CHM faculty members should regularly communicate y obtained and/or applied knowledge and analytical thinking to their peers both within and outside the university. Accordingly, generating high-quality, peer-reviewed publications (e.g., journal articles, electronic publications, other scholarly works) based on original research by faculty members, *including research conducted in collaboration with colleagues, students, and postdoctoral associates*, represents a major source of evidence for productive research activity [emphasis added].21

Not all schools have gone so far as to specifically include new policy language in promotion and tenure documents. At one school, for example, the dean made an announcement about including translational research in the consideration of scholarship at the 2004 state of the school address. Yet, without codifying such pronouncements into formal policy, their effectiveness may be unclear, especially as administrators and tenure and promotion committee members come and go. Rewarding the collaborative contributions of faculty is an integral component of an organizational milieu that supports interdisciplinary work. Turning rhetoric into policy and practice is essential to facilitate collaborative and team-based science. As basic research and clinical application require greater links among and beyond disciplines and across institutions, institutions will need to interweave these realities into the fabric of promotion and tenure.

Expanded definition of scholarship

Another revision to appointment, promotion, and tenure policies is the incorporation of an expanded definition of scholarship. Scholarly activity has been a prominent component of medical schools' tripartite mission of clinical care, education, and research. Traditionally, recognition of scholarship has focused on the conventional areas of hypothesis-driven research or clinical application. In the last decade, the academic medicine community, as well as higher education more broadly, has debated the notion of educational scholarship, its role in career advancement, and evidence of its achievement for purposes of academic recognition and reward.22

Medical schools are engaging in these discussions because of the rapid growth in the number of clinical faculty with heavy patient care responsibilities who have a difficult time meeting promotion criteria that reward a traditional notion of arship.23 Broadening these definitions to include other types of scholarly activities acknowledges the various career structures and pathways at the modern medical school. Although discussions about this matter have occurred during the past

several decades, it has only been recently that medical schools have incorporated different forms of scholarship into their promotion and tenure guidelines. For example, at the University of Michigan Medical School, the criteria for promotion on the instructional track states:

An Instructional Track faculty must be individuals of scholarly ability and achievement. Scholarship may be categorized in terms of the scholarship of discovery (basic research), scholarship of integration, scholarship of application, and scholarship of education. Interdisciplinary work, success in training graduate and professional students (as attested to by academic/research positions obtained), participation and leadership in professional associations, and editing of professional journals are measures of success and stature in scholarship. Peer-reviewed papers and grant funding are strong evidence of scholarship with high impact. Independent and peer-reviewed funding is the norm in research-based careers. There should be a strong prediction of continued excellence throughout the faculty member's professional career.[24]

Similarly, the University of Kansas Medical Center recently added a clinical scholar track for faculty "whose primary mission is education with a component of their position to include the scholarship of education, learning, or discovery and/or service." Other institutions such as Case Western Reserve University School of Medicine, the University of Washington School of Medicine, and Mercer University School of Medicine are working to include revised advancement criteria for various faculty pathways, including the evaluation of clinical care or teaching for promotion and tenure.

The Continuing Evolution of Faculty Policies

For the last 30 years, financial uncertainty, changes in health care delivery and reimbursement, and changing workforce needs have prompted medical schools to depart from faculty employment norms that were developed in a different era and to continually refine their appointment and tenure policies. Given the predictions about the new generation of faculty members,[19] we would expect to see continued growth of flexible policies such as probationary period extensions, track changes, and flexible career pathways.

An institutional environment and culture that support the use of flexible policies are also important in encouraging a match between academic structure and faculty career needs. Yet, our data also suggest that having policies in place is not necessarily sufficient to address the issues for which they were created. The fact that, on average, fewer than three men and en per medical school used clock-stopping policies from 2003 to 2005, and the low number of faculty that used policies to work less than full time while remaining on a tenure-eligible track, indicates a dissonance between policy and practice. Although some faculty choose not to use these policies out of a desire to move through the faculty ranks at a normative rate, others may not take advantage of the flexible policies because of constraints of the clinical and research workplace, an institutional culture that discourages their use, or their ignorance that such policies exist. Each barrier must be removed.

The ultimate goal of faculty appointment and tenure policies, of course, is to structure career pathways that accommodate the needs and preferences of both the medical school and its faculty to ensure academic quality, attractive and rewarding work environments, and sustainable institutions. Thirty years ago, Spellman and Meiklejohn [1] predicted the "continuing modification and experimentation" of faculty policies "to promote equity, retain the effectiveness of faculty members, assure access to the academic ladder for young persons and members of minority groups and women, and at the same time enable appropriate institutional responses to financial problems." We suspect this will still hold true 30 years from now.

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*Wright State University School of Medicine does not offer tenure *per se*, although a small number of basic science faculty are eligible for tenure through their joint appointment in the Wright State University College of Science and Math. For basic science faculty at the University of Missouri-Kansas City School of Medicine, tenure is awarded through the university rather than the medical school. The elimination of tenure for clinical faculty at Sanford School of Medicine of the University of South Dakota occurred in 2002 when the faculty practice plan was significantly downsized. At that time, most faculty in clinical departments left the faculty practice and joined another clinic or hospital. Most tenured clinical faculty lost that status, although a few near-retirement tenured faculty were placed in other positions at the school for the duration of their careers. Clinical faculty are no longer eligible for tenured or tenure-track positions (Ronald Lindahl, PhD, dean, Basic Biomedical Sciences, Sanford School of Medicine of the University of South Dakota, written communication, October 2005). [Context Link]

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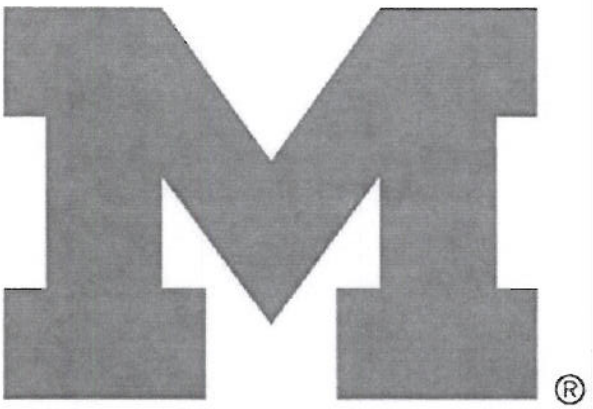

University of Michigan
Medical School

Faculty Handbook
2008 - 2009

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2. UNIVERSITY OF MICHIGAN MEDICAL SCHOOL OVERVIEW OF THE FACULTY TRACKS

The Medical School utilizes three faculty tracks in addition to several supplemental appointments and we will describe each of these separately. Faculty members are expected to be role models of collegiality, integrity, scholarship, and excellence in their professions. Respect for diversity and engagement in the community of the university and the world at large are the norms. Affirmative Action Guidelines apply to all tracks.

I. The *Instructional Track* was the original fulltime faculty track in the Medical School with ranks of assistant professor through professor (the instructor title is no longer utilized in this track). This track is governed by Regents' Bylaw 5.09 that mandates a tenure clock of eight years. This is the only faculty track for which tenure applies. The Instructional Track duties encompass; instruction of medical students, graduate students, residents, and other trainees; scholarly activity that is typically manifested by medical research; organizational contribution to the mission of the Medical School; and in many instances professional work that usually relates to health care.

II. The *Research Track* began in 1974 and has two pathways. The Medical School uses only the research investigator title in the research scientist pathway. Promotion beyond this rank ascends through the research professor pathway. As the title indicates, Research Track faculty have a predominant commitment to the research arena. Although there is no mandated ascension in rank, such ascension reflects achievements in research. Faculty members at the rank of research assistant professor and above are engaged in teaching missions within the context of research programs in the Medical School.

III. The *Clinical Track* began in 1986 and actively contributes to the clinical and teaching missions of the Medical School, as well as scholarship and administration. The ranks are instructor through professor. Although there is no mandated ascension in rank, ascent to senior level titles requires scholarly engagement and productivity as well as excellence in health care and teaching.

IV. The *Supplemental Appointments and Other Titles* are used for entry level faculty (lecturers/clinical lecturers) before assignment to the Instructional Track or Clinical Track or for special faculty appointments that fall outside the standard categories. Adjunct (or supplemental) faculty contribute to research and teaching missions of the Medical School while maintaining primary employment outside the Medical School. Visiting faculty spend specified lengths of time at the University of Michigan, usually before returning to their home institution.

I. EXPECTATIONS FOR EACH PROFESSORIAL RANK OF ALL TRACKS

Professor

1. National and international stature
2. Significant impact on their field
3. Recognition as a thought leader in relevant professional organizations
4. Ongoing commitment to Institutional missions and citizenship

Associate Professor

1. National or regional stature
2. Recognition by peers for significant scholarly contributions to their field
3. Emerging role as a thought leader in relevant professional organizations
4. Substantive participation in Institutional missions and citizenship

Assistant Professor

1. Local or regional stature
2. Shows progress toward becoming a scholarly leader in their field
3. Participation in relevant professional organizations
4. Contributions to Institutional missions

Instructor/Investigator

1. Training relevant to chosen career path
2. Declared willingness to fulfill responsibilities of academic position

Promotion to the next level is determined by the track specific metrics.

II. INSTRUCTIONAL TRACK

A. Definition of the Instructional Track

The Instructional Track was the original fulltime faculty track in the Medical School. Members of this track are expected to make contributions to the Medical School in the areas of scholarly research, teaching, organizational service, and health care if it pertains to their professional field. Instructional Track faculty have no significant employment outside of the University of Michigan. Tenure may be granted by the Board of Regents to Instructional Track faculty at the ranks of associate professor or professor. Medical School faculty members assigned to the Ann Arbor Department of Veterans Affairs Medical Center, the Howard Hughes Medical Institute, or to the Life Sciences Institute may be included in the Instructional Track.

Faculty in the Instructional Track are voting members of the Executive Faculty (governing faculty) and University Senate, have representation on the Executive Committee of the Medical School and University Senate Assembly, and are candidates for tenure, sabbatical, and emeritus status.

B. Ranks in the Instructional Track

The Instructional Track includes three professorial ranks: assistant professor, associate professor, and professor. In the past, some Instructional Track faculty were appointed as instructors, but this is no longer the case inasmuch as two promotional events would be necessary during the eight-year pre-tenure period.

Assistant Professor

Assistant professor is the rank appropriate to a person who has demonstrated competence in teaching and scholarly activity, but has yet to achieve exceptional status as a teacher or regional/national recognition in their professional field. Persons who have begun to publish scholarly work and/or who may have had teaching responsibilities (e.g., seminars, bedside instruction, small group interactions, and/or didactic activities) before their initial faculty appointment, may begin their faculty careers at the rank of assistant professor. Some others achieve this rank by being appointed from the rank of lecturer/clinical lecturer. Appointments to assistant professor, a tenure-track position, require review by the Advisory Committee on Appointments, Promotions, and Tenure (ACAPT) and approval by the Medical School Executive Committee.

Associate Professor

Appointment to associate professor is given only to persons of well-established professional position and demonstrated scholarly or creative ability that positively impacts their field. Those promoted or appointed to this rank must have achieved national recognition for scholarly accomplishment of significance as evidenced by: evaluations from independent national leaders in their field, national lectureships, memberships on editorial boards and peer review committees, significant involvement in peer organizations beyond membership, and scholarship. Scholarly independence or a strong collaborative contribution to a scientific team effort is typical for associate professors. Usually this is evidenced by peer-reviewed

publications published over the previous five years. For those with a predominate expectation of clinical or laboratory research, a sustained level of external research funding is the norm. An associate professor must have demonstrated a significant contribution to the educational missions of this school or another medical school. If it pertains to their professional field, high quality clinical care or clinical service is expected. Persons with clinical responsibilities are board certified before they become associate professors, recognizing that exceptions may be granted by the Medical School Executive Committee for some internationally-trained physicians who do not fulfill American Board requirements but bring critical expertise to the medical school. The associate professor signals the passage into medical academia's senior rank. Unless otherwise specified, appointments and promotions to associate professor are with tenure although persons may be appointed as associate professors without tenure. Appointments and promotions to associate professor require review by ACAPT; approval of the Medical School Executive Committee; endorsement by the Dean, the Executive Vice President for Medical Affairs, the Provost and Executive Vice President for Academic Affairs, and the President; and approval by the Board of Regents.

Professor

Appointment to professor is given only to persons of nationally and internationally established professional reputation and demonstrated scholarly or creative ability. This title is our highest academic rank. All of the expectations for the associate rank pertain in equivalent or greater measure for the professor. The difference between the ranks of professor and associate professor is primarily one of ongoing achievement usually over a period of five-to ten-years; promotion to professor is not automatic after a certain time in rank as associate professor. A person appointed to the rank of professor must have demonstrated *continued* scholarship, productive research, contributions to the teaching mission, organizational service, and clinical care when relevant to career. This ongoing achievement is roughly equivalent in quantity to the accomplishments that gained the previous promotional step. National and international impact must pertain to this person's work. Continued and consistent publication that contributes significantly to an area of knowledge is essential. It is expected that the case for promotion to the professorial rank may reference the work done to achieve the rank of associate professor, but will be based largely on new work accomplished since the last promotional review. For those predominantly involved in clinical, educational, or laboratory research, sustained external funding is the norm. Unless otherwise specified, appointments and promotions to professor are with tenure; persons may be appointed as professors without tenure. Appointments and promotions to professor require review by ACAPT; approval of the Medical School Executive Committee; endorsement by the Dean, the Executive Vice President for Medical Affairs, the Provost and Executive Vice President for Academic Affairs, and the President; and approval by the Board of Regents.

C. Criteria for Appointment and Promotion in the Instructional Track

Teaching, scholarship/research, and service are three areas examined in all appointment and promotion considerations. As we are a Medical School, contributions to health care and human welfare are also a substantial area of consideration for many of the faculty. Interdisciplinary work is a core value of a Medical School and needs to be accounted for in the evaluative process. Some individuals of great value to our institution have truly outstanding performance and contributions in one area when compared with the norm of faculty performance in that area, yet the performance in other areas may be satisfactory only. A recommendation for appointment, promotion, or the award of tenure to a nominee with such an asymmetrical mix of qualifications must be justified by the department chair. In all cases, the minimum requirements must be met. Longevity in a rank or position is not sufficient evidence of accomplishment or merit for promotion.

1. *Teaching*

   Essential qualifications for appointment or promotion are personal integrity and the ability to teach one's professional area of knowledge to relevant learning groups. Critical elements to be evaluated include experience, knowledge of subject matter, skill in presentation, interest in students, ability to stimulate youthful minds, capacity for cooperation, mentorship, and enthusiastic devotion to teaching. A teaching portfolio helps convey the scope of instructional accomplishment. The full responsibility of the teacher as a guide and friend extends beyond the walls of the classroom, laboratory, or clinical arena into other phases of the life of the student as a member of the University and world community. It also involves the duty of initiating and improving educational methods both within and outside the faculty member's department. Outcomes of instruction in the form of teaching evaluations can be described. Pedagogical research and funding are strong evidence of teaching expertise. The spectrum of instruction spans the gamut from premedical students and graduate students to established practitioners.

2. *Scholarship and Research*

   All Instructional Track faculty must be individuals of scholarly ability and achievement. Scholarship may be categorized in terms of the scholarship of discovery (basic research), scholarship of integration, scholarship of application, and scholarship of education. The University of Michigan is a research university committed to extending and understanding the knowledge base of humanity. Accomplishment in scholarship is typically demonstrated by the quality and quantity of published and other creative work. Interdisciplinary work, success in training graduate and professional students (as attested to by academic/research positions obtained), participation and leadership in professional associations, and editing of professional journals are measures of success and stature in scholarship. Peer reviewed papers and grant funding are strong evidence of scholarship with high impact. Independent and peer-reviewed funding is the norm in research-based careers. There should be a strong prediction of continued excellence throughout the faculty member's professional career.

3. *Service*

   Service may consist of organizational service in the Medical School and University, in the public sector, or in the national organizations of a faculty member's peer group. Service may include participation in committee work and other administrative tasks, counseling, internal review boards, and special training programs within the Medical School and University. The University also anticipates that many of its instructional faculty will render extramural services to other schools, industry, relevant professional organizations, governmental agencies, and the public at large. These services may be paid (within University guidelines), advisory, or volunteered. Organizational and volunteer services are of importance, although given less weight in promotion and appointment decisions than are teaching, scholarship, and clinical activities, when relevant to career.

4. *Health Care/Clinical*

   Many faculty have a professional role related to health care, generally in terms of clinical responsibility, teaching or research. Competence is expected at entry levels in the faculty ladder and excellence is expected at the higher levels. Excellence is evidenced by documentation from independent authorities in the relevant field, regional reputation, and published work of clinical successes, innovations, or insights.

III. RESEARCH TRACK

A. Definition of the Research Track

The Research Track in the Medical School consists of four ranks: Research Investigator, Research Assistant Professor, Research Associate Professor, and Research Professor.

Research faculty actively contribute to the Medical School research and teaching missions. Research faculty appointments are intended for individuals whose primary activity is research; and who also teach and mentor within the context of research in the Medical School. Substantive curricular teaching by Research faculty may be reflected in a fractional appointment in another track.

Research faculty (except for research investigators) are voting members of the Executive Faculty and University Senate, have representation on the Executive Committee of the Medical School and University Senate Assembly, and are candidates for emeritus/emerita status. They do not qualify for sabbatical leave but may be granted leaves for educational or training purposes.

B. Ranks and Criteria for Appointment and Promotion of Research Faculty

Research faculty must have achieved or demonstrated the potential for autonomy as independent scientists or as part of a scientific team and excellence in initiation, direction and completion of research projects. Longevity in a rank or position is not sufficient evidence of accomplishment or merit for promotion. A record of substantial teaching and mentoring within the context of one or more research programs with postdoctoral fellows, junior research colleagues, or students at any level is an expectation in the Research Track.

Research Investigator

A person appointed to the position of Research Investigator must hold a doctoral degree or its equivalent in professional and technical experience, have shown potential to develop autonomy as an independent researcher either singly or as part of a scientific team, and typically has completed two or more years of postdoctoral work. The typical candidate for this position demonstrates evidence of potential for scholarship, including obtaining external funding. A person appointed as a research investigator should have a specific role in a project that could be developed under a specific mentor. Candidates for research investigator are not expected to have a record of Institutional citizenship or teaching, although achievement in these areas is a welcome addition.

Research investigator positions are intended for persons for whom a full-time career in research is expected. Appointments are recommended by the Department Chair or unit head, within the constraints of the University appointment procedures, and must be approved by the Dean's Office of Faculty Affairs.

Research Assistant Professor

Candidates who are appointed or promoted to this rank must have a record of publications in peer-reviewed journals. Participation at professional meetings is usually present. Candidates for Research Assistant Professor should show promise of ability to obtain external funding, either singly or as part of a scientific team, and evidence that they can conduct self-directed or autonomous research. Contributions to education and Institutional citizenship are typical. Candidates at this rank typically have documented teaching and mentoring within the context of one or more research programs with postdoctoral fellows, junior research colleagues, or students at any level.

Appointments and promotions to research assistant professor require review by the Advisory Committee on Primary Research Appointments, Promotions, and Titles (APRAPT) and approval by the Medical School Executive Committee.

Research Associate Professor

Appointment or promotion to this rank requires independent, distinguished, and productive research. There should be clear evidence of an essential role in obtaining external funding past the level of initial research grants and fellowships, in the form of, for example, grants, subprojects, program projects, and center programs. There should be a strong record of publication in peer-reviewed journals, including numerous first-author and/or senior-author publications and evidence that this accomplishment will continue. Many researchers appointed or promoted to research associate professor also have a substantial record of book chapters, abstracts, and textbook co-authorships.

A Research Associate Professor must have produced research that has achieved a national reputation. A candidate for this rank should have a record of invited national lectures, seminars, study sections, and *ad hoc* reviews. Candidates at this rank will have a record of substantial teaching and mentoring, both in quantity and quality, within the context of one or more research programs with postdoctoral fellows, junior research colleagues, or students at any level. Institutional citizenship is expected to achieve this rank but cannot substitute for distinguished research performance. Promotion to Research Associate Professor signals the passage into medical academia's senior rank.

Appointments and promotions to Research Associate Professor require review by APRAPT; approval by the Medical School Executive Committee; endorsement by the Dean, the Executive Vice President for Medical Affairs, the Vice President for Research, the Provost and Executive Vice President for Academic Affairs, and the President.

Research Professor

Appointment and promotion to this highest rank in the Research Track requires an internationally recognized record of continued excellence in research. A Research Professor will have a substantial record of first-author and/or senior-author publications in peer-reviewed journals. A Research Professor will have served as principal or co-principal investigator on center grants, major grants (e.g. NIH R01) or equivalent. National and international lectures, seminars, study sections, and *ad hoc* reviews are expected of a Research Professor. Research Professors are expected to perform mentoring, supervising, and laboratory or research based teaching in a number of venues. Institutional citizenship is expected of a Research Faculty.

Appointments and promotions to research professor require review by APRAPT; approval by the Medical School Executive Committee; endorsement by the Dean, the Executive Vice President for Medical Affairs, the Vice President for Research, the Provost and Executive Vice President for Academic Affairs, and the President.

IV. CLINICAL TRACK

A. Definition of the Clinical Track

The Clinical Track is designed for those pursuing a career that focuses mostly on clinical care and teaching with a variable degree of involvement in scholarship and organizational service in the Medical School. Although there is no mandated ascension in rank, scholarly engagement and ascent in rank are desirable. The University is the sole employer of Clinical Track faculty. Appointments are made for up to seven years and are renewable.

Faculty in the Clinical Track are voting members of the Executive Faculty of the Medical School and have representation on the Executive Committee of the Medical School. They are not members of the University Senate and do not participate in the election of representatives to the University Senate Assembly, and do not qualify for sabbatical leave although other types of leave may be granted for specific educational or training purposes. Clinical privileges in the units are granted only by the Medical Staff Executive Committee on Clinical Affairs (ECCA). Clinical Track faculty may be candidates for emeritus/emerita status.

B. Ranks in the Clinical Track

The Clinical Track includes four ranks: instructor, assistant professor, associate professor, and professor. The official title (Assistant Professor, Clinical Track) is used on all appointment, promotional, university human resources correspondence and the curriculum vitae. Routine correspondence (e.g., patient correspondence, scholarly work, etc.) can use shorter working title, e.g. Assistant Professor without identifying track. Time in rank alone is NOT sufficient for advancement in rank.
To obtain a faculty position in the clinical track for persons without an MD degree, a terminal degree in their field is expected.

Instructor
An instructor is fully trained to provide clinical care and is qualified to participate in educational programs at the University of Michigan Medical School. Appointment to this rank requires evidence that the individual has received an appropriate medical and graduate medical education and documentation of full clinical competence. Certification by the relevant professional board must be pending or completed, recognizing that exceptions for some internationally trained physicians may be granted by the Medical School. Evidence of competence in clinical and didactic teaching is expected. Letters from individuals with firsthand knowledge of the candidate are helpful in documenting the candidate's clinical competency, suitability for an academic medical environment, potential as a teacher and clinical role model, and potential for growth in clinical and scholarly areas. Publications in a candidate's professional field are encouraged but not required. Instructor appointments are made by the department chair or unit head, within the constraints of University appointment procedures, and must be approved by the Dean's Office of Faculty Affairs.

Assistant Professor

An Assistant Professor has excelled in clinical care and teaching, and these are the primary requirements for appointment or promotion to this rank.

1. *Clinical work*
   Clinical excellence is documented by letters, which may be from local sources and must attest to the quality of clinical service. Certification by a relevant professional board or the equivalent is a usual expectation at this rank, although this qualification may be in progress at the time of appointment according to the requirements of the relevant professional board; exceptions for some internationally trained physicians may be granted by the Medical School.

2. *Teaching*
   Quality of teaching is usually documented by objective teaching evaluations from the learner groups that are being taught (medical students, residents, fellows, undergraduate and graduate students as well as peer education), letters, and awards. If the candidate comes from an outside institution, letters describing the teaching efforts and quality are required.

3. *Scholarship*
   An Assistant Professor should show progress toward becoming scholarly engaged in their field. On the Clinical Track, invited presentations as well as publication of articles in professional journals, chapters, reviews, abstracts, textbooks, videotapes, or other educational materials are evidence of scholarly contributions and are usual features of faculty at this rank.

4. *Service*
   The candidate's organizational service, if present, to his or her department should be documented. For faculty members with predominantly clinical effort, several years of postgraduate clinical experience (post residency or post fellowship) combined with excellent teaching evaluations may qualify for promotion or appointment at this level, although some evidence of scholarly contribution is generally expected as noted above. New faculty members with evidence of distinct clinical expertise may also be appointed at this level.

   Appointments and promotions to assistant professor require review by the Advisory Committee on Clinical Track Appointments and Promotions (CLINACAP) and approval by the Medical School Executive Committee.

Associate Professor

An Associate Professor has excelled in teaching and clinical work, and has achieved a regional or national reputation in his or her area of expertise. Peer-reviewed published scholarship and service to the institution, regional or national organizations is expected. The associate professor signals the passage into medical academia's senior rank. Individuals at this rank are expected to be role models of collegiality, integrity, scholarship, and excellence in their professions. Typically, a reputation of this sort is documented by letters from impartial external sources.

1. *Clinical work*

   As an Associate Professor on the clinical track, development as a clinician has progressed to the point of establishing broad interdepartmental and regional recognition by professional colleagues for clinical expertise. This is usually documented in letters from colleagues and peers who attest to the clinical excellence. Appointment or promotion to this rank requires board certification or the equivalent (although occasional exceptions for some internationally trained physicians may be granted by the Medical School)

2. *Teaching*

   Evidence of continued valuable contribution to medical education is expected. This may be through customary teaching situations (lectures, clinical instruction of students and residents, mentorship pairing, or scholarly work with trainees including formal evaluations to assess quality) or through the preparation of educational materials, including educational brochures and learning aids, textbook chapters, reviews, videotapes, web based learning, and other instructional interfaces. Teaching evaluations from all learner groups should be available. Administration and organization of teaching programs are also valued activities, and creativity in their execution can be documented by letters from appropriate knowledgeable faculty, students, and peers.

3. *Scholarship*

   The candidate should have produced scholarship that influences knowledge and/or clinical care. Scholarship should include peer – reviewed papers, but may also include books, book or web based chapters, or some other mode of communicating results and ideas.

4. *Service*

   Administration or leadership at the school level or at local, regional, or national organizations are a typical feature of this rank.

   Appointments and promotions to associate professor require review by CLINACAP; approval by the Medical School Executive Committee; endorsement by the Dean, the Executive Vice President for Medical Affairs, the Provost, and Executive Vice President for Academic Affairs, and the President.

Professor

Appointment and promotion to this highest rank in the Clinical Track requires continued outstanding teaching, mentoring and clinical service. A national reputation is expected in scholarship, research or teaching.

A Clinical Professor has many products of their scholarly activity and will have a substantial record of first-author and/or senior-author publications in peer-reviewed journals that have resulted in broad peer recognition in their area of expertise. Service in regional or national specialty societies or boards is the norm. Institutional citizenship is expected of a Senior Clinical Faculty.

Appointments and promotions to professor require review by CLINACAP; approval by the Medical School Executive Committee; endorsement by the Dean, the Executive Vice President for Medical Affairs, the Provost, and Executive Vice President for Academic Affairs, and the President.

C. Criteria for Appointment and Promotion in the Clinical Track

The criteria for appointment and promotion in the Clinical Track will be applied with an emphasis on the impact of the nominee on his or her professional environment. This impact may be in the teaching arena, in professional activity usually manifested by clinical care, in institutional citizenship (organizational, administrative, community, or volunteerism for example), or in scholarship and research.

Longevity in a rank or position is not sufficient evidence of accomplishment or merit for promotion to a senior level. Although tenure is not a facet of Medical School Clinical Track, the University and the Medical School envision parallelism between the Clinical Track, the Instructional Track, and the Research Track, not only in accomplishments but also in the mechanics of appointment and promotion.

1. *Clinical Work*

   A clinical faculty member has usually significant clinical responsibilities and a high level of clinical competency is expected in all ranks. Clinical excellence may be documented by letters from UM faculty and current or former colleagues as well as former trainees. Letters typically attest that the nominee is considered by the medical community as a clinical resource, is sought out for clinical expertise, and has a strong referral base. By their nature these letters will often come from sources that have personal knowledge of the individual's clinical skills and character. A clinician is a role model for medical students and must demonstrate outstanding compassionate patient care, collegiality, integrity, professional excellence, respect for diversity, engagement in community, and commitment to individual learning and scholarship.

2. *Teaching*

   Successful teaching of medical students and residents is an important component of the Clinical Track. In the senior ranks, sophisticated and broad-based educational achievement is expected with the creation/ integration of new (clinical) knowledge and the teaching of other teachers.

   Educational excellence may be demonstrated in a variety of settings. Some faculty will have assigned responsibility for teaching individual medical students and house officers one-on-one in the course of delivering clinical care or for organizing and leading clinical educational programs. The educational roles of other clinical faculty may involve a broad range of educational activities targeted at diverse audiences such as organizing or participating in local or regional CME activities or developing patient education tools, health profession education modules, or public health education programs. Objective evaluation of teaching from all learner groups should be available. In addition to the usual peer sources,

letters from former trainees or from colleagues may document educational impact in special circumstances.

In the Adjunct Clinical Track, sufficient involvement in the educational program of the department is defined as a minimum of *50 hours of direct participation* in clinical education per year or an *equivalent contribution* to the academic mission of the Medical School, as documented by the department chair or unit leader.

3. *Scholarship*
   Promotion to the senior levels of the Clinical Track requires scholarly engagement and productivity. Excellence in scholarship or academic achievement is evidenced by published peer-reviewed and other creative work, participation in grant-funded research, success in training graduate and professional students in scholarly methods, participation and leadership in professional associations, and in editing of professional journals. The ideal clinical professor is a scholar, engaged in life-long professional learning related to some clinical aspect of the human condition. Written evidence of scholarship may also include chapters, review articles and other creative ways to education. Individual scholarship is an essential part of the clinical professoriate, as it professes its work through instruction and role modeling for the next generation of physicians.

4. *Service*
   Many organizational service activities are expected of more senior faculty in the Clinical Track, such as participation in committee work, IRB, administrative tasks, counseling, and special training programs. Medical staff activities (such as leadership of or service on a quality assurance, risk management, or utilization review committee) also pertain to this type of service. In addition, the University expects many of its staff to render extramural services to relevant professional organizations other schools, industry, governmental agencies, and the public at large. Examples include:
   - Memberships and offices held in professional societies.
   - Continuing participation and leadership roles in medical service organizations (e.g., American Cancer Society, Planned Parenthood, American Red Cross).
   - Public service activities that relate to the health of the general public.

   Usually a promotion is based on a balance between all 4 areas discussed above. In exceptional circumstances a faculty member may have had a profound effect on his or her environment in the role of clinician, educator and/or with extensive administrative responsibilities. This may qualify the candidate for appointment or promotion to a senior level, with such extraordinary service offsetting to some degree the usual expectation of scholarly activity. In this case, letters of support must explain the individual's impact with great detail and specificity.

V. SUPPLEMENTAL APPOINTMENTS AND OTHER TITLES

A. Definitions of Supplemental and Other Titles

Supplemental Titles are used for entry level faculty before assignment to one of the three principal tracks (e.g. lecturers/clinical lecturers) or for special faculty appointments that fall outside the standard categories.

Clinical Lecturer
Some faculty members are appointed as clinical lecturers by the Medical School before moving into the Instructional Track or Clinical Track. Clinical lecturers have shown competence as teachers and hold a doctoral degree or its equivalent in professional and technical experience. An appointment as a clinical lecturer does *not* start the tenure clock for a faculty member. If a person is appointed clinical lecturer as the result of a normal, open, national search process that includes posting, advertising, and efforts to secure a diverse applicant pool, an Affirmative Action document is filed at the time of the initial appointment as clinical lecturer. Otherwise, the clinical lecturer must compete in a national search process in order to be recommended for appointment at a higher rank. Appointments of clinical lecturers are the prerogative of the department chair or unit head, within constraints of University appointment procedures, and must be approved by the Dean's Office of Faculty Affairs. The appointments are for one year and are renewable, usually for up to four years.

Lecturer
The lecturer title pertains to those individuals whose sole responsibility is to teach in an academic setting. Appointments of lecturers are the prerogative of the department chair or unit head, within constraints of University appointment procedures, and must be approved by the Dean's Office of Faculty Affairs. The appointments are for one year and are renewable, usually for up to four years.

Visiting I
- This title may be used in conjunction with all instructional, clinical, and research titles.
- Appointees to this title *must* have employment responsibilities with another institution of higher education and are usually on leave from that institution. (e.g. A professor from UCSF who is here for a six month sabbatical).
- Appointees may be full-time, with a maximum length of appointment of one year or less.
- Written requests to extend appointments beyond one year may be granted under unusual circumstances. Such requests must specify what contributions the visiting faculty member has made, why an extension is needed, and what provisions are being made for allocation of space and for payment of any salary.

Adjunct

According to the Regents' Bylaws (Sec. 5.22 Adjunct Professorships and Sec. 5.23 Clinical Instructional Staff):

- Require annual renewal.
- Are part-time (less than 50%).
- Are used for the Instructional Track, Clinical Track, or Research Track.
- May be compensated or uncompensated.

Further Special Notes on Adjunct Faculty

Increased collaboration between the University and industry has resulted in requests for faculty appointments in the Medical School from qualified employees of industrial companies. These appointments should enhance the Medical School's instructional programs and foster research collaboration with industry. Adjunct appointments are appropriate for individuals with special talents to provide this industrial interface. People whose primary employer is a for-profit organization should be appointed only as adjunct faculty.

In 1990, the Medical School Executive Committee compiled procedures, privileges, and restrictions for adjunct faculty whose primary employment is with an industrial organization. At the time of appointment, there must be full disclosure of all details of employment status so that any potential for conflict of interest can be prospectively addressed. Ownership of intellectual property must be thoroughly disclosed: the nominating chair should define claims to patent ownership and royalties and should identify eligibility to publish and present findings. Appointment of adjunct faculty as principal investigators on University extramural grants will not occur under ordinary circumstances. Any University space, for example, must be requested by the department chair of the prospective adjunct faculty and must be used primarily for the academic benefit of the department and the Medical School.

Adjunct faculty are generally *not* eligible for clinical privileges at the UMHS or VAMC. Adjunct faculty may be involved in medical education, graduate medical education, or clinical research in the clinical setting at UMHS, but they should *not* be the attending of record or responsible for the delivery of patient care.

Adjunct faculty are not voting members of the Executive Faculty of the Medical School, may not serve on the Executive Committee of the Medical School, are not members of the University Senate, nor participate in the election of representatives to the University Senate Assembly.

Adjunct Instructional Track

Adjunct Instructional Faculty appointments are used to supplement teaching in a specific field; to facilitate research collaboration with individuals in other units of the School or University, with individuals at other educational or health care institutions, or with scientists employed by industry; or to permit faculty or trainees who are leaving the University to complete ongoing educational or research responsibilities.

Portfolio & Promotions Workshop
University of Washington College Faculty
18 July 2006

Information Packet for Promotions

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(Available on the Colleges web site at
https://courses.washington.edu/colleges/faculty/index.shtml)

PROCEDURE FOR PROMOTIONS

Faculty Code Section 24-54

Effective April 25, 2000, Faculty Code changes to promote "openness" in tenure proceedings became effective. Please be mindful of the following during the promotion and tenure process:

I. **Candidates are responsible for assembling their promotion record, which shall include a self-assessment of their accomplishments. The format of the self-assessment shall be determined within each department.**

II. **When a departmental committee evaluates a candidate for promotion or tenure, and makes a recommendation on the qualifications of the candidate, the committee shall produce a written report of its proceedings.**

- The Division Head or Department Chair (or their designee), as relevant, shall produce a written summary of the Committee's report and recommendation and provide it to the candidate.
- All names shall be omitted from the summary.
- Vote counts may be omitted from the summary.
- The candidate is entitled to respond in writing to the summary within 7 calendar days.
- The committee report and candidate's response, if any, shall be forwarded to the voting faculty before they make a decision on the candidate.

III. **The Division Head or Department Chair, as relevant, shall write a report of the proceedings of the voting faculty, summarizing the discussion and recommendation.**

- All names shall be omitted from the report.
- Vote counts may be omitted from the report.
- The candidate is entitled to respond in writing within 7 calendar days.

IV. **In the case of mandatory promotion decisions:**

- All of the above referenced documents shall be provided to the A & P Council.
- The Chair's independent analysis and recommendation shall be forwarded as well.

V. **In the case of non-mandatory promotion decisions:**

- If the decision is favorable, or if the candidate responds in writing and does not indicate a desire for the decision to be deferred, then the A & P Council must review the package and advise the Dean on promotion.
- All of the above referenced documents shall be provided to the A & P Council.
- The Chair's independent analysis and recommendation shall be forwarded as well.

Section 13-31, April 16, 1956; S-A 24, June 23, 1959: both with Presidential approval

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Section 24-53. Procedure for Renewal of Appointments

When it is time to decide upon renewal of a nontenure appointment to the faculty (Section 24-41), the procedure described below shall be followed.

A. The voting members of the appropriate department (or undepartmentalized college or school) who are superior in academic rank to the person under consideration shall decide whether to recommend renewal or termination of the appointment. Research faculty shall be considered by voting faculty who are superior in rank to the person under consideration, except that the voting faculty at the rank of Professor shall consider whether to recommend renewal or non-renewal of the appointment of a Research Professor.

B. If this recommendation is a departmental one, the chair shall transmit it to the dean. If the chair does not concur in the recommendation he or she may also submit a separate recommendation.

C. The dean shall decide the matter within the time prescribed in Section 24-41 and inform the faculty member concerned of the decision.

D. If a faculty member requests a written statement of the reasons for the non-renewal of his or her appointment, the dean shall supply such a written statement within thirty days.

Section 13-31, April 16, 1956; S-A 41, April 3, 1972; S-A 60, June 25, 1979; S-A 81, January 30, 1990; S-A 94, October 24, 1995; all with Presidential approval

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Section 24-54. Procedure for Promotions

Each member of the faculty below the rank of professor shall be considered annually for possible promotion. The procedure described below shall be followed.

A. The voting members of the appropriate department (or undepartmentalized college or school) who are superior in academic rank to the person under consideration shall decide whether to recommend the promotion. Research faculty shall be considered by voting members of the appropriate department, or undepartmentalized college or school, who are superior in academic rank to the person under consideration. In this decision they shall take into account the qualifications prescribed in Sections 24-32, 24-33, 24-34, and 24-35 for the various academic ranks. Promotion shall be based upon the attainment of these qualifications and not upon length of service. In arriving at recommendations for promotion, faculty, chairs, and deans are directed to study the whole record of candidates' qualifications described in Section 24-32.

B. If this recommendation is a departmental one, and if it is favorable, the chair shall transmit it to the appropriate dean with any supporting data the dean may request. If the chair does not concur in the recommendation, he or she may also submit a separate recommendation.

C. The dean shall be advised by a committee or council of the college or school. This advisory group, elected by the faculty of the college or school, shall consider each case presented to it and submit its recommendations with reasons therefor to the dean. In a departmentalized school or college, when a candidate for promotion is under consideration, any member of the committee or council who is also a member of the candidate's department may be excused.

D. After receiving the recommendation of this committee or council the dean shall decide the matter, and if the decision is favorable shall transmit his or her recommendation to the President.

Section 13-31, April 16, 1956; S-A 22, April 18, 1958; S-A 59, April 23, 1979; S-A 64, May 29, 1981; S-A 81, January 30, 1990; S-A 94, October 25, 1995: all with Presidential approval. [See footnote on Documentation following Section 24-57]

Section 24-55. Procedure for Salary Increases Based Upon Merit

When the President allocates funds for faculty salary increases and determines that the increases are to depend upon merit, the following procedure shall govern where appropriate.

A. In arriving at recommendations for salary decisions, faculty, chairs, and deans shall study the cumulative record of the candidate, taking into account the qualifications prescribed in Sections 24-32, 24-33 , 24-34, and 24-35 for the various academic ranks. Salary recommendations shall seek to minimize salary inequities. Salary compression and other inequities, including those resulting from variations in the level of merit funds available over time, may be considered in making merit salary recommendations.

B. The salary of each faculty member below the rank of professor shall be considered by the voting members of the department, or undepartmentalized college or school, who are his or her superiors in academic rank, and they shall recommend any salary increase which they deem merited.

C. If their recommendation is a departmental one, the chair shall transmit it to the dean with any supporting data the dean may request. If the chair does not concur in the recommendations he or she may also submit a separate recommendation.

D. The dean shall then decide the matter and transmit the decision as a recommendation to the President.

E. The dean of an undepartmentalized college or school, or the chair of a department shall consider the salary of each full professor responsible to him or her. In an undepartmentalized college or school the dean shall seek the advice of the full professors of the college or school before transmitting to the President any recommendation for any salary increase he or she deems merited. If the procedure is departmental, the chair shall seek the advice of the full professors of the department before transmitting to the dean recommendations for any salary increase he or she deems merited. After such procedure the dean shall decide the matter and transmit the decision as a recommendation to the President.

F. The dean of each college shall determine the salary increase of the chair in each of the departments and shall recommend the decision to the President.

Promotions: Mandatory Review

- **Titles/Ranks:**
  - ✓ Assistant Professor
  - ✓ Research Assistant Professor

Mandatory review for promotion from assistant professor to associate professor and research assistant professor to research associate professor takes place during the third year of the second, three-year term (the sixth year) by the voting members of the department who are superior in rank. (See Appendix A-4, *Timeline of an Assistant Professor and a Research Assistant Professor Appointment*.) All promotions are effective July 1 of the following academic year.

I. Procedures –

A. **School of Medicine Office of Faculty Appointments Notifies Departments:** The School of Medicine Office of Faculty Appointments sends a notice to the departments in June with a deadline of September 15 for submitting mandatory promotions.

B. **Departments are instructed to:**

1. Assemble Records –
   Have the candidates assemble their promotion records, which shall include written self-assessments (format to be determined by the department). (See Appendix F-5, *Procedure for Promotions* and the *Faculty Code*, Section 24-54.)

2. Review and Vote –
   Review and vote for the promotions of assistant professors to associate professors and research assistant professors to research associate professors who are in their sixth year. (See Appendix A-1 *for Voting Membership and Eligible Voting Groups.*)

3. Prepare Written Summaries –
   Prepare written summaries for the candidates throughout the departmental promotion process and allow the candidate to respond in writing within seven calendar days (See Appendix F-5, *Procedure for Promotions* and the *Faculty Code*, Section 24-54.)

4. Submit Promotion Packages –
   Promotion packages should be submitted to the School of Medicine Office of Faculty Appointments (Box #358220) including the originals and 16 sets in the following order:

a. A letter from the Chair to the Dean recommending promotion. (See Appendix F-2, *Promotion Letter from Chair to Dean* for a detailed summary of what should be included in the letter.)
b. *For Candidates with Joint Appointments*:
   - A letter of concurrence from the Chair(s) of the secondary department(s) including a vote.
c. *For Candidates with Adjunct Appointments*:
   - A letter of concurrence from the Chair(s) of the secondary department(s). A vote is not required.
d. A copy of the departmental criteria for promotion.
e. An example letter of solicitation from the Chair to the referee (individuals writing letters of recommendation). (See Appendix F-1, *Solicitation Letter* sample.)
f. A minimum of five letters of recommendation. Of the five letters, at least two must come from outside the University. The additional three letters can come from within the University; one must be from within the department.
   ✓ In reference to the outside letters, a minimum of two (preferably a maximum of five letters) should come from external University referees (senior faculty) at institutions comparable to ours that have not had close personal interaction with the candidate. These individuals should not be former colleagues, teachers, students, friends, mentors or collaborators. Letters from former UW faculty are welcome but will not necessarily be considered as external letters. When soliciting letters, it is appropriate to submit all that are received unless the respondent is unfamiliar with the candidate.
g. A copy of the University of Washington School of Medicine *External Referee Form* for each outside letter of recommendation (See Appendix F-3).
h. Candidate's self-assessment and written summaries provided to the candidate during the departmental promotion process as well as responses from the candidate (refer to *Faculty Code*, Section 24-54).
i. Candidate's updated CV/Bibliography in University of Washington School of Medicine format (See Appendix E-9). An asterisk should identify five of the candidate's most significant scholarly contributions.

In addition, two sets of the following should be submitted with the promotion package:

- Five of the most significant scholarly contributions.
- Teaching evaluations and a separate summary of evaluations (See Appendix F-4, *Teaching Evaluation Form*).

II. Promotions Approved –

A. **Promotions Receiving Favorable Recommendation:**
Promotions receiving favorable recommendation from the School's Appointments and Promotions Council go before MSEC for consideration.

B. **Departments will be asked to submit to the Dean, 32 copies of the following:**

1. Chair's letter and candidate's C.V. (for those candidates who receive a unanimous recommendations or one negative vote by the A&P Council)

2. Chair's letter, letters of recommendation, and candidate's C.V. (for those candidates who receive more than one negative vote by the A&P Council)

C. **Following a favorable recommendation by MSEC and the Dean:**

1. The Dean submits a letter of recommendation to the President for final approval. A copy of the Dean's letter to the President is sent to the department Chair.

2. Upon approval, the President notifies the faculty member in writing of the promotion.

III. Promotions Denied –

A. **Promotions Denied by Appointments and Promotions Council:**
Promotions that are denied by the School's Appointments and Promotions Council can be appealed by the Chair of the department.

- The Chair must resubmit new material to Appointments and Promotions Council for a vote.
- If the promotion is denied a second time, the Chair can appeal to the Dean.

B. **Final Decision is to Deny the Promotion:**
If the final decision is to deny promotion, the Chair is advised to take the results to the faculty member and the faculty member can resign.

- If the faculty member does not resign by June 30 of the sixth year, he/she is given a final year (seventh year).

IV. Request for Postponement –

A. **Department Wants to Postpone the Mandatory Decision to Promote:**

- If a department wants to postpone the mandatory decision to promote an assistant professor or research assistant professor, the voting members of the department who are superior in rank must review and vote in the fall of the sixth year to recommend a one-year postponement. (See Appendix A-4, *Timeline of an Assistant Professor and a Research Assistant Professor Appointment*.)
- Be mindful that the candidates are responsible for assembling their record, which should include a self-assessment.
- The department shall prepare written summaries for the candidate throughout the departmental process and the candidate is entitled to respond in writing

within seven calendar days. (See Appendix F-5 *Procedure for Promotions* and *Faculty Code,* Section 24-54 and.) These documents are to be submitted with the postponement package.

B. **General Guidelines to Process a Postponement Package:**

1. Medical School Appointments and Promotions Council: Guidelines for Requests for Postponement –

Since the A&P Council must advise the Dean on each recommendation by a department for postponement of a mandatory review, the recommendation package should include the following:

- A letter from the Chair indicating the vote of the faculty and outlining clearly the reasons why an additional 12 months before a final decision would be likely to alter in a significant way the recommendation of the department. The letter should also indicate the substance of the most recent annual meeting with the candidate and the unfulfilled expectations that were discussed.
- An updated C.V., including indications of teaching and service responsibilities as well as a record of grant support.
- Evidence of effectiveness in teaching and/or clinical activities.
- Two recent publications that indicate the focus of the candidate's scholarly activities.
- Although not required, letters from other members of the faculty may be helpful to support the proposition that additional time would present a realistic opportunity for the candidate to address identified shortcomings.
- A postponement package may not be as complete as one recommending promotion, but it should provide the Council with sufficient materials to evaluate the wisdom of postponing the decision for 12 months. A critical difference between a postponement package and a promotion package is that outside letters may not have been solicited. If solicited, however, they must be submitted with the package to the Council.

2. Postponement Packages –

Postponement packages should be submitted to the School of Medicine Office of Faculty Appointments (Box #358220) including the originals and 16 copies of the letters, C.V., self-assessment, written departmental summaries, candidate's responses, and two sets of the candidate's publications.

3. Postponement Recommended –

If postponement is recommended by the School's Appointments and Promotions Council:

- The recommendation goes to the Dean for review and approval.
- Upon approval, the Dean submits a letter to the President for final approval.

C. **Postponement Granted:**
If postponement is granted, the voting members of the department who are superior in rank must review and vote in the seventh year to promote or terminate.

D. **Postponement Denied:**

- If the School's Appointments and Promotions Council does not recommend postponement, the Chair can appeal the decision by submitting new material to the Appointments and Promotions Council.
- If postponement is denied a second time, the Chair can appeal to the Dean.
- If postponement is not granted, the voting members of the department who are superior in rank must proceed and review and vote to promote or terminate.
- If the assistant professor is not recommended for promotion, the Chair is advised to take the results to the faculty member and the faculty member can resign.
- If the faculty member does not resign by June 30 of the sixth year, he/she is given a seventh, terminal year.

Promotions for Non-Mandatory Faculty

Titles/Ranks:

- ✓ Assistant Professor
- ✓ Research Assistant Professor
- ✓ Associate Professor
- ✓ Research Associate Professor
- ✓ Lecturers (Full-Time)

current titles

Departments may submit non-mandatory promotions of assistant professors and research assistant professors prior to the mandatory review in the sixth year. In addition, departments may submit non-mandatory promotions of associate professors, research associate professors and lecturers. Promotions are effective July 1 of the following academic year.

I. **Procedures** –

A. **The School of Medicine Office of Faculty Appointments Notifies the Departments:**
The School of Medicine Office of Faculty Appointments sends a notice to the departments in June with a deadline of December 1 for review by the School's Appointments and Promotions Council. Promotions are effective July 1 of the following academic year.

B. **Departments are instructed to:**

1. Assemble Records –
Have the candidates assemble their promotion records which shall include written self assessments (format to be determined by the department). (See Appendix F-5, *Procedure for Promotions* and the *Faculty Code*, Section 24-54.)

2. Review and Vote –
Review and vote for the non-mandatory promotions of lecturers, assistant professors, research assistant professors, associate professors and research associate professors. (See Appendix A-1for *Voting Membership and Eligible Voting Groups*.)

3. Prepare Written Summaries –
Prepare written summaries for the candidates throughout the departmental promotion process and allow the candidate to respond in writing within seven calendar days (See Appendix F-5, *Procedure for Promotions* and the *Faculty Code*, Section 24-54.)

4. Include the ORIGINALS and 16 SETS in the Promotion Package in the following order:

   a. A letter from the Chair to the Dean recommending promotion. (See Appendix F-2, *Promotion Letter from Chair to Dean* for a detailed summary of what should be included in the letter.)

   b. Joint Appointments:
      - A letter of concurrence from the Chair(s) of the secondary department(s) including a vote.

   c. Adjunct Appointments:
      - A letter of concurrence from the Chair(s) of the secondary department(s). A vote is not required.

   d. A copy of the departmental criteria for promotion.

   e. An example letter of solicitation from the Chair to the referee (individuals writing letters of recommendation). (See Appendix F-1, *Solicitation Letter* sample.)

   f. A minimum of five letters of recommendation. Of the five letters, at least two must come from outside the University. The additional three letters can come from within the University; one must be from within the department.
      - In reference to the outside letters, a minimum of two (preferably a maximum of five letters) should come from external University referees (senior faculty) at institutions comparable to ours that have not had close personal interaction with the candidate. These individuals should not be former colleagues, teachers, students, friends, mentors or collaborators. Letters from former UW faculty are welcome but will not necessarily be considered as external letters. When soliciting letters, it is appropriate to submit all that are received unless the respondent is unfamiliar with the candidate.

   g. A copy of the University of Washington School of Medicine *External Referee Form* for each outside letter of recommendation (Appendix F-3).

   h. Candidate's self-assessment and written summaries provided to the candidate during the departmental promotion process as well as responses from the candidate (refer to *Faculty Code*, Section 24-54).

   i. Candidate's updated C.V./Bibliography in University of Washington School of Medicine format (Appendix E-9). An asterisk should identify five of the candidate's most significant scholarly contributions.

D. **In addition, TWO SETS of the following should be submitted with the promotion package:**

   1. Five of the most significant scholarly contributions.

   2. Teaching evaluations and a separate summary of evaluations (Appendix F-4, *Teaching Evaluation Form*).

II. **Promotions Approved** –

A. **Promotions Receiving Favorable Recommendation:**
Promotions receiving favorable recommendation from the School's Appointments and Promotion Council go before MSEC for consideration.

B. **Departments will be asked to submit to the Dean, 32 COPIES of the following:**

1. Chair's letter and candidate's C.V. (for those candidates who receive a unanimous recommendations or one negative vote by the A&P Council)

2. Chair's letter, letters of recommendation, and candidate's C.V. (for those candidates who receive more than one negative vote by the A&P Council)

C. **Following a Favorable Recommendation by MSEC and the Dean:**

1. The Dean submits a letter of recommendation to the President for final approval. A copy of the Dean's letter to the President is sent to the department Chair.

2. Upon approval, the President notifies the faculty member in writing of the promotion.

III. **Promotions Denied** –

Non-mandatory promotions that are denied can be appealed by the department Chair. New information must be submitted to the Appointments and Promotions Council for a second vote. If promotion is denied a second time, the Chair can appeal to the Dean.

College Portfolio Outline – Clinician Educator Track

1. **CV**
2. **Self-Assessment of Accomplishments**
   Brief and succinct description of short-term and long-term career goals and brief highlights from sections 3-10 below
3. **Teaching Activities**
   a. Student teaching
      i. Course materials/ Curriculum development
      ii. Lectures
      iii. Evaluations
   b. Residency teaching
      i. Course materials/ Curriculum development
      ii. Lectures
      iii. Evaluations
   c. Fellowship
      i. Lectures
      ii. Evaluations
   d. Other – National, regional, boards, etc
4. **Mentoring**
   a. Medical students (how do we characterize the time commitment?, students who require more 1:1 time, additional meetings with Student Progress Committee, etc in behalf of students?)
   b. Other [be specific, e.g., Residents or Junior Faculty or Undergraduates]
5. **Scholarly**
   a. Presentations (CME, research only, as teaching is already listed above?)
      i. Evaluations
   b. Publications
   c. Research/grants
6. **Clinical Activities**
   (including % clinical time, call frequency, description of clinical work performed and clinical setting)
7. **Administration**
8. **CME**
9. **Honors/Awards**
10. **Other Service, Community Service, etc.**

UNIVERSITY OF WASHINGTON
SCHOOL OF MEDICINE CURRICULUM VITAE

DATE OF CV

The curriculum vitae should contain the following information:

1. **Personal Data**: Place of birth, citizenship, if applicable; date of birth optional.
2. **Education**: University of undergraduate and graduate degrees (indicate dates).
3. **Postgraduate Training**: Internship, residencies, fellowships (place and dates).
4. **Faculty Positions Held**: (place and dates).
5. **Hospital Positions Held**: (place and dates). Do not duplicate #3 above.
6. **Honors**: Phi Beta Kappa, Sigma Xi, AOA, Prizes, RCDA's, Young Investigator Awards, Teaching Awards, etc.
7. **Board Certification**: General Medical and Specialty Boards (indicate date received).
8. **Current License(s) to Practice**: States and dates.
9. **Professional Organizations**: Include offices held.
10. **Teaching Responsibilities**. List specific courses, specific responsibility and percentage of responsibility if shared course. Indicate role in teaching committees. List recent CME. List trainees during last 5 years, if primary mentor.
11. **Editorial Responsibilities**: Mention only Editorial Boards. Do not mention occasional reviewing duties.
12. **Special National Responsibilities**: Study sections, training grant committees, American Heart Associates and other similar responsibilities.
13. **Special Local Responsibilities**: University and Hospital committees. Do not duplicate teaching committees listed in #10.
14. **Research Funding**: Sources, dates and dollars. Include training grants. NOTE: Even if you have no research funding, put: Research Funding: None.
15. **Bibliography** [use the format in (a) for (b) through (f)]:
    a) The first section should be Manuscripts in Referred Journals with authors listed in the order they appear in the original publication. Include manuscripts in press (i.e. accepted for publication). Number these articles consecutively and include the first and last page numbers of each article.
    b) The second section: Book chapters
    c) The third section: Published books, videos, software, etc.
    d) The fourth section: Other publications e.g. in non-referred journals and letters to the editor.
    e) The fifth section: Manuscripts submitted, listed separately with date of submission. Do not list manuscripts in preparation or work in progress.
    f) List Abstracts in a final section.
16. **(Optional) Other**: National invitational lectures, etc.

UNIVERSITY OF WASHINGTON
SCHOOL OF MEDICINE CURRICULUM VITAE

DATE OF CV

The curriculum vitae should contain the following information:

1. **Personal Data**: Place of birth, citizenship, if applicable; date of birth optional.
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    b) The second section: Book chapters
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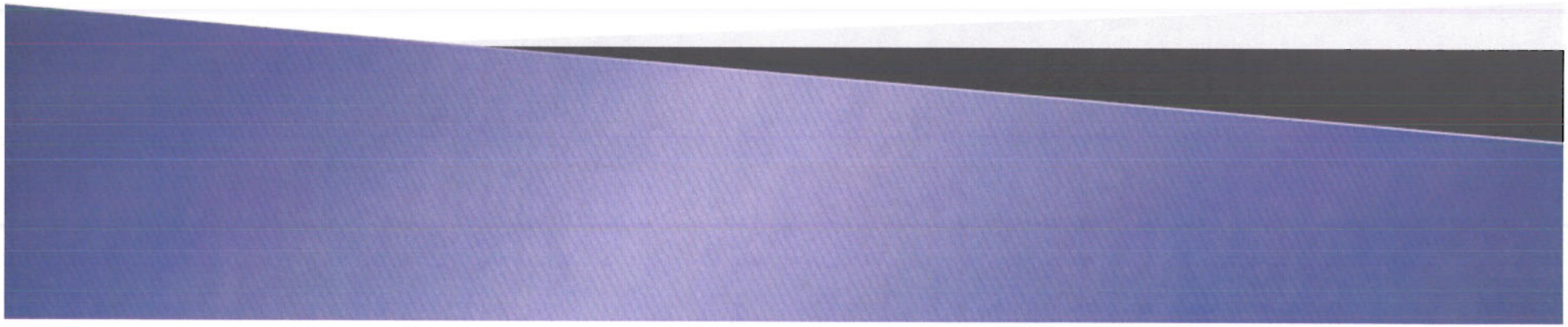
    d) The fourth section: Other publications e.g. in non-referred journals and letters to the editor.
    e) The fifth section: Manuscripts submitted, listed separately with date of submission. Do not list manuscripts in preparation or work in progress.
    f) List Abstracts in a final section.
16. **(Optional) Other**: National invitational lectures, etc.

New Faculty Orientation
November 14, 2008
Welcome - New Faculty

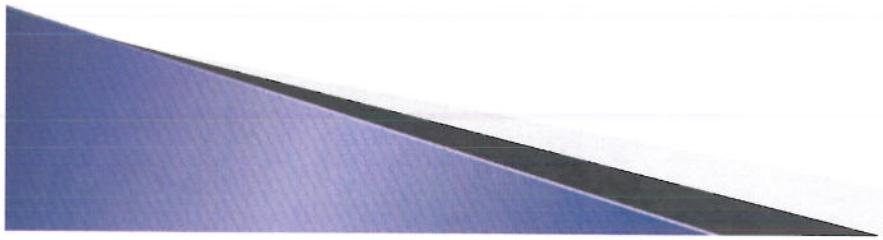
Christina M. Surawicz, MD
Professor of Medicine
Assistant Dean for Faculty Development
(206) 744-7070
Box 359773
e-mail: surawicz@u.washington.edu



ACADEMIC TRACKS

- **Regular Faculty Tracks**
  - **Assistant professor (tenure or WOT)**
  - **Associate Professor (tenure or WOT)**
  - **Professor (tenure or WOT)**

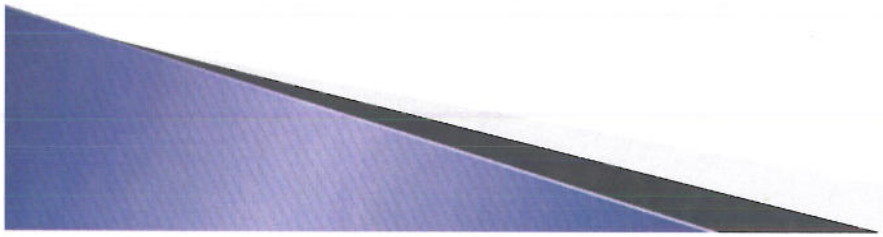
- **Research Faculty Tracks**
  - **As above (Research Asst Professor, etc.)**



Pathways

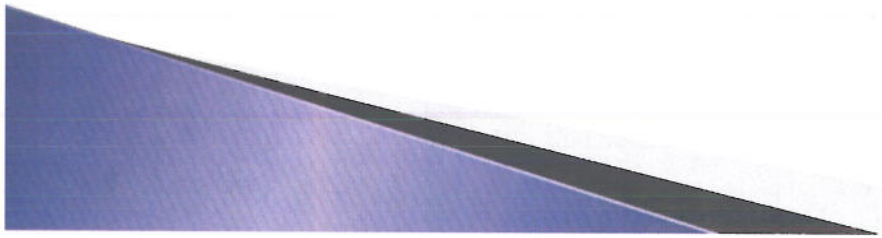
- **CLINICAL DEPARTMENTS**
  - **Physician scientist**
  - **Clinician teacher**

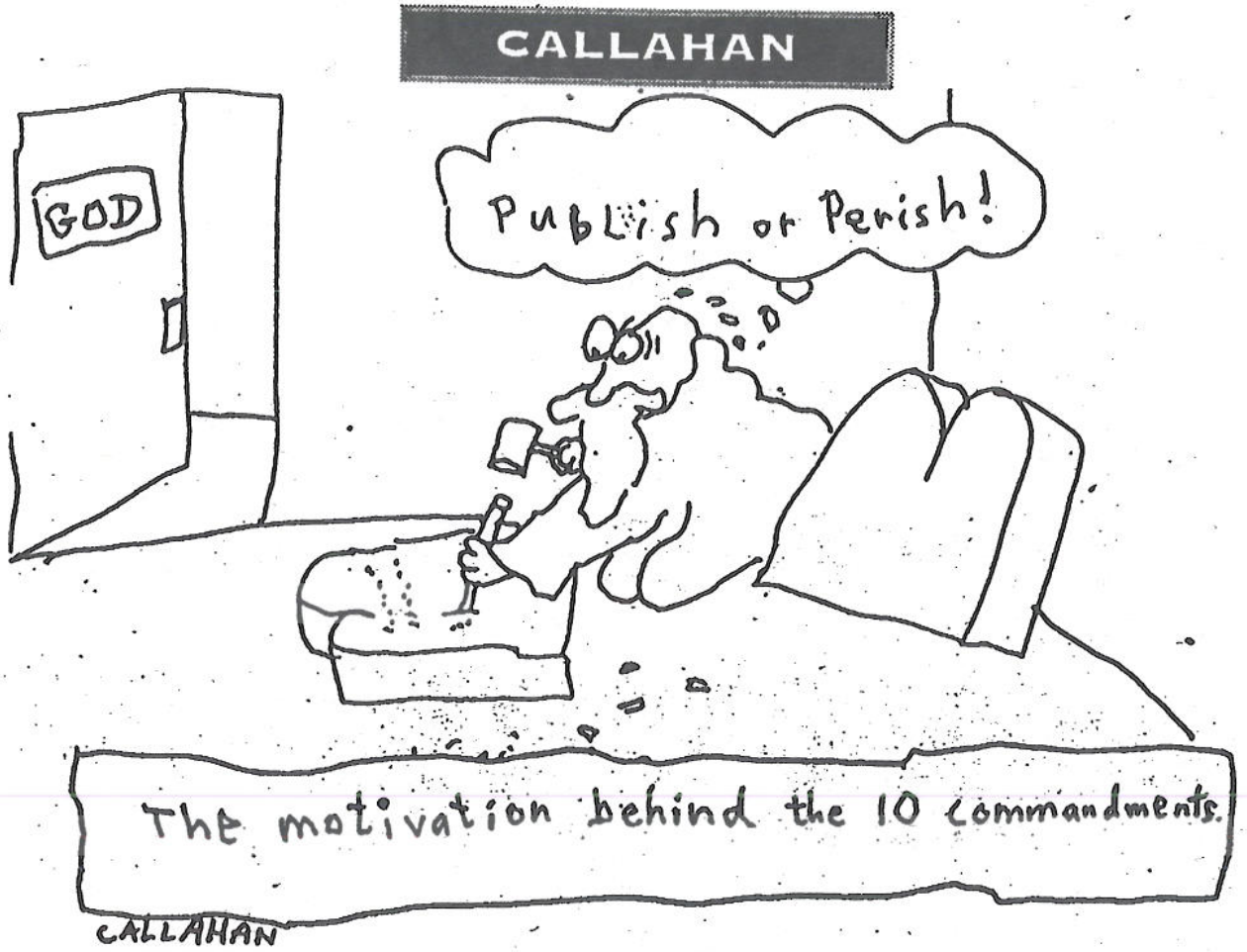
  - **FULL TIME CLINICAL FACULTY**
    - **Not a pathway**



Promotion Criteria

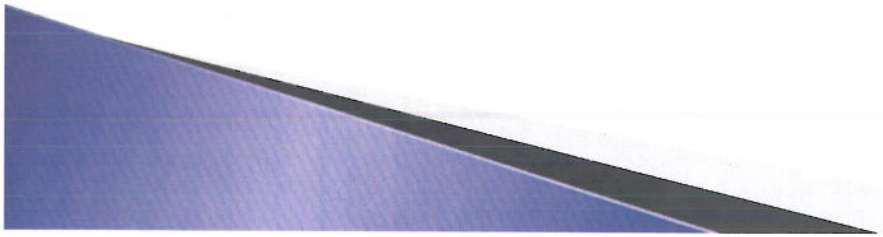
- **DEPEND ON**
  - **Track**
  - **Dept Criteria**




CALLAHAN
GOD
Publish or Perish!
The motivation behind the 10 commandments.
CALLAHAN

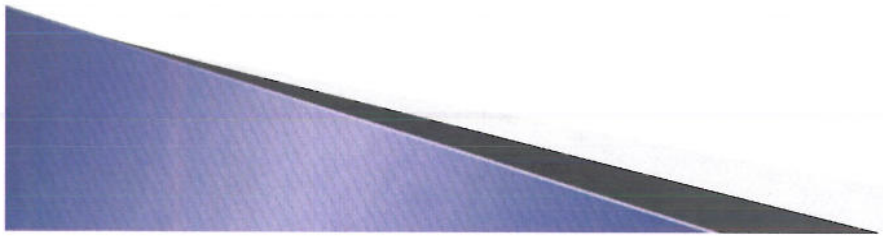
Assistant Professor

- Faculty Code requires search
- Annual review
- Duration of initial appointment - 3 years
  - Reappointment to 2d. 3 yr term spring of 2d year
- Mandatory Review at 5 yr for promotion
  - Prepare at 5 year
  - Submit fall of 6th year



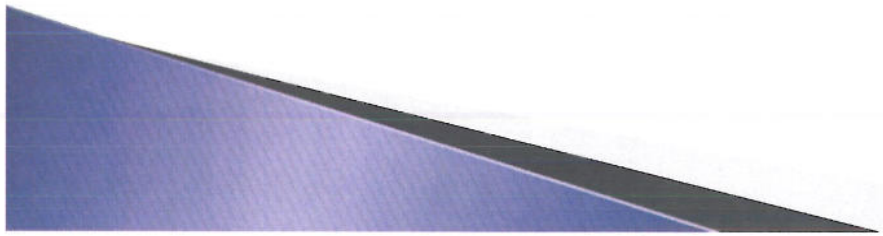
Extending the Clock

- Illness/Child bearing
- Adopted infants; extended care for parents/ children
- Special circumstances
  - Lab space not ready
  - Animals die
- Requires approval of
  - Department/Dean's office/Provost



Basic Science Depts.

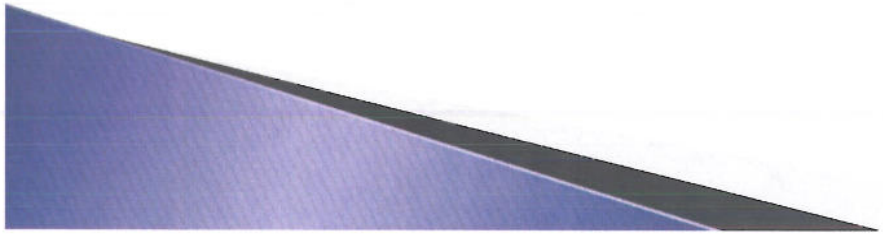
- Scholarship, papers, grants
- Original Independent work
- Teaching and Administration are looked at



Physician Scientist

- **Scholarship of discovery**
  Peer reviewed papers & grants
  Independence
  Quality more important than quantity

- **Clinical, teaching, administration are looked at also**

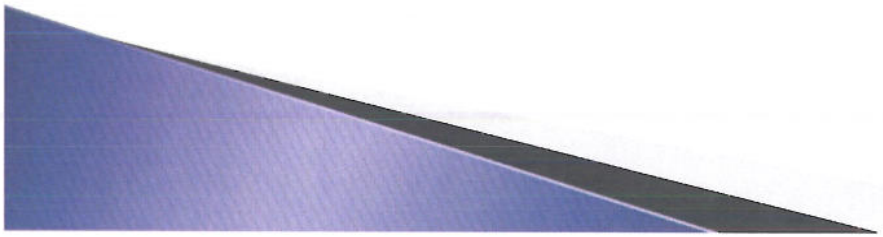


Clinician Teacher- 1989

80% clinical/teaching
- **Peer evaluation**
- **Teaching portfolios**

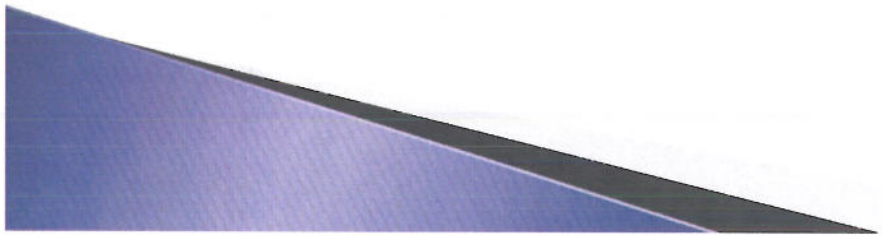
20% scholarly
- **Papers, chapters, videos, web syllabi**

Administration may be part, but role in promotion may be unclear



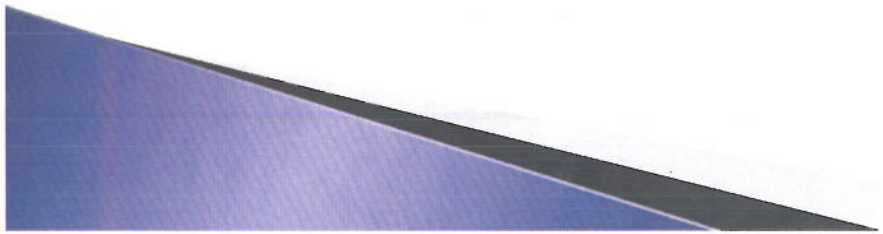
Clinician Teacher Pathway Changes as of 7/03

- **Flexibility in time spent**
- **1989- 80% clinical and 20% scholarly**
- **2003- Flexible; each dept. to reevaluate**
- **Ongoing evaluation of how to evaluate clinical work & teaching**



Changing Pathways – Clinical Departments, from Physician Scientist to Clinician Teacher

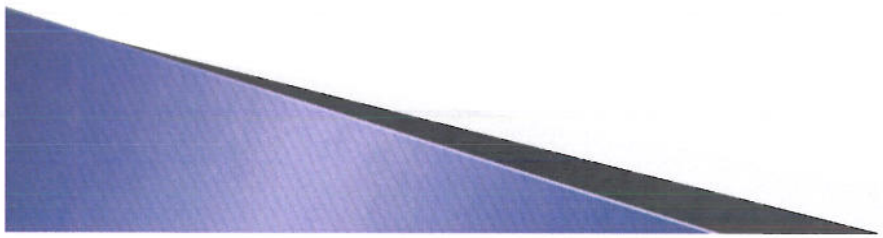
- **Assistant Professor: Before end of 4th year**
- **Associate Professors can pathway after 3 years in rank**
  - **Recognizes the changes in faculty careers/interests**



Full Time Clinical Faculty - 1998

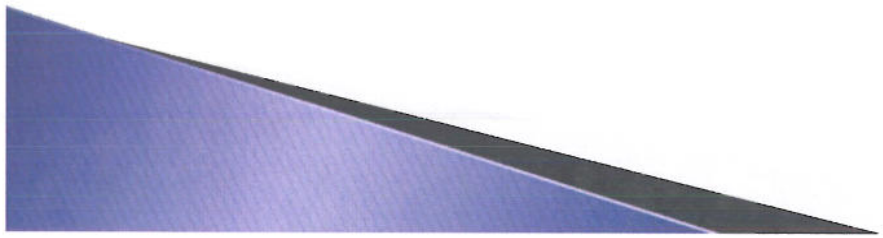
- Not in all depts.
- Annual appointment/ no mandatory promotion review
- Expectation: Clinical excellence and Productivity
- Support mission of school

  Enhance clinical services by improved patient access/ practice management/ teaching and training



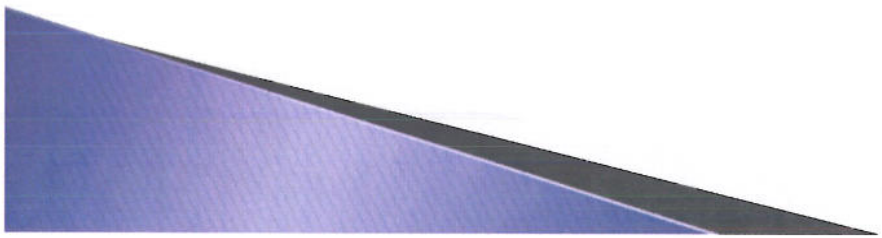
Full Time Clinical Faculty

- **Does have promotion criteria and faculty have been promoted to Associate Professor on this track**
- **Currently 130 in School of Medicine**
- **Most in departments of Medicine, and Pediatrics; also Psychiatry, Anesth and Rehab**



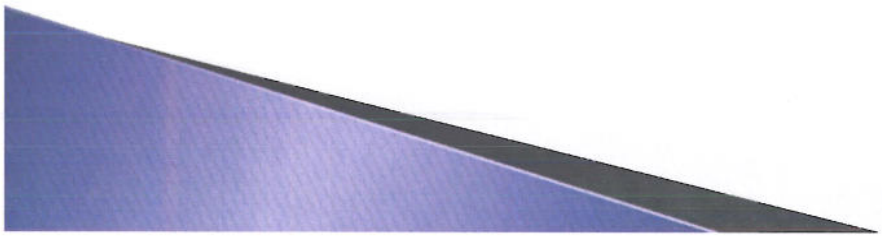
Promotion – In Past

- **Scholarship**
- **Teaching**
- **Clinical care**



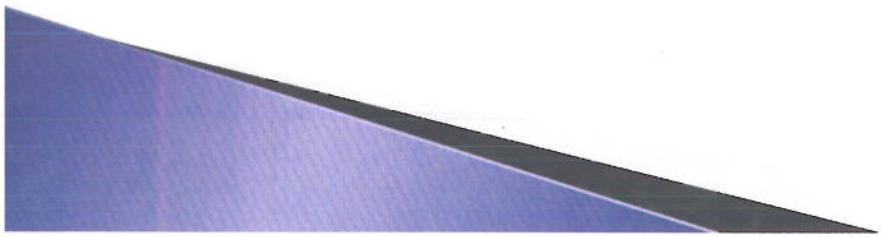
Promotion – What Counts Now

- **Scholarship**
- **Teaching**
- **Clinical care**
- **Professionalism**
- **Administration service ?**



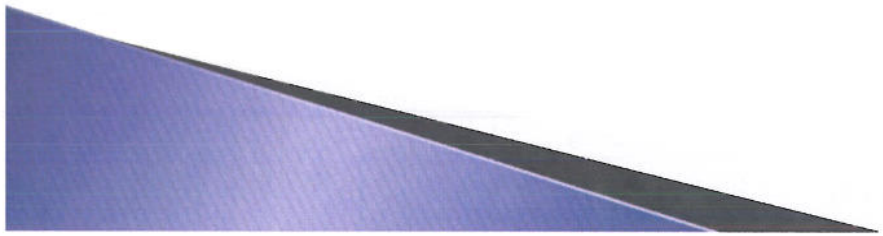
Scholarship

- **Objective evidence and excellence**
  - **Peer reviewed**
  - **Must be disseminated**
  - **Departmental criteria exist**



Types of Scholarship

- **Scholarship of discovery**
  - **Peer reviewed journals**
  - **Abstracts**
  - **Presentations**

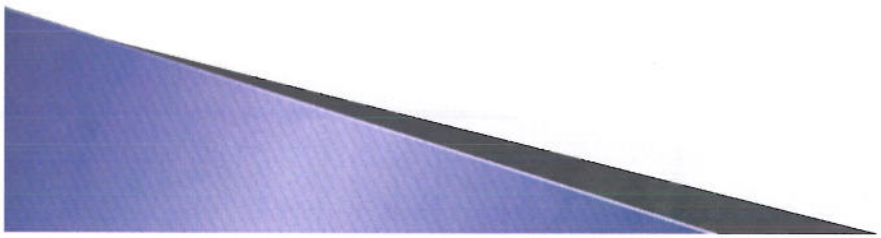


Scholarship of Integration

- **Systematic reviews, meta-analyses**

  Chapters, reviews articles

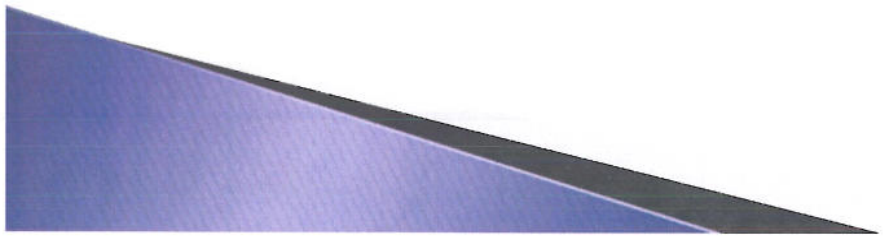
- **Editorial board**



Scholarship of Teaching

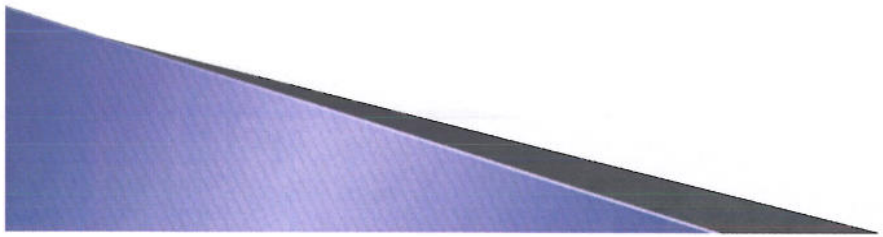
- **Curricila**

  Material – handbooks
  EBM guidelines
  Software



Teaching Portfolio

- Teaching Scholars developed a template
  - Philosophy
  - Activities
  - Mentoring
  - Educational administration
  - Professional development
  - Recognition
  - Honors/awards
  - Long term goals



Clinical Care

- **Quality and Productivity**

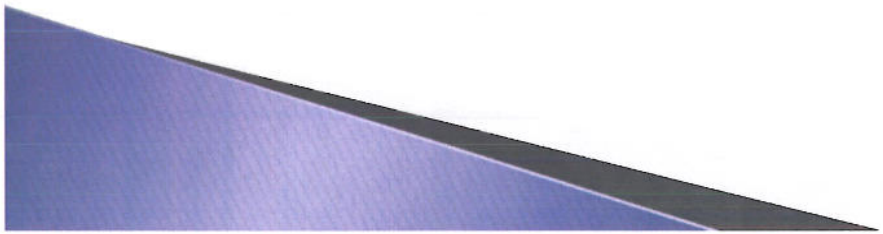
  - Medical knowledge, problem solving, management of complex patients and overall clinical skill

  - Humanistic qualities

  Responsibility, compassion and management of psychological aspects

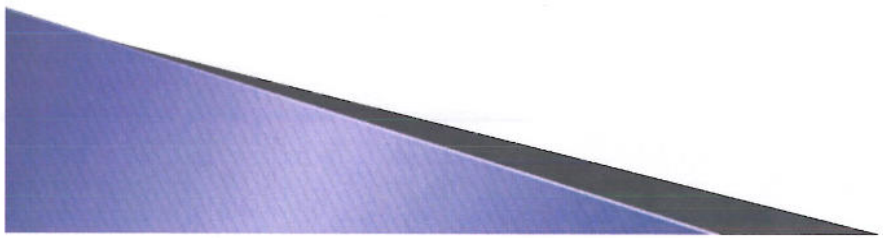
  - Peer evaluation

  Department of Medicine Form n= 13



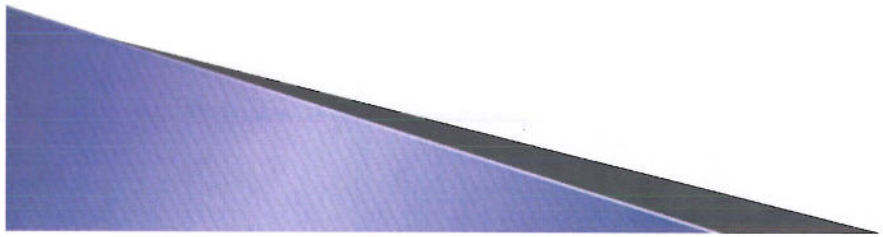
Administrative Service

- Has not been part of promotion criteria
- Important for UW medicine
- Many different metrics
    - Financial
    - Operational
    - Program development
    - Leadership, etc.



Professionalism

- Has not been part of promotion criteria
- New requirement for promotion



National Recognition

- Awards/Prizes
- National advisory boards/study sections
- Elected to scholarly societies
- Editorial boards
- Peer reviewer for journals
- Presenting your work
- State of art or invited lectures
- Visiting professorship
- Organizing regional, national or international meetings

Process of Promotion (Associate Professor)

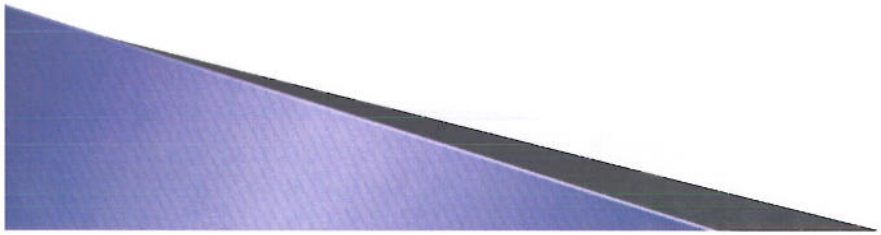
Chair review

annually > 3 yrs

Division - yearly

Concurrence criteria are met

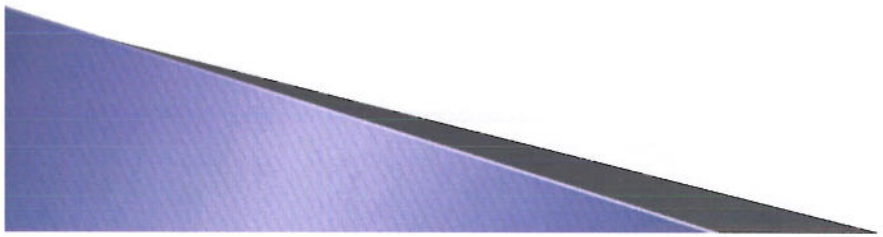
Preparation of package



Process of Promotion (Associate Professor) – cont'd

Preparation of package:

1. **Updated CV (School of Medicine format)**
2. **Your top 5 papers – 2 copies**
   Regional/National reputation
3. **Teaching evaluations**
4. **Peer evaluations – clinical if appropriate**
5. **Your written self assessment**
6. **Letters or recommendation (5)**
   - **Internal (3)**
   - **External (2)**
     Relationship to you is disclosed



Process of Promotion (cont'd)

- **Departmental A & P Committee**
  - **Written summary sent to you**
  - **You can respond w/in 7 working days**
- **Faculty vote**
  - **Same as above**
- **Chair support letters**

Process (cont'd)

School A & P Committee
MSEC/Dean
Provost
Board of Regents
President's letter

} Do not vote

Appointments & Promotions Council

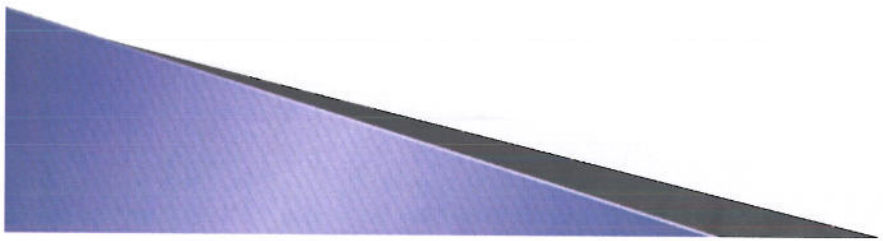
- **Advises Dean and MSEC on faculty appointment and promotions**
- **10 members elected**
  - **10 Clinical**
  - **5 Basic Science**
  - **1 Research**

Chair, Peter Esselman

2004 - 2005

- To Associate professor

Approved	Deny	Delay
29	0	2
21	0	0



2006 - 2007
School of Medicine

Promotions to:	APPROVED	DENIED	POSTPONED
Associate Professor (mandatory)	31	0	2
Associate Professor (non-mandatory)	20	1*	-
Research Associate Professor (mandatory)	6	0	2
Research Associate Professor (non-mandatory)	4	0	-
TOTAL:	61	1	4

* Approved by the School's Appointments and Promotions Council but denied by the Provost's office.

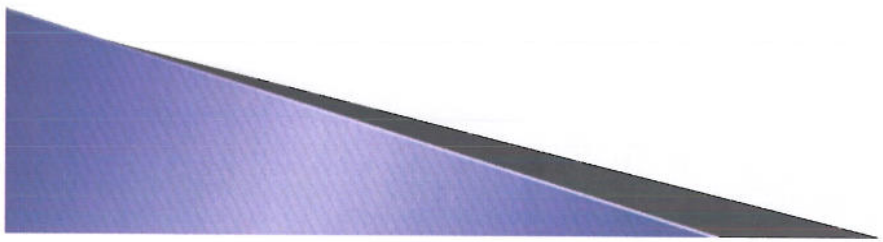
Additional Points

Secrecy not intentional

Process selective but at point of hire

Most people get promoted
no pyramid

Criteria imprecise to permit flexibility



CHAPTER 3: FACULTY APPOINTMENT, PROMOTION, AND TENURE

Introduction

The following section on appointment, promotion, and tenure is applicable to the faculty of Arts and Sciences, the Pratt School of Engineering, the Nicholas School of the Environment, the Divinity School, the Fuqua School of Business, and the basic science departments in the School of Medicine. Details of procedures of each of these units may be found in relevant appendices. Procedures for the School of Law may be found in Appendix I, and for the School of Nursing in Appendix K. Bylaws related to the clinical sciences in the School of Medicine are in Appendix L.

The quality of its faculty is the most vital determinant of a great university. Further, the highest standards of appointment, promotion, and awarding of tenure are best achieved by a process of careful examination and review. Such review is most effectively accomplished by a collaborative process whereby the faculty itself, through highly respected representatives, provides its best judgment and advice to the responsible administrative officers.

Judgments of academic excellence are complex. They cannot be reduced to a quantitative formula nor can the considerations that must be applied in each individual case be completely described in general terms. At the same time, the criteria to be applied in all cases must represent excellence in the quality of the candidate's performance, especially as a teacher and as a scholar. Scholarly productivity must reflect a serious and sustained commitment to the life of scholarship.

Appointment, Promotion, and Tenure

All members of the university's regular rank faculty are appointed or promoted by the Board of Trustees or the Executive Committee of the Board of Trustees upon the recommendation of the provost, with the approval of the president.

Appointment and Promotion without Tenure

Faculty appointments may be made without tenure either in a tenure track or a non-tenure track. The terms of that appointment shall be made clear to the faculty member at the time of appointment.

Tenure track positions are normally filled by faculty with the Ph.D. at the three regular rank tenure track titles of assistant professor, associate professor, or professor. In Arts and Sciences, regular rank faculty without the Ph.D. are commonly appointed at the non-tenure track rank of lecturer. When such an appointment is made, the faculty member will not begin to accrue time toward tenure until the degree is awarded and he or she has been given a tenure track appointment. Subject to variations in some schools, initial appointment to a regular rank tenure track position without tenure will be for a term of four years.

Faculty who do not hold tenure track positions will be given modified titles. The complete set of modified titles for non-tenure track faculty, approved by the Academic Council and affirmed by the Board of Trustees, appears in Chapter 2 of this handbook.

Term (non-tenured) tenure track appointments at the ranks of assistant professor and associate professor, and promotions to assistant professor or associate professor without tenure, shall be made by the provost, based on appropriate recommendations by the deans or the heads of trustee-authorized faculty hiring units in accordance with internal departmental or school procedures. Additional review by an advisory committee is not required.

Annual Reviews and Reappointment to a Second Term

Annual reviews of regular rank non-tenured tenure track faculty will be conducted by the director of a program, chair, or dean for the purpose of providing direction and advice to the faculty member regarding progress at Duke. In general, the advice of senior faculty in the unit will be solicited for this review. Renewal of the initial tenure track appointment for a second term which may extend through the end of the probationary period will be made only on the basis of a careful departmental or school review and of approval by the dean and provost. The purpose of this

comprehensive review is to develop a judgment as to the faculty member's probable suitability for tenure at Duke. Once approval has been granted for the second term appointment in a tenure track rank, the faculty member becomes eligible to apply for a junior faculty leave (see policy on leaves).

Appointment and Promotion with Tenure

Appointments or promotions of full-time faculty members to tenured rank are made upon recommendations originating in the academic units authorized to make such appointments (e.g., departments and schools) described in Chapter 2 of this handbook. Recommendations for appointments from the outside must take into account program, departmental, school, and university needs.

Tenure at Duke University, whether awarded to a faculty member currently on the Duke faculty or offered to a scholar who is being recruited for the Duke faculty, should be reserved for those who have clearly demonstrated through their performance as scholars and teachers that their work has been widely perceived among their peers as outstanding. Persons holding the rank of associate professor with tenure are expected to stand in competition with the foremost persons of similar rank in similar fields and to show clear evidence of continuing excellence in scholarly activity in their years at the university. Good teaching and university service should be expected but cannot in and of themselves be sufficient grounds for tenure. The expectation of continuous intellectual development and leadership, as demonstrated by published scholarship that is recognized by leading scholars at Duke and elsewhere must be an indispensable qualification for tenure at Duke University.

Full professors play a critical role in determining the intellectual quality of the university. Thus the rank of professor should be reserved for those who have clearly met the criteria for tenure and have demonstrated their continuous intellectual development and leadership. It should be clear that appointment to associate professor does not necessarily imply eventual promotion to full professor. Promotion to full professor should be reserved for those who have an academic record documenting a continuous high-quality performance level in at minimum two of the following three required components of scholarly productivity--research, teaching and service--together with a good performance record in the third required component. Length of service alone should not produce an expectation for promotion.

Responsibilities of the Department, Program, or School

All Trustee-authorized faculty hiring units (e.g., departments, programs, and schools) must have a set of formal procedures to govern their internal evaluation processes. The deans, directors, and department chairs are responsible for submitting these procedures to the provost. The provost will review the procedures and assure that they are generally acceptable and consistent with the policies described herein. The deans, directors, and department chairs will be responsible for distributing these procedures, once endorsed, to all members of the department, program, or school and to new members of the faculty at the time of appointment.

Appointments

For appointments at the rank of associate professor with tenure or at the rank of full professor made from outside Duke University, the evaluation process can be initiated at any convenient time. Although the thoroughness and completeness of the process must not be compromised, sometimes the evaluation may pose problems in the recruitment process and must be conducted with delicacy and dispatch. The procedures to be followed are essentially the same as those for promotion described below and will be initiated whenever the outside scholar indicates a willingness to become a candidate and the authorized unit places his or her name in nomination along with a dossier (see section on dossier).

Promotion and Tenure

Reviews for granting tenure or for promotion to associate professor with tenure or to professor shall be conducted first in the basic authorized academic unit, be it the department (in Arts and Sciences or the Pratt School of Engineering), the section, division, program or institute, or the school. The head of the unit shall inform the candidate of the review and indicate the approximate time in which the review process will be completed. Prior to requesting approval from the dean for the membership of the departmental review committee or inviting any faculty to serve on it, the head of the unit shall request from the candidate (providing a copy to the dean to inform the dean's required approval of the review committee and for inclusion in the dossier) a brief written synopsis of his or her intellectual interest, including a description of any factors – interdisciplinary or otherwise – that the candidate believes should be taken into consideration in establishing said review committee. Except in cases when a basic authorized academic unit has fewer than five tenured faculty eligible and available to vote (see below), whenever a

tenured faculty member from another authorized academic unit is invited to serve on a candidate's review committee, said extra-departmental faculty member shall be added to the standard unit review committee for this instance. All members of the review committee shall have the right to vote on the report of the committee and to attend the discussion in the candidate's department regarding the case.

When candidates hold secondary/joint appointments and/or participate in interdisciplinary activities beyond the primary department, it is expected that such other academic units will be asked to provide a statement for the dossier about the level and quality of the candidate's contribution there. Furthermore, the dean shall be actively involved in determining the membership of the faculty review committee so as to assure an informed evaluation of the candidate's disciplinary or interdisciplinary contributions.

When the unit has completed its review, if it has reached a favorable decision the chair shall forward the recommendation along with the complete dossier (see section on dossier) of the candidate to the dean, and the dean, in turn, to the provost. A recommendation for promotion and/or tenure is made by secret unsigned ballot of tenured faculty members, consistent with the unit's procedure. These recommendations should be forwarded along with a list of those present and the tally of the vote.

When the review by the basic authorized academic unit (generally a department) reaches a negative conclusion, the chair or director shall inform the dean and the candidate of the decision and the reasons for it. The provost may review the dossiers of all faculty whose candidacy for tenure has been given a negative judgment by their departments or schools. All faculty members have the right to appeal departmental decisions to the provost.

When a basic authorized academic unit has fewer than five tenured faculty available to vote, the provost, after consulting with the head of the unit (generally the chair or dean), shall add tenured faculty members from other authorized academic units who are considered knowledgeable in the candidate's area. In this way, the voting membership of those passing on the candidate's credentials will number at least five.

Schedule

Formal review procedures for promotion and/or tenure by the basic authorized academic unit (e.g., department or school) shall be initiated in the spring or summer of the academic year prior to that in which action by the Board of Trustees is required. Review schedules may vary slightly among the schools. It should, however, be noted that the work of the provost's Advisory Committee on Appointment, Promotion, and Tenure is conducted principally during the fall and spring semesters of the regular academic year. Faculty members will be notified of the provost's decision by April 1 when the recommendation of the department or school and complete dossier, including the dean's written assessment, are submitted to the committee no later than November 1 for promotion to full professor and December 1 for promotion with tenure.

Dossier

It is the responsibility of the recommending unit to assemble all the materials necessary for the review. The head of the unit initiating the recommendation (e.g., director of a program, chair [in Arts and Sciences or the Pratt School of Engineering], or dean) has the responsibility of insuring that the dossier sent on for review is as complete as possible.

The complete list of materials to be included in the dossier is provided to the deans by the Office of the Provost.

Responsibilities of the Deans of the Faculty of Arts and Sciences, Divinity School, Pratt School of Engineering, Nicholas School of the Environment, Fuqua School of Business, and Medical School

In Arts and Sciences, the Pratt School of Engineering, the Nicholas School of the Environment, and the Medical School, the dean will examine the dossier submitted by a department (or Trustee-authorized division in the Nicholas School of the Environment) for completeness and, if the dean considers it incomplete or inadequate, return it to the department or division for more preparation. In schools without departments (e.g., Divinity School and Fuqua School of Business), the dean will examine the dossier for completeness. If the dean considers the dossier adequately presented and documented, it will be forwarded to the provost. However, the dean may seek supplementary information to inform his or her recommendation. All such requests and the resulting information shall be added to the dossier and kept confidential. The dean shall present in writing his or her assessment of the candidate's scholarly credentials and suitability for appointment, reappointment, tenure, or promotion. For the purposes of the AP&T Committee's consideration, the dean should address only the candidate's scholarship, teaching, and service. If he or she so wishes, in a separate letter addressed only to the provost, the dean may also

present in writing additional information about the school, its goals, needs, and the relation of the dossier to them; this institutional information is solely for the provost's consideration and is not germane to the considerations of the AP&T Committee. Such strategic considerations are not to be considered by the AP&T Committee or the provost in cases of internal promotion to tenure.

Responsibilities of Provost's Advisory Committee on Appointment, Promotion, and Tenure

All appointments and promotions that confer tenure and promotions to the rank of professor shall be considered by the Advisory Committee on Appointment, Promotion, and Tenure (AP&T), a group that advises the provost.

This committee is appointed by the provost and, in addition to the chair, consists of twelve full professors nominated by the Executive Committee of the Academic Council (ECAC) on the basis of scholarly distinction, aptitude for service on this demanding committee, and availability for the term involved. In making nominations, ECAC shall seek balance among divisions, schools, and academic disciplines within the faculty. Normally at least two members will come from the Arts and Sciences Division of Humanities, two from the Division of Social Sciences, two from the Division of Natural Sciences, one from the Pratt School of Engineering, one from the Fuqua School of Business, one from the basic medical sciences, and three from these or other units, subject to review. The chair shall be a faculty member nominated by ECAC and appointed by the provost. The chair will be appointed for a one year term, renewable. The president, the provost, and the dean of the Graduate School will serve as nonvoting ex-officio members of the committee.

The Advisory Committee on Appointment, Promotion, and Tenure is charged with evaluating the dossiers forwarded to it, consistent with standards enunciated in this document. If the AP&T Committee has questions about materials in the dossier, or if it lacks certain documentation, the committee will ask the chair, director of the program, or dean of the originating unit for clarification or additional materials. The AP&T Committee may supplement the outside letters received about a candidate with additional letters or reports from evaluators who are competent to judge the candidate's scholarship. Should the AP&T Committee decide, in its sole discretion, that it needs additional advice, it reserves the option to establish an ad hoc panel to review the dossier. This panel may gather additional information, if necessary, and will be asked to provide the AP&T Committee with a written evaluation. Panel members will be selected on the basis of their knowledge of the candidate's field and an overall balance of perspectives. One or more panel members may be Duke faculty, and it is typical to include at least one member from another institution. An AP&T Committee member normally will serve as liaison between the ad hoc panel and the AP&T Committee. In the case of current Duke faculty being evaluated for tenure the chair (or director) of the originating academic unit and dean will meet with the AP&T Committee to discuss significant issues raised in the course of the evaluation; in the case of external tenure candidates or internal candidates for promotion to full professor such interviews may be scheduled at the AP&T Committee's discretion.

Individual faculty members may write to the AP&T Committee (or to the provost, who will refer such letters to the AP&T Committee) with regard to any case being considered by that committee. Such communications will be added to the dossier and kept confidential.

The Advisory Committee on Appointment, Promotion, and Tenure must then formulate its own recommendations for presentation to the provost. In general, a quorum requires nine voting members unless a sufficient number of votes, affirmative or negative, has been cast to represent an absolute majority (seven) of the committee. A recommendation should be considered definitive only if it has been supported, affirmatively or negatively, by vote of an absolute majority (seven) of the AP&T Committee. In the event the AP&T Committee's recommendation is negative, the provost will review the dossier (prior to notification of the candidate or department) to determine whether all factors relating to the merit and value of the candidate, including ethnic, racial, and gender diversity, have been fully and adequately considered.

The provost will inform the AP&T Committee of his or her decision. Should the provost choose not to accept the recommendation made by the AP&T Committee, the provost shall so inform the committee in writing and indicate the basis for the decision.

The provost will communicate to the appropriate dean his or her decision and the major factors underlying it. The dean of the school is responsible for transmitting this information to the head of the originating academic unit (e.g., department chair), if there is one, and either the dean or chair will communicate this to the candidate. If the provost intends to render a negative decision on a case already considered by the AP&T Committee, or a case that has not received a positive recommendation from the department, the provost will inform the candidate, the departmental chair and the relevant dean. An appeal of the provost's impending decision, from any or all of these

three parties, may then be made within the following two weeks, submitted through the Dean. The provost will also provide a copy of the official APT memo summarizing the case and the deliberations of the APT Committee, or of the chair's review summary. If the provost intends to act contrary to a positive recommendation from the APT Committee, the provost must provide the basis for this decision. On the basis of this appeal, the provost may then either refer the case back to the AP&T Committee, including the departmental appeal, and ask for reconsideration of its recommendation or make his or her decision without referral. On any one case the originating academic unit, school, and/or candidate is limited to one appeal of the decision to the provost.

Generally if a candidate's tenure dossier is forwarded by the academic unit, the AP&T Committee will consider the candidate only once. Thus, a faculty member whose tenure review is undertaken by the AP&T Committee during his or her initial contract term, and who is turned down for tenure by the University, shall be allowed to complete the term of the original appointment, but his or her tenure track appointment shall not be renewed or extended. However, a tenure track faculty member who has been turned down for tenure by the University may apply during an authorized national search for an existing non-tenure track position at Duke.

When the provost's recommendation is favorable, the provost shall consult with the president. With the president's approval, the provost shall submit the recommendation to the Board of Trustees for final action.

Records of each case shall be properly safeguarded and when the case is completed, retained or deposited under appropriate controls in the University Archives for a period to be determined by the university counsel.

APPENDIX J: BASIC SCIENCES SCHOOL OF MEDICINE

In this Appendix:

Bylaws of the Basic Sciences Faculty Steering Committee	1
Procedures and Criteria for Appointment, Promotion, and Tenure	3
Materials to be Submitted by the Department in Support of Nominations for Tenured Appointments and Promotions	6

Bylaws of the Basic Sciences Faculty Steering Committee

I. Preamble

On May 4, 1987, the faculty of the basic sciences departments of the Duke University School of Medicine met as a whole and voted to establish and elect a Faculty Coordinating Committee for the Development of the Basic Sciences. The Coordinating Committee was charged with drafting a plan for the reorganization and development of the basic sciences departments. The Coordinating Committee's report, which was approved by a vote of the basic sciences faculty on October 9, 1987, furnished the blueprint for subsequent development and faculty governance in the basic medical sciences at Duke Medical Center.

In adopting the Coordinating Committee's report, the basic sciences faculty replaced the Coordinating Committee with a permanent body of elected faculty representatives, the Basic Sciences Faculty Steering Committee, which serves as a faculty senate for the basic sciences. The job of the Steering Committee is to ensure that faculty opinions are ascertained, articulated, and voiced in all debates and decisions involving the interests of the basic sciences faculty.

II. Membership of the Faculty Steering Committee

The Faculty Steering Committee for the Basic Sciences shall consist of one member from each basic sciences department and one member from each section that has at least four tenure track faculty members in addition to its chairperson. Any tenure track faculty member with a primary appointment in a basic sciences department or section, other than the chairperson of that department or section, is eligible to be nominated and elected as its representative to the Faculty Steering Committee.

In the event that a department or section ceases to exist, its representative to the Faculty Steering Committee shall continue to serve as a member of the committee at large until the next election of representatives to the Faculty Steering Committee. A member of the Steering Committee who becomes a temporary or interim chairperson of a department or section may serve out the remainder of his or her term if a majority of the other members of the Steering Committee vote to allow this. A member of the Steering Committee who is appointed to serve as the permanent chairperson of a department or section shall resign from the Steering Committee and be replaced by the alternate representative from that department or section, following the procedures in these by-laws governing the resignation of representatives to the Steering Committee.

III. Election Procedures

Members of the Steering Committee are elected to two-year terms. One cohort of its members shall be elected in odd-numbered years and the remainder in even-numbered years, to ensure continuity. The two cohorts shall contain the same number of representatives, or as close to the same number as possible.

Members of the Steering Committee shall be elected by vote of the entire basic sciences faculty on the first Monday in May of every year. During the first three months of a year in which the term of a Steering Committee member is due to expire, the faculty of the department or section represented by that member shall meet to nominate three candidate successors, who shall be chosen by a secret ballot. The current Steering Committee member shall help to count the ballots, verify the eligibility and willingness of the

three nominees, and forward their names to the presiding officer of the Steering Committee on or before the first Monday in April. That officer shall devise a ballot listing all the nominees for each department and see to it that one copy is distributed to each member of the basic sciences faculty at least one week prior to the date of the election. Faculty may vote for one nominee from each of the departments listed. For each department or section, the nominee receiving the highest number of votes from the entire basic sciences faculty shall become the representative to the Steering Committee. The second- and third-place candidates shall become first and second alternates respectively, and shall succeed in that order to the Steering Committee in the event of the resignation or indisposition of the elected representative. If and when it becomes necessary to choose additional alternates, they shall be elected by the faculty of the department or section they are to represent.

A presiding officer of the Steering Committee shall be elected by a majority vote at the committee's first meeting following each annual election, and at any other time following the resignation or indisposition of the presiding officer. Members who are acting chairpersons of departments or sections are not eligible to preside over the Faculty Steering Committee.

IV. Duties of the Faculty Steering Committee

It shall be the responsibility of the Faculty Steering Committee for the Basic Sciences to consider and make proposals to the Medical Center administration regarding all aspects of education, faculty development, faculty research and teaching activities, and other functions of the Medical Center involving the basic sciences faculty. The Steering Committee will also serve as a conduit for the transmission and dissemination of ideas and issues between the Medical Center administration and the basic sciences faculty. The Steering Committee will undertake to survey faculty opinion and form faculty committees when necessary to meet these responsibilities. Individual members of the committee are expected to keep the faculty of the departments and sections they represent informed on all matters of consequence that come before the committee.

The Faculty Steering Committee shall serve as a committee on committees for the basic sciences faculty. In that capacity, it shall nominate faculty to serve on standing and ad hoc committees in the Medical Center and present these nominations to the administrative officer empowered to form the committees in question. Administrators are of course free to consult any faculty they wish on an individual basis, but should seek nominations and approval from the Faculty Steering Committee in all situations where the opinions of a faculty member are to be construed as representative of basic sciences faculty opinion. It is expected that an administrative officer will not appoint basic sciences faculty representatives to standing advisory committees without seeking nominations from the Faculty Steering Committee. The administrative officer may suggest nominees to the Steering Committee if he or she so wishes. If the faculty nominated by the Steering Committee are unacceptable to the administrative officer, he or she should return to the Steering Committee to seek additional nominations.

Except in emergencies, it is expected that all major plans and decisions of the Medical Center administration that significantly affect academic affairs will be submitted to the Faculty Steering Committee so that it can solicit and articulate faculty views before those plans and decisions are implemented or submitted to the university's president or Board of Trustees. The presiding officer of the Steering Committee will see to it that the faculty's views are represented to the administrators or trustees of the university when proposals involving the Medical Center are presented to them for their consideration.

The Faculty Steering Committee shall be responsible for scheduling, announcing, and presiding over a general meeting of the basic sciences faculty of the School of Medicine at least once annually during the spring or fall semesters of the academic year. At that meeting, the presiding officer of the Steering Committee will report to the faculty on the committee's deliberations and actions during the preceding year. The chief administrative officers of the Medical Center and the School of Medicine shall also be invited to attend this meeting and present reports on matters of faculty concern for open discussion.

Revised version approved by Faculty, 1993

Procedures and Criteria for Appointment, Promotion, and Tenure

I. Non-Tenured Tenure Track Positions (Assistant and Associate Professors):
   A. Criteria:
      1. The candidate must have an outstanding research record in his or her field, and the potential for developing an outstanding independent research program, obtaining the appropriate extramural funding, and becoming an excellent teacher.
   B. Procedures:
      1. National searches must be carried out unless an exception is approved by the dean, School of Medicine/vice chancellor for medical center academic affairs.
      2. A minimum of three letters of recommendation should be obtained. These letters should indicate the candidate is truly outstanding and provide documentation for this assertion.
      3. A department vote must be reported and a record kept of those voting. If possible, comments from the faculty or a letter from a faculty recruitment committee should be obtained.
      4. The letter from the chair should summarize the search and selection procedures, including information about the numbers of applications received and interviews carried out. Efforts made to ensure that minorities and women were represented in the final pool should be addressed and how the person fits into the overall departmental plan indicated.
   C. Review:
      1. Appointment recommendations for assistant professors will be reviewed by the dean, School of Medicine/vice chancellor for medical center academic affairs. The final decision shall rest with the chancellor.
      2. Appointment recommendations for associate professors will be reviewed by the standing Basic Sciences Appointments, Promotions, and Tenure Committee, the dean, School of Medicine/vice chancellor for medical center academic affairs. The final decision shall rest with the chancellor.
      3. Under special circumstances, promotion from assistant to associate professor without tenure will be considered. The review process will be the same as for appointment at the non-tenured associate professor level, but the criteria and documentation will be established by the reviewing agencies on a case-by-case basis.

II. Promotion to Tenure and Professor and Tenure Appointments:
   A. Criteria:
      1. The candidate must have made outstanding contributions to his or her field. The specific contributions made must be clearly indicated in both the internal and external documentation. In addition, the publication record must be outstanding, and the candidate should have demonstrated the ability to obtain a level of funding from peer-reviewed sources that supports the research effort expected from a tenured faculty member in his or her specific research area. The candidate also should have made significant contributions to teaching which should be documented. Service to the department and university also should be taken into consideration.
      2. The rank of professor is reserved for those who have clearly met the criteria for tenure and have demonstrated continuous intellectual development and leadership.
   B. Departmental Level Review:
      1. If an appointment is made from outside the department, a national search must be carried out unless an exception is approved by the dean, School of Medicine/vice chancellor for medical center academic affairs. The documentation should provide information about the search, including the number of applications and interviews and efforts made to ensure that minorities and women were represented in the final pool.
      2. Each candidate for appointment and/or promotion with tenure shall be notified by the department chair a minimum of one month in advance of a scheduled departmental review and shall be invited to submit all relevant documents including (1) curriculum vitae, (2) statement of research and teaching contributions, (3) copies of scholarly publications, (4) description of research funding, and (5) list of suggested outside reviewers. A complete list of

required documents is available from the dean, School of Medicine/vice chancellor for medical center academic affairs.

3. The chair will solicit six to ten (a minimum of six) letters from individuals external to Duke University who are qualified to evaluate the candidate's scholarly contributions. At least half of these letters should be obtained from a list of qualified individuals suggested by the evaluating faculty of the department (or section), but not by the individual being reviewed. Letters from persons who have served as mentors or who have published jointly with the candidate may be included, but these letters shall be in addition to the six required letters.
4. The complete dossier will be presented to all tenured faculty within the department or section of rank equal to or higher than the rank sought by the candidate. A secret vote will be taken at a subsequent meeting of these tenured faculty members and the results recorded by the chair together with the names of those faculty members voting.
5. In the case of positive action within the department or section, the dossier will be forwarded to the dean, School of medicine/vice chancellor for medical center academic affairs accompanied by a letter from the chair detailing the qualifications of the candidate, the vote by the faculty on the candidate's promotion, the names of the faculty voting, and the personal recommendation of the chair. If the department or section reaches an unfavorable decision, the dean, School of Medicine/vice chancellor for medical center academic affairs is so informed and the dossier forwarded to this individual for review. A negative decision of the department can be appealed by the faculty member to the dean, School of Medicine/vice chancellor for medical center academic affairs. If his or her decision is positive, the case shall be directed to the Basic Sciences Appointment, Promotion, and Tenure Committee to be processed according to the procedures for a positive department recommendation. If his or her decision is negative, further appeal by the faculty member can be made to the provost.
6. Non-tenured faculty must be reviewed by the tenured faculty of the department at least every three years and advised of their standing in the department or section. In the case of section members, the review should be conducted jointly by the section chair, tenured faculty members of the section, and the appropriate department. Any faculty member may formally request that he or she be considered for promotion or tenure by submitting a letter to the department or section chair.

C. Review by the Dean, School of Medicine/Vice Chancellor for Medical Center Academic Affairs:
   1. The standing Appointments, Promotions, and Tenure Committee consisting of seven tenured professors shall be appointed by the dean, School of Medicine/vice chancellor for medical center academic affairs. A list of twelve nominees for membership on this committee shall be provided by the elected Faculty Steering Committee for Basic Sciences. No member shall be appointed without the approval of this elected body. No department or section chair may serve. Nominations will include appropriate individuals with (1) primary appointments in the basic sciences departments, (2) primary appointments in the College of Arts and Sciences, and (3) primary appointments in the clinical sciences departments and secondary appointments in a basic sciences department. It is anticipated that no more than two of the Appointments, Promotions, and Tenure Committee will be from the latter group.
   2. All dossiers approved and forwarded by the department or section shall be submitted to the Appointments, Promotions, and Tenure Committee for consideration and subsequent recommendation to the dean, School of Medicine/vice chancellor for medical center academic affairs. The operating rules of this committee shall be in concert with those of the provost's Committee on Appointment, Promotion, and Tenure.
   3. After review by the committee, the chair of the Basic Sciences Appointments, Promotions, and Tenure Committee shall forward a detailed summary statement of the deliberations on each candidate together with a recorded formal vote to the dean, School of Medicine/vice chancellor for medical center academic affairs. This summary statement becomes a permanent part of the dossier, as do all additional documents generated by the committee during its review process.
   4. Following the review by the Appointments, Promotions, and Tenure Committee, the dean, School of Medicine/vice chancellor for medical center academic affairs shall forward the dossier together with his or her recommendation to the chancellor for health affairs.

D. Review by the Chancellor for Health Affairs:
   1. The complete dossier including administrative recommendations, the summary statement, and all additional review documents from the Appointments, Promotions, and Tenure Committee for the Basic Sciences shall be forwarded to the chancellor for health affairs who is responsible for addressing institutional concerns relevant to the candidate's application. Following his or her review, the dossier is forwarded to the provost indicating by cover letter his or her recommendation.

E. Review by the Provost:
   1. The complete dossier is reviewed by the provost's Advisory Committee on Appointment, Promotion, and Tenure as detailed in the Duke University Faculty Handbook, Chapter 3, and their recommendation forwarded to the provost.
   2. The provost, in turn, forwards his or her positive recommendations, after consultation with the president, to the Board of Trustees for their action. The provost will communicate to the chancellor for health affairs his or her decision and the major factors underlying it.
   3. The chancellor for health affairs will, in turn, notify the dean, School of Medicine/vice chancellor for medical Center academic affairs and the appropriate department chair.
   4. The chair, in turn, communicates the decision to the candidate.
   5. If the provost reaches a negative decision, he or she will so notify the chancellor for health affairs. The department or school will have two weeks within which it can communicate to the provost any grounds on which it feels the decision is inappropriate. An appeal should be forwarded by the department to the chancellor for health affairs who will send the appeal to the provost, along with the chancellor's recommendation for disposition. On any one case the department or school is limited to one appeal of the decision by the provost.

F. Expectation of Privacy:
   1. Pursuant to university custom and policy, all documents contained in the dossier with the exception of the materials submitted by the candidate are considered confidential as is the identity of all external reviewers. The total dossier is made available to those individuals officially responsible for recommendations and/or decisions on the candidate's status. These individuals include (1) the tenured department faculty of rank equal to or higher than the rank sought by the candidate, (2) the department chair, (3) the dean, School of Medicine/vice chancellor for medical center academic affairs, (4) the Basic Sciences Committee on Appointments, Promotions, and Tenure, (5) the chancellor for health affairs, (6) the provost, (7) the provost's Advisory Committee on Appointment, Promotion, and Tenure, (8) the president, and (9) the Board of Trustees. All individuals participating in the appointment, promotion, and tenure process are expected to adhere to this statement regarding confidentiality.
   2. Ad-hoc panels and/or individual additional external reviewers may be consulted by any of the above listed university administrators or faculty bodies with the expectation that the privacy and confidentiality of the dossier is protected.

Materials to be Submitted by the Department in Support of Nominations for Tenured Appointments and Promotions

Twelve copies of the complete dossier (the original and eleven copies) in three-ringed binders tabbed to indicate the individual sections should be submitted. The department should retain a copy of the complete dossier in its files. Copies of the complete list of materials to be submitted by the department in support of nominations for tenured appointments and promotions in the Basic Sciences are available on the Duke University Medical Center web pages at:

http://medschool.duke.edu/wysiwyg/downloads/Required_Materials1. pdf

A Faculty Handbook For Success

Advancement and Promotion at UCSF

UCSF

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During your recruitment, you also must negotiate your starting package with the Department Chair or Division Chief. Your starting package includes the designation of time to conduct your research, teaching, and professional activities; appropriate space for your laboratory; and administrative support. Faculty in the Academic Senate Series (Professor, Professor In Residence, and Clinical X) are also eligible to apply for University-administered home loan programs. To assist you with your negotiation, you should consider each of the points summarized in the checklist for new faculty appointments provided by the Department Chair or Division Chief.

The section regarding Academic Personnel on the Office of the President's Web site features (www.ucop.edu) complete information on salary scales for the University of California. More information on the University's home loan programs is available in the Facilities Administration section.

2.3 The University Health Sciences Compensation Plan

Your base salary is directly related to your academic series, rank, and step. In other words, your base salary increases as you advance. At times, your base salary may also be increased by a cost of living adjustment directed by UC system-wide. Remember that your Department Chair does **not** have the authority to increase your base salary.

The University's Health Sciences Compensation Plan is used by each Department to foster balance between teaching, research, patient care, and other public responsibilities. Individual levels of compensation are established to recruit and retain the faculty necessary to fulfill the University's missions at a level of excellence. Membership in the Compensation Plan is a term and condition of employment at UCSF as specified in the Plan.

Compensation Plan members receive a base salary and may be eligible for additional compensation. A faculty member's total compensation is comprised of the base salary (X) plus, if appropriate, a negotiated additional amount of compensation (Y), plus, if appropriate, incentive/bonus compensation (Z). Base salary is the approved rate on the Health Sciences Compensation Plan Salary Scales associated with your academic rank and step. Benefits related to the base salary may include health insurance (medical, dental and vision), employee-paid disability insurance, and employee-paid regular term life insurance. Information regarding such benefits is presented online at the UCSF HR Web site. The base salary is considered covered compensation for the purposes of the University of California Retirement Plan (UCRP) up to the amount permissible under law.

The component of pay beyond the base, if any, is the negotiated amount of additional compensation known as the **Y-Component**. This component is based upon the recommendation of your Department Chair and must be approved by your School Dean. ***The Y-Component may be re-negotiated on an annual basis. The Y-Component is not considered covered compensation for purposes of the University of California Retirement Plan.*** Factors that may be considered when determining your negotiated additional compensation include (but are not limited to) academic performance, quality of work, and productivity in the areas of teaching, scholarly activity, clinical activity, research, and service. Compensation Plan members may also earn additional incentive or bonus compensation beyond the base salary and Y-component compensation, known as the **Z-Component**. A major factor in determining incentive/bonus compensation is revenue generation from consulting, clinical, and other types of revenue-generating professional activity. The Z-Component is negotiated with your Department Chair.

Information regarding the reporting requirements for outside professional activities can be found in your school's approved Health Sciences Compensation Plan (HSCP). You should request a copy of your School's plan from the Dean. The HSCP for the School of Medicine is online at www.medschool.ucsf.edu/academicaffairs/resources/comp_plan.aspx. The HSCP for the School of Pharmacy HSCP is online at www.ucsf.edu/njw/academic/spcompplan.html. You should also consult APM 025, "Conflict of Commitment and Outside Activities of Faculty Members."

2.4 Advancement

2.4.1 Merit Increases

Merit increases reflect advancement through the **steps** (see section 1.4 for more on steps). These are not automatic and require review and approval for faculty in all schools by both peers and administrators at different levels of the organization (e.g., department, school, and campus levels). Normal periods of service are assigned to various steps. Although these reflect the usual intervals for advancement, they do not preclude more rapid advancement in the case of exceptional merit or slower advancement, when warranted. On-time merits or one-year accelerated increases are not usually reviewed by the Academic Senate's Committee on Academic Personnel (CAP).

2.4.2 Promotion

Promotion marks advancement through the **ranks** (e.g. Assistant Professor to Associate Professor. For more on Ranks, see section 1.3). *Promotions are not automatic.* Reviewers will evaluate your accomplishments and productivity based on the criteria outlined for your series and rank in the APM and as provided by your department. *Remember that departmental or divisional criteria may exceed those listed in the APM.* Therefore, it is critical that you understand what is expected of you. This information can be obtained from your Department Chair.

The University takes great pride in its academic review process and believes that continuous peer review contribute to maintaining faculty excellence, from appointment through retirement. You should know that **the review process for promotion could, at times, take six to nine months**! You can minimize the time of your review by maintaining and submitting a current, up-to-date Curriculum Vitae (CV) (See Appendix III) that includes a clearly and concisely written one-page summary of your teaching and/or research contributions, and by having copies of all publications that have occurred since your last promotion readily available. More detailed guidance on preparing your promotion package follows in section 2.5.

2.4.3 Criteria for Advancement

Creative Activity
May include development of innovative programs, innovative teaching materials, or enhancement of a service.

Scholarly Activity
Includes contributions to the literature in the form of manuscripts, chapters, books, participation in invited lectureships, and development of new methods and tools.

Research Productivity
Includes publication of original articles, independent extramural research funding, principal investigator status, and long-term-extramural support.

Teaching Activity
Includes formal classroom lectures as well as teaching in the laboratory or clinical setting. Teaching in continuing education programs is also an important component.

Public Service
Includes departmental, school, and University committee service as well as service to national academic societies and to the community.

2.5 Preparing Your File

2.5.1 Internal and External Evaluators

When preparing your dossier, your Department Chair will request letters of evaluation from both internal and external evaluators. These references will assess your productivity compared to others in similar appointments in your field.

Three to five letters from UCSF faculty are required for promotion, often including assessment by faculty in other departments. Remember that someone in your own department—who did not already submit a letter of recommendation on your behalf—may be asked by the Committee on Academic Personnel (CAP) to provide peer review. *Thus, you should deliberately not include one or two departmental faculty who are knowledgeable about your academic progress on the list of internal evaluators.*

Five to seven external letters will be requested by your Department Chair. You should submit to your Department Chair a list of individuals who are leaders in your field and who are knowledgeable about your work. Most of your evaluators should be full professors at comparable institutions and senior leaders in your field. From the time you begin your assistant professorship at UCSF, you should maintain a list of individuals who are appropriate for this eventual review of your progress. It is important to contact everyone you have suggested write letters on your behalf and let them know the request is forthcoming. Non-responses could be viewed as a negative evaluation.

2.5.2 Curriculum Vitae and Recordkeeping

You should pay careful attention to the preparation of your CV since it presents your activities and accomplishments in the most favorable light (see Appendix III). Your CV is your academic autobiography and should be updated frequently. Be sure to include information on grants, e.g., dates, sources, amounts awarded, your role, effort and responsibility, and project status.

Your CV records your activities as a faculty member and serves as the primary document by which you will be reviewed for advancement and promotion. Many reviewers, some of whom are not specialists in your field, will evaluate your CV. For this reason, focus on clarity and try to avoid undefined acronyms. Be as concise as possible. List items in chronological order beginning with oldest to most recent. Your CV should be up-to-date and formatted consistently with the example in Appendix III. Most current sample is posted online at academicaffairs.ucsf.edu.

These guidelines are intended to assure that evaluations are accomplished for all of your personnel actions (appointments, promotions, merit advancements, appraisals for promotion, etc.) by Departmental, School, Campus, and Academic Senate reviewers in a fair and impartial manner, with adequate data that represents the entire scope of your academic activities. To avoid delays in the review of your dossier, it is strongly recommended that you maintain an up-to-date CV using this format.

2.5.3 Teaching: Student and Peer Review

Student and peer review of your excellence as a teacher are essential components of your promotion package. Student evaluations are solicited electronically both for formal classroom teaching and for your work as a Clinician with post-doctoral Residents. All evaluations received by your Department Chair are summarized in the chair's letter. To complete the review of your teaching excellence, you should solicit individual letters from selected students with whom you have had a recurrent teaching relationship. We recommend that you obtain letters at the end of such a relationship, deposit these with your department, and retain a copy for your own records.

For information about the online E*Value system for student review used in the School of Medicine, refer to the School of Medicine's Web site at medschool.ucsf.edu.

For information about the online CoursEval system for student review used in the School of Pharmacy, refer to the School of Pharmacy Web site at www.ucsf.edu/sopirc/.

2.5.4 Publications

Your bio-bibliography is the record of your research productivity. All publications should be listed in the appropriate section. Although published abstracts provide a record of your ongoing research, it is important to culminate your work into documents published in peer-reviewed sources. **Peer-reviewed publications are the main criteria by which your research productivity will be evaluated.** Your publications should reflect the focused development of your research career as well as your role in the research conducted. **First authorship** usually signifies the lead role in the conduct of the research reported as well as the primary responsibility for writing the manuscript. **Senior (or Last) authorship** usually reflects the overall guidance of the research reported as well as careful and frequent review of the manuscript. Hence, first or senior authorship helps to document your research independence.

2.5.5 University and Public Service

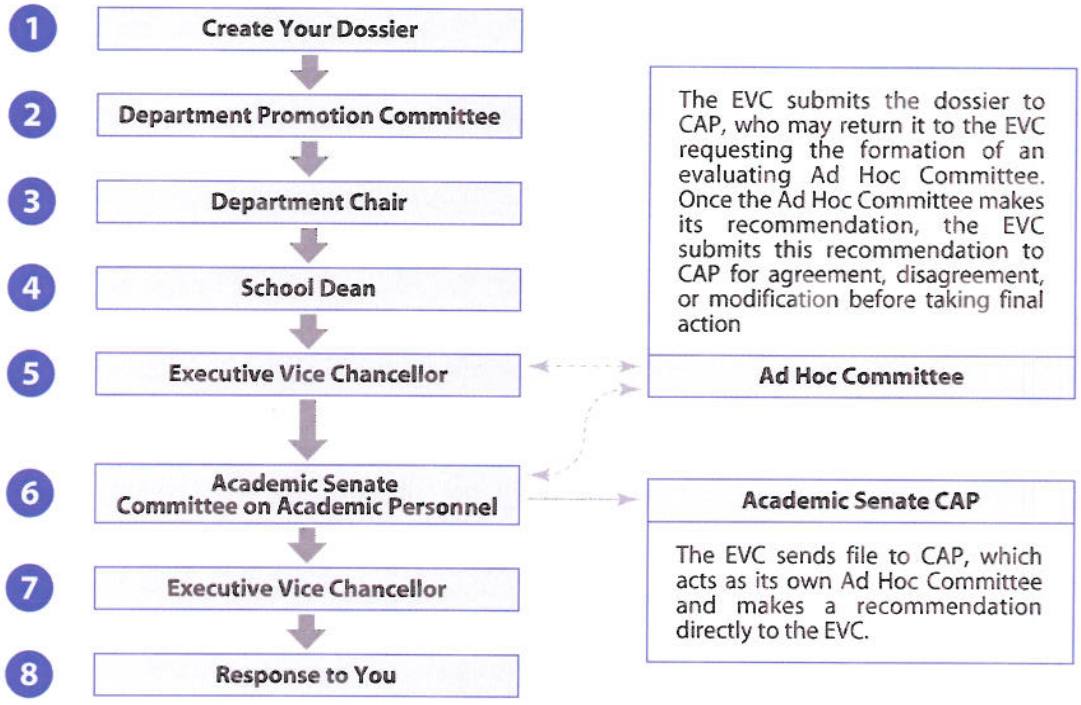
Throughout your career, University and public service are important components of your academic life. University service may include administrative responsibilities and service on search committees, departmental committees, Academic Senate Committees (UCSF or system-wide) or University of California systemwide committees. During your Assistant Professor years, you should limit your University service in order to assure that you have adequate time available for your research activities. As you advance through the Associate and Professor years, your University service should increase.

2.6 The Appointment and Promotion Process

Initially, the faculty member prepares a dossier (also known as a "packet" or a "file") which includes current CV, recent publications, internal and external Letters of Review, Student Evaluations, and a Summary Statement of research and/or teaching. This packed is submitted through the Chair's office to the Department Promotion Committee which evaluates the candidate, and upon making an evaluation submits the recommendation to the Department Chair. The Department Chair prepares a letter and transmits the dossier to the Dean. The Dean or Dean for Academic Personnel reviews and makes a recommendation and passes the dossier on to the Executive Vice Chancellor (EVC).

The Executive Vice Chancellor transmits the dossier to Academic Senate Office for review and recommendation by the Academic Senate Committee on Academic Personnel (CAP), who will determine if an Ad Hoc Committee is required. If so, CAP makes a recommendation to the EVC for the composition of Ad Hoc, which is typically composed of three UCSF faculty as follows: one faculty member at or above proposed Rank/Step; one faculty member from the Department of the person under review, and one faculty member who typically has expertise in the same or similar field as faculty under review.

FIGURE 4: STEPS IN THE REVIEW PROCESS



If an Ad Hoc Committee is recommended by CAP, the dossier is returned to the EVC who will appoint the Ad Hoc Committee. After they perform their review, the Ad Hoc Committee will return the dossier to the EVC, who will send it back to CAP for their own review and recommendation (agree with, disagree with, or agree with modification of the Ad Hoc Committee recommendation).

The Committee on Academic Personnel transmits a letter of recommendation and returns the file to the EVC for final disposition (action).

If CAP determines that an Ad Hoc Committee is not necessary, CAP may act as its own Ad Hoc Committee and recommend action directly to the EVC. The Executive Vice Chancellor may approve or disapprove the CAP recommendation or may request additional information.

Once a final determination is made, the EVC sends a letter to the faculty member (or candidate) and Dean informing them of final disposition. If improvement is needed, the Department Chair will discuss this with the faculty member.

Generally, if a dossier is complete, and no Ad Hoc Committee is recommended, the review process is significantly shorter in duration.

The process for promotion from Associate to full Professor is the same as that for promotion from Assistant to Associate, except that evidence of a higher level of distinction, including international recognition, is required.

2.7 Review and Evaluation Process

2.7.1 Department

The first level of review is within your department. Your initial appointment, salary, merit increases, Assistant Professor Appraisal, and promotion to Associate Professor depend largely on decisions made within your department. Senior departmental faculty review your academic progress and vote to support or not support your proposed promotion. Before the departmental recommendation is determined, you have the right to inspect all non-confidential documents in your personnel review file and to receive a redacted copy of the confidential academic review documents (APM 220-80-d, e). **It is important to know that you have the right to request that your promotion go forward for consideration even if your departmental review group does not endorse your promotion.**

2.7.2 Department Chair

It is your responsibility to see your Department Chair or his/her designee at least once annually for an evaluation of your progress to promotion. Your Department Chair highlights aspects of your performance in a letter of evaluation to the dean of your school. The choice of rhetoric can influence the eventual outcome.

The Department Chair's letter includes a report of the departmental review; a summary of your teaching responsibilities and expertise, including teaching hours; a summary of your research and creative work, professional competence and activity, and University and public service; and finally, the Chair's own evaluation of your academic progress.

2.7.3 Your Promotion Package

The promotion package that is submitted by your department is identical for Professor, In Residence, and Clinical X faculty, and includes the following:

1. Your Department Chair's letter
2. 3-5 formal course evaluations of teaching from students and peers
3. At least 5 representative reprints reflecting your creative activity
4. At least 3 intramural letters of evaluation
5. At least 5 extramural letters of evaluation
6. A CV that includes a one-page description of your current research program as well as one page documenting your current teaching responsibilities

It is important to remember that, although preparation of portions of your promotion package may be delegated to a departmental administrator, the final responsibility for providing a complete package reflecting your academic productivity rests with you. **After your promotion package leaves the department, you may not add new information unless it is requested by one of the reviewing groups.**

If you like, you can prepare a statement of your record of research and publications, teaching, administrative activities, professional activities, public service, and awards and honors as part of your promotion packet. A statement of your future or current research direction should be included. However, the Department Chair's letter will also include special information about you and your unique scholarly activities. If you believe additional material is essential as part of the package, it is wise to discuss with your chair and mentors how to best present this material (i.e., in the Chair's letter or in a letter from you).

Prepare packets of your work to be considered, including a statement of your research directions. These packets will be forwarded to intramural and extramural colleagues along with your Department Chair's request for letters of evaluation. The Committee on Academic Personnel (CAP) will also use these packets to assess your academic contributions. Because national recognition is required for promotion to Associate Professor, it is important that you carefully select outside evaluators who can understand and articulate the independence of your work and significance of your contributions. Extramural evaluators may include referees from outside the country, but remember to alert them of the importance of their letters in the process of your promotion. You should contact each individual to determine his/her willingness to respond in a positive and timely manner. Be aware that the absence of a letter of recommendation following a request is viewed as a negative response.

2.7.4 Dean

Once your promotion package is complete, your Department Chair will forward it to your School Dean. After the Dean appraises your package, he or she will add their own letter of evaluation to your file.

2.7.5 The Academic Senate Committee on Academic Personnel

Your promotion package next reaches the Executive Vice Chancellor (EVC) and is transmitted to the Academic Senate Office for review and consideration by the Committee on Academic Personnel (CAP).

CAP reviews faculty appointments at Assistant Professor (any series) Step III or higher, and promotions, non-reappointments, above-scale and off-scale promotions, and merits for Professor Step V to VI. After reviewing your package, CAP votes and forwards its recommendations to the Executive Vice Chancellor.

2.7.6 Ad Hoc Review Committee

The Committee on Academic Personnel may nominate an Ad Hoc committee to review your file. The ad hoc committee, which is officially appointed by the Executive Vice Chancellor, consists of members in fields pertinent to your own and at least one member from your department.

The ad hoc committee writes its own assessment of your academic progress and makes its recommendation regarding promotion. The report and recommendation of the ad hoc committee, once complete, are returned to CAP for further discussion and a formal vote. The membership and deliberations of ad hoc committees are confidential, but you can have some influence on its composition by notifying your Department Chair (in writing) before your package leaves your department if there are any individuals who you feel are personally antipathetic to you or your work and therefore be unable to objectively evaluate your qualifications and/or performance. Your written statement must include your reasons and will be included in your promotion package (see APM 220-80-c).

2.7.7 Executive Vice Chancellor/Chancellor

The Executive Vice Chancellor reviews the dossier and the recommendations of CAP, the Dean, the Department Chair, and the departmental faculty. If the recommendations are favorable and the Executive Vice Chancellor agrees, then the Chancellor will notify you of your promotion. In advising the Chancellor, the Executive Vice Chancellor can reject the advice of CAP, although CAP's decision is most often upheld. If the Executive Vice Chancellor's preliminary assessment is to make a terminal appointment, you and your Department Chair will be notified and you will be given the opportunity to respond in writing and to provide additional information. Any change of duties, new manuscripts, publications, or grants, or new teaching evaluations or accomplishments should be submitted at that time.

You then have an opportunity to respond in writing in order to provide additional information. However, the preliminary assessment serves as a formal warning that if the assessment remains negative, then your appointment will terminate in one calendar year. The final decision rests with the Chancellor.

If you wish to learn the status of your review at any time during the review process, talk with your Department Chair. He or she may check with your school's Associate Dean for Academic Affairs to ascertain the status of your review.

2.7.8 Formal and Informal Complaints

If you feel that you have been unfairly evaluated for promotion, you have several channels through which to express your complaint and to seek appropriate corrections. It is generally advisable to seek informal resolution through internal consultation before filing a formal complaint. These informal channels include (1) your Division Chief, (2) your Department Chair, (3) your Dean, and

(4) the Vice Chancellor for Academic Affairs. Any of these Administrators can look into your file, correct errors and injustices, and advise you about other courses of action. The Affirmative Action office can also advise you on courses of action, particularly related to discrimination issues. The Academic Senate also has a Board of Advisors who can provide information related to the Academic Senate Committee on Privilege and Tenure.

After having exhausted informal consultations, you may undertake a formal internal complaint if you remain unsatisfied. A formal complaint can be filed with (1) the Executive Vice Chancellor, (2) the Academic Senate Committee on Privilege and Tenure, (3) the Affirmative Action office (complaint of discrimination only), (4) the Office of Sexual Harassment, or (5) the campus' whistle blower coordinator. Redress may also be sought in some cases filing a complaint with applicable external agencies (e.g. DFEH or EEOC) or in the courts.

2.7.9 Appraisals of Achievement and Promise

Appraisals of Achievement and Promise constitute an evaluation of Assistant Professors midway through the eight-years of service at this rank (typically during your fourth year as assistant professor). The purpose of the Appraisal is to assess your progress and to provide advice and guidance for successful progression to the rank of Associate Professor. The Appraisal review does not normally result in a merit increase or promotion; rather, it is meant to provide junior faculty with constructive advice and sufficient time to address any deficiencies. At the completion of the Appraisal review, ask your Department Chair for detailed information on your strengths and weaknesses as they relate to the criteria for your series. If a promotion, change-in-series, or separation occurs prior to the submission of an Appraisal packet, the Appraisal review will not proceed.

2.7.10 Eight-Year Rule for Academic Senate Series

If you are appointed to an Academic Senate series (Professor, In Residence, and Clinical X), it is important to be aware of the eight-year rule:

> *An Assistant Professor, who has completed eight years of service in that title, or in that title in combination with other titles as established by the President, shall not be continued after the eighth year unless promoted to Associate Professor or Professor (APM 133-0).*

The University gives unsuccessful candidates in this series a one-year terminal appointment; thus, review for promotion must be completed no later than the seventh year. It is critical that you are aware that your eight-year clock starts with your initial appointment, includes your years as an instructor, and that your progress will be evaluated during your fourth year by an Appraisal of Achievement and Promise as described in the previous section.

The San Francisco campus of the University of California is set apart from other UC campuses in that it currently does *not* apply an eight-year limit to the Adjunct or salaried Clinical series. This is extremely important to know if you have served time in either of these series at the assistant rank at UCSF and are considering a transfer to an assistant rank at another UC campus. **Your services as Assistant Adjunct Professor or Assistant Clinical Professor *will* count against the eight-year clock *on all other UC campuses*. Likewise, services as Assistant Professor at other UC campuses will count against the eight-year clock at UCSF.**

In addition, it is important to know that if you have received a final decision not to be promoted, and are given a one-year terminal appointment, you may not be hired as a faculty member in any series on any UC campus for a period of five years after your appointment ends.

There are categories of leave and time off which do not count as time spent in the system with respect to the eight-year rule. For more information on "stopping the clock," see section 8.8 of this handbook.

2.7.11 Five-Year Review

Most advancement reviews take place every two to four years depending on one's rank and step. If a faculty member has not been reviewed in the previous five years, a Five-Year Review is initiated. The purpose of this five-year review is to ensure that your performance is appraised at regular intervals, to assess your productivity since your last successful advancement, and to identify what needs to be accomplished for further advancement. At UCSF, faculty who are employed at less than 50% time will not be required to undergo a five-year review. However, if the faculty member wishes to be reviewed, he/she may request it.

The five-year review may result in:

1. Advancement, if performance warrants it;
2. No advancement, but with performance monitoring and scheduling of the next review date if progress is satisfactory;
3. Establishment of a remedial plan and timetable for progress if progress is deemed unsatisfactory; or
4. Further disciplinary action consistent with UC policy governing incompetent performance in a ladder rank faculty member.

2.7.12 Career Review

Occasionally, the series, rank and step of a faculty member may be inconsistent with their accomplishments. If you feel this is the case, you may request a career review to reassess your entire UCSF career, from initial hiring to your current position. If warranted, you may be placed into a different series and/or the appropriate rank and step (no retroactive action will be taken). You can initiate this review by submitting a written request to your department chair with supporting documentation (similar to what you would assemble for a promotion). The department will then assemble a review file seeking appropriate internal and external letters, etc., but the dossier will address your overall record.

2.7.13 Access to Review File

Confidentiality is a controlling factor at all levels. The statements transmitted by the department faculty, Department Chair, Dean, CAP, and the Executive Vice Chancellor are all confidential. Breaches of confidence are subject to disciplinary action. You are allowed to see a redacted copy of the confidential portions of your own file at three stages during the review process: before the departmental recommendation is determined, upon completion at the departmental level, and upon completion of the entire review. You have a right to respond to the redacted summary. The redacted file provides the "full flavor" of the file while maintaining confidentiality of the names of those involved in the review(s). (See APM 160)

3.0 Mentors

UCSF is a large and complex institution. Advancement through the system requires considerable knowledge on your part and personal attention from senior faculty as well as your peers. After joining UCSF, it will be critically important that you participate in your department's mentoring program, both by attending departmental workshops and by meeting with your department-assigned mentor or mentoring team. If you are already on the faculty and you have not been assigned a mentor by your department, you should contact your Department Chair or your department's "Mentoring Facilitator." While many departments focus their mentoring efforts on new or junior faculty, it is critical that faculty at all career stages take advantage of mentoring opportunities to enhance their career and to increase satisfaction.

Mentoring extends beyond the teaching of a specific skill; it encompasses personal, professional, and civic development—the development of the whole person to full capacity and the integration of the person into the existing hierarchy through socialization to its norms and expectations. Expecting a single person to fulfill all of these roles is unrealistic. Rather, it is important to identify mentors from a variety of perspectives. For example, the mentor assigned to you by your department may have insights on departmental policies regarding advancement and promotion, but may have little knowledge in your research area. In this scenario, a mentor from outside your department might be better able to advise you on scientific matters, networking opportunities, or personal issues. In addition to identifying multiple mentors to meet your multiple needs, it is important to remember that you may need to identify new mentors as you develop through different stages of your career.

Your scientific mentor should be a faculty member who is working in your area of research. This mentor should provide guidance or involve you in appropriate research, help you identify appropriate grants, assist you in developing an *independent* research program, introduce you to professional colleagues, provide you with opportunities to present your research at appropriate meetings, and provide other career-enhancing opportunities in order to increase your visibility. Ideally, this mentor will take the time to review and comment on your grants and manuscripts. It is essential that you work with the best scientific mentor available to you, regardless of gender, ethnicity, or location.

Depending on the complexity of your personal life, it may be important to identify additional personal mentors or to request additional mentors from your department's Mentoring Facilitator. For example, a significant personal illness, responsibility for elder care, or childbearing/ child-rearing responsibilities will have an impact on your life within the University and on your research productivity. In these instances and others, the identification of a mentor who has had similar experiences may provide you with perspective and help you to balance your personal and professional life. Similarly, peer mentors (other faculty members at your rank) may be able to provide you with advice and insights based upon their own experiences.

Mentors and Mentees

A successful mentoring relationship depends on both the mentor and the "mentee." You, as aspiring mentee, should look within your division, department, and school as well as across schools to identify ideal mentors. Work with your department's Mentoring Facilitator to identify potential mentors or to establish formal mentoring relationships with mentors you have identified. **Be assertive in contacting potential mentors, and consider what you might bring to the relationship.**

HANDBOOK FOR FACULTY AND ACADEMIC ADMINISTRATORS

A SELECTION OF POLICIES AND PROCEDURES OF THE UNIVERSITY OF PENNSYLVANIA

http://www.upenn.edu/assoc-provost/handbook/

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later than October 15 of each year, giving the names of the members of the Faculty Committee on Academic Freedom and Responsibility that is currently in existence. Each Faculty Committee on Academic Freedom and Responsibility shall elect its own chair.

It is the policy of the University of Pennsylvania to maintain and encourage freedom of inquiry, discourse, teaching, research, and publication and to protect any member of the academic staff against influences, from within or without the University, that would restrict him or her in the exercise of these freedoms in his or her area of scholarly interest.

The teacher is entitled to freedom in research and in the publication of results, subject to the adequate performance of his or her other academic duties, and to the institutional policies and procedures as set forth in the research policies of the University. Research for pecuniary return should be based upon an understanding with the authorities of the institution.

The teacher is entitled to freedom in the classroom in discussing his or her subject.

The teacher is a member of a learned profession and of an educational institution. When speaking or writing as an individual, the teacher should be free from institutional censorship or discipline, but should note that a special position in the community imposes special obligations. As a person of learning and a member of an educational institution, the teacher should remember that the public may judge the profession and the institution by his or her utterances. Hence the teacher should at all times show respect for the opinions of others, and should indicate when he or she is not speaking for the institution.

II.B. Structure of the Academic Staff

(Source. Standing Resolution of the Trustees, adopted on September 9, 1983 and Statutes of the Trustees, Article 9)

The academic staff of the University of Pennsylvania is divided into seven classes: the Standing Faculty, the Standing Faculty-Clinician-Educators, the Associated Faculty, the Academic Support Staff, the Postdoctoral Fellows, the Teaching Graduate and Professional Students, and the Emeritus Faculty.

II.B.1. Standing Faculty

The essential requisite for membership in the Standing Faculty is a commitment to both the advancement and the communication of knowledge. The Standing Faculty is composed of all faculty members with tenure or in tenure probationary status. Permissible ranks in the Standing Faculty are Professor, Associate Professor, and Assistant Professor.

Professor. The title of Professor signifies that the holder is a mature scholar whose

achievements have won outstanding approval both by scholars outside the University and by his or her faculty colleagues, and whose presence on the faculty enhances the prestige of the University. Appointment to this rank is not merely a recognition of length of service, but also of outstanding quality. Such an appointment is for an indefinite term.

Associate Professor. Appointment to this rank is made only to a person who has demonstrated the personal and intellectual qualities that with increased maturity are expected to lead to appointment to a professorship. Appointment to the rank of Associate Professor may be for a fixed term or for an indefinite term.

Assistant Professor. Appointment as Assistant Professor is accorded to a person who has completed his or her final earned degree or other professional certification relevant to his or her discipline and who has given evidence of superior potential for development in academic stature. As most persons in this rank are passing through an early period of their scholarly growth, an effort is made to design departmental and school policies in such a way as to provide them with a variety of educational experiences, including the opportunity to conduct original research and to participate in both undergraduate and graduate levels of instruction. Appointment in this rank provides a period during which an individual has an opportunity to confirm his or her own interest and motivation as being appropriate to the broad scope of University faculty responsibilities, and also one in which senior faculty may assess the promise and the competence of the faculty member's performance in both instruction and scholarly productivity. Appointment to the rank of Assistant Professor is always for a fixed term.

II.B.2. Standing Faculty-Clinician-Educator

(Source. Office of the Provost, January 8, 1985)

Introduction

The University of Pennsylvania has five schools that have established a faculty category called "Clinician-Educator": the School of Dental Medicine, the School of Medicine, the School of Nursing, the School of Veterinary Medicine and the School of Social Policy and Practice. For each of these schools, appropriate Trustee action has been taken. In the School of Dental Medicine, the Clinician-Educator category was established in 1981; in the School of Medicine, in 1976; in the Schools of Nursing and Veterinary Medicine, in 1983; and in the School of Social Policy and Practice in 1987.

Candidates for appointment or promotion in the Clinician-Educator faculty are urged to consult the appropriate department chair or the Dean of the appropriate school for additional information concerning membership in the Clinician-Educator faculty.

Health Schools

Purpose

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.

Appointment

All appointments of Clinician-Educators are full-time untenured appointments to the Standing Faculty. Hence procedures governing appointments to the Standing Faculty will be followed.

In the School of Dental Medicine a proposal to appoint or promote will be initiated by a recommendation from the department to the Dean. To take effect such a proposal must be reviewed and approved by the School of Dental Medicine's personnel committee (the Committee of Professors) and the Dean.

In the School of Medicine, the same procedure applies with review being carried out by the Committee on Appointments and Promotions and the Dean.

In the School of Nursing, which does not have a departmental structure, the proposal to appoint or promote a Clinician-Educator will be initiated by a recommendation from the clinical section through its chair to the Dean. Review will be by the School's Personnel Committee.

In the School of Veterinary Medicine, the proposal to appoint or promote will be made by the department chair to the Committee on Appointments and Promotions and to the Dean.

In all cases, the review criteria shall be appropriate for the Standing Faculty; however, the identifying feature of criteria governing Clinician-Educator appointments is emphasis upon patient care and teaching performance rather than upon research performance. In all cases further review is carried out by the Provost's Staff Conference with appointment being made by the Trustees upon recommendation of the President.

Title

To assure conformity with approved nomenclature, appointees in the Clinician-Educator category will hold modified titles as Assistant Professor, Associate Professor or Professor of (clinical specialty) at the (school or appropriate department, hospital, teaching unit or other base facility). That is, a clear and correct modifier must be attached to the professorial title. This title is to be written in full whenever used in documents, in listings of University personnel, or in correspondence.

A full statement of the conditions of employment, salary and benefits, professional activity, rights and privileges, limitations on the size of the Clinician-Educator faculty, timing of appointments, shift in faculty category, termination and scope of appointments is available in Appendix 2.

II.B.3. Associated Faculty

Members of the Associated Faculty play varied and important roles in the teaching, research, and professional programs of the University. However, they do not acquire tenure. Permissible ranks in the Associated Faculty are those used in the Standing Faculty preceded by one of the descriptive modifiers "Research", "Clinical", "Adjunct", "Visiting", "Visiting Executive", "Practice" or "Wistar Institute". Also, Artists-in Residence are members of the Associated Faculty.

Research Faculty

(Source. Office of the Provost, August 5, 1983, Revised June 16, 2005)

The purpose of Research Faculty appointments is to increase the quality and productivity of the research programs in the University by permitting the appointment of scholars to the faculty on a non-tenure basis in order to collaborate with the research efforts of other faculty and/or carry out independent research. Salaries over the period of the appointment are mainly derived from research grants or other external funds. Compensation for the limited teaching effort permissible to the Research Faculty is derived from sources other than research grants.

An individual on the research track should not be supported for an extended period of time from funds derived from the unrestricted budget.

Members of the Research Faculty do not acquire tenure. The Research Faculty will be appointed in the Associated Faculty on a full-time basis only. Part-time appointments in the Research Faculty are not offered. As a full-time employment category, recommendations for appointment to the Research Faculty must be in compliance with the Affirmative Action Plan of the University.

The Research Faculty is composed of individuals who hold a terminal degree and who choose to concentrate on research. Appointees are not part of the teaching faculty, although invitations to present guest lectures may be accepted. Members of the Research Faculty may not take responsibility for courses or seminars in their home departments or in other departments of the University, nor may they supervise theses or doctoral dissertations unless prior approval of the Provost is obtained for each such activity. However, if the individual wishes to participate in the training of students in an area of expertise in which he or she is uniquely qualified, the department chair may permit a limited teaching assignment in a course or seminar for which a faculty member with a tenure-significant appointment holds responsibility. Over the term of an appointment,

course and seminar teaching by a member of the Research Faculty may not exceed 10% of the expected course and seminar teaching load of a member of the Standing Faculty in the school and in any one year no more than 10% of the course and seminar teaching in a department may be done by research faculty. Supervision of theses or doctoral dissertations or other laboratory supervision is regarded as part of the research enterprise and the proportion of effort devoted to such supervision is not included in this limitation. Under no circumstances may a member of the Research Faculty be continuously engaged over an extended period in the same activities as faculty members having tenure or serving in a probationary period for tenure. Appointments to the Research Faculty should not be made to displace or make unnecessary the appointment of individuals in the tenure-significant ranks.

Permissible ranks are: Research Professor, Research Associate Professor, and Research Assistant Professor. These titles are to be written in full whenever used on documents, in listings of University personnel, and in correspondence. All appointments are for the term specified, or for the duration of the external financial support, whichever is shorter. Research Professors and Research Associate Professors may be appointed for terms of up to 5 years and may serve without limit of time through successive reappointments. Research Assistant Professors may be appointed for terms up to 4 years, but in no case may a person hold that rank for more than 10 years.

Initial appointments may be made as Research Assistant Professor. An individual appointed initially as Assistant Professor in the Standing Faculty may request review for transfer to the research faculty prior to reappointment. Time served in the tenure probationary appointment will be counted as part of the ten-year maximum period for Research Assistant Professors. In the ninth year of the single-track or combined-track appointment, Research Assistant Professors are subject to a mandatory review for promotion to research associate professor. Failure to obtain promotion requires termination of the faculty appointment at the end of the tenth year assuming external funding is available for the terminal year appointment.

Members of the Research Faculty do not normally move to positions on the Standing Faculty, and they may do so only in conjunction with a national search. If a Research Assistant Professor moves to an untenured position on the Standing Faculty, the beginning of the tenure probationary period in the Standing Faculty will be set at the date at which the probationary period for promotion to Research Associate Professor had begun. If the move occurs within a school the tenure probationary period may not be extended. If the move involves a change of schools, a maximum of two additional years in the tenure probationary period may be granted with the Provost's approval. Under no circumstances may appointment to the Associated Faculty be used as a device to extend the tenure probationary period.

Because appointments to the Research Faculty are contingent upon external funding and may be terminated when the funding ceases, indefinite continuity of appointment at any rank should not be assumed. For that reason all initial appointments

and reappointments shall specify the sources of funding. The dependence of research appointments on grant funding reflects the University's policy to limit guaranteed long-term appointments to faculty who contribute in significant measure to both the teaching and the research mission of the University. Research Faculty appointments are for enhancement of research programs, particularly in those areas where unique expertise is required.

Promotion to Associate Professor rank in the Research track requires collaborative or independent research of high quality with a distinctive, original, and expert intellectual contribution that is recognized by external reviewers. Promotion to professorial rank requires independent research of high quality, which may be in addition to collaborative research.

While imposition of a firm limit on the relative size of the Research Faculty may be harmful in its application to a particular program, the number of Research Faculty in a school may not exceed 20% of the combined Standing Faculty and Standing Faculty-Clinician-Educator in the school or five positions, whichever is larger.

The faculty of a school may grant the Research Faculty voting rights in the school's faculty. Voting rights in the appointees' home department are at the discretion of the respective departments. Members of the Research Faculty may not vote on matters related to Standing Faculty appointments and promotions, or on matters concerning the teaching mission of the school. Members of the Research faculty may serve on promotions committees as nonvoting members. Members of the Research Faculty may not serve on committees concerned with teaching (i.e., curriculum, student advising, academic standards, etc.). Individuals in the Research track enjoy all the rights and privileges of academic freedom and responsibility and have access to the grievance procedures of the University.

As noted above, failure to secure promotion to research associate professor by the end of the nine-year probationary period will result in a one-year terminal reappointment provided external funding is available.

Although continued funding may be available, reappointment may be denied for the following reasons: 1) lack of suitable facilities; 2) inconsistency with the research priorities of the department or school; or 3) failure to maintain excellence in the quality of research and productivity. In such instances, the individual should be given a one-year advance notice in writing that, at the conclusion of the term appointment, he or she will not be recommended for reappointment or promotion. However, in most cases of programmatic change, appointment will normally be maintained to the expiration date of current grant support if a Research track faculty member has independent funding. An appointment can be terminated prior to the expiration of its term only if the source of external funding for the research faculty member has ended. In that event, the individual should be notified immediately of the cessation of funding. An attempt may be made to carry the individual on other funding sources, either to the conclusion of the term

appointment or for a reasonable period in which the individual may attempt to secure other employment. When there is reason to believe that the individual may be eligible for transfer of employment to another University research group, efforts should be made to effect such placement.

Research Faculty are subject to termination for "just cause" as customarily determined within the University.

At the time a Research Faculty position is offered to a candidate, the relevant Dean shall inform the candidate in writing of the conditions and limitations on such appointments.

Academic Clinician

Purpose: The School of Medicine has found it desirable to make long-term, full-time faculty appointments to individuals whose responsibilities are in patient care and in the instructional programs of the University and not in the research activities engaged in by members of the Standing Faculty or the Standing Faculty—Clinician-Educator Faculty. These faculty members are called "Academic Clinicians." Such a group is essential for assuring program stability and continuing excellence of patient care.

Appointment: All appointments of Academic Clinicians are full-time untenured appointments to the Associated Faculty. Hence, procedures governing appointments to the Associated Faculty will be followed. This track is available to full-time faculty at core hospitals (HUP, CHOP, Presbyterian and Pennsylvania Hospital); as on the Clinician-Educator track, a reduction of duties (not less than fifty percent) is also permissible. HSC physicians at these sites may, with the approval of their departments, elect to transfer into this track, or they may remain in the HSC designation. Clinician-Educator (and even tenure-significant) faculty may elect to switch into this track with the approval of their departments; such faculty (mostly Clinician-Educators) may have amassed clinical and teaching credentials appropriate to the Academic Clinician track, but may not have produced sufficient scholarship to advance on their present track. The number of full-time faculty on this track may not exceed twenty percent of the Standing Faculty (tenured, tenure-probationary, and Clinician-Educator), but there is no limit in any one department.

Title: To assure conformity with approved nomenclature, appointees in the Academic Clinician track will hold modified titles of the form Assistant Professor of Clinical (department). This title is to be written in full whenever used in documents, in listings of University personnel, or in correspondence.

Conditions of Employment: As is the case with other faculty categories, all Academic Clinicians receive a clear statement of their conditions of employment, including use of facilities and access to patients; the responsibilities of the school or other budgetary unit for payment of salary and specified benefits; the right of persons to due process by mechanisms available to all University faculty in the event of grievances or alleged failure

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Faculty Handbook

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Section V. Faculty Appointments

Detailed information on many items covered under this section can be found on the Provost Policies and Procedures website.

A. General Appointment Types/Principles

The types/terms of appointments can vary according to a number of factors, including duration of appointment, permanent or temporary, etc. The most commonly used types of appointment are defined as follows:

1. Academic Year Appointments: Shall consist of two semesters for a total of nine months with service required for the period August 16 through May 15 (with no allowable vacation). They are always paid over a twelve-month basis with exceptions for: 1) Initial-partial term appointment if financial hardship is determined; 2) final term appointment; and 3) temporary/visiting appointments.

2. Annual Appointments: These are twelve-month appointments. Staff members on annual appointment perform academic duties for eleven months and receive one month of paid vacation.

3. Ten-Month Appointments: These require ten months of service paid over twelve months with no allowable vacation. They are generally available to academic professional employees, but under certain circumstances, can be applied to a non-tenured faculty position. Typical service dates are from two weeks prior to the academic year to two weeks following the academic year. Dates of no service may vary so a written statement (offer letter) specifying the service period must be signed by the unit head and employee.

4. Summer Appointments: Faculty employed on a nine-month or ten-month appointment may receive additional appointments not to exceed two months for nine-month and one month for ten-month appointments. The UIC Faculty Senate recently approved an expansion to UIC's current summer session structure. Starting in 2008, summer session will expand to an overall 12 weeks, configured as a 4-week session that begins one week after Spring semester ends, followed immediately by an 8-week session. Summer appointments for nine-month faculty can be made for any two-month period during these 12 weeks beginning May 16 through August 15. For ten-month employees, the "summer appointment" period may vary depending on the period of non-service e.g., non-service may be during the months of December and January, resulting in a "summer appointment" during the month of January.

B. Tenure/Tenure-Track Faculty/Appointments

The American Association of University Professors defines tenure as "a means to certain ends; specifically: (1) freedom of teaching and research and of extramural activities, and (2) a sufficient degree of economic security to make the profession attractive to men and women of ability. Freedom and economic security, hence, tenure, are indispensable to the success of an institution in fulfilling its obligations to its students and to society".

The ***University of Illinois*** ***Statutes***, Article II, Section 3 (a.1.) defines the faculty of the University and any of its units except for the Graduate College as "those members of the academic staff with the rank or title in that unit of professor, associate professor or assistant professor who are tenured or receiving probationary credit toward tenure, and those administrators in the direct line of responsibility for academic affairs (persons who hold the title director or dean in an academic unit, provost, chancellor and president)."

"As the responsible body in the teaching, research, and scholarly activities of the University, the faculty has the inherent interests and rights in academic policy and governance. Each college or other academic unit shall be governed in its internal administration by its faculty, as defined above. Governance of each academic unit shall be based on unit bylaws established and amended by the faculty of that unit. The bylaws shall provide for the administrative organization and procedure of the unit, including the composition and tenure of executive or advisory committees."

These bylaws may not conflict with the University of Illinois Statutes, or other actions by the Board of Trustees.

1. Assistant Professor

An appointee receiving his/her first contract as an assistant professor enters a probationary period of seven academic years of service. Prior academic service at other academic equivalent institutions *may* be credited, normally up to a maximum of three years, toward the fulfillment of the probationary period.

An initial appointment that begins after the eighth week of the academic year ordinarily does not count toward the probationary period of a faculty member on definite tenure nor does it ordinarily count as service in establishing eligibility for a sabbatical leave with pay, unless recommended and agreed upon in advance.

The rule of thumb is that the year will count if the appointment begins before the opening of the ninth week of the semester. If unusual circumstances apply in the case of an appointee who begins after August 16 but before the ninth week, the unit executive officer may appeal on behalf of the faculty member, through the appropriate administrative chain, for a delay in the start of the tenure clock until the next August 16. The provost will make the final decision in such cases. The appointee's choice, if approved, cannot be reversed thereafter.

It is important for faculty members to understand the implications of counting or not counting years in which they provide less than a full year's service toward completion of the probationary period, since that will affect the timing of promotion and tenure decisions. This also applies to initial appointments with respect to the question of prior service credit. In each instance, the department is responsible for assisting faculty members to understand fully the implications of their requests.

2. Associate Professor

The rank of associate professor normally entails indefinite tenure and both rank and tenure are generally awarded during a review of promotion and tenure. It is possible, with appropriate justification and prior approval by the Provost and endorsement by the Dean of the Graduate College, to request indefinite tenure at the rank of associate professor for an initial hire.

Tenure implies reciprocal responsibilities on the part of the University and the faculty member. To that end the University provides academic freedom and the faculty members are obligated to provide and maintain high standards of teaching, research, professional service, and the communication of information and knowledge to others.

3. Professor

The rank of professor is associated with indefinite tenure and both rank and tenure are generally awarded during a review of promotion and tenure. It is possible, with appropriate justification and prior approval by the Provost and endorsement by the Dean of the Graduate College, to request indefinite tenure at the rank of professor for an initial hire.

Tenure implies reciprocal responsibilities on the part of the University and the faculty member. To that end the University provides academic freedom and the faculty members are obligated to provide and maintain high standards of teaching, research, professional service, and the communication of information and knowledge to others.

4. Initial Term ("Q") Appointment for New Associate and Full Professor

"Q" appointments are appropriate to consider when a unit recruiting a person from outside the University finds that the candidate does not yet possess the record of particular achievement expected of a tenured member on this campus, even though the person is of relatively senior standing in the field. The "Q" status involves appointments at either an associate professor or full professor level with an initial probationary period before review for indefinite tenure.

The authority for the "Q" appointment status is found in the University of Illinois ***Statutes***. Article X, Section 1a(1) provides that "an appointment as professor or associate professor shall be for an indefinite term except that first appointments or temporary appointments may be for shorter periods."

UIC policy allows the hire of a new associate or full professor, non-tenured, on an initial term, or "Q" appointment, for as long as three years. During the final year of the "Q" appointment, the faculty member may be approved for indefinite tenure following a review through the campus promotion and tenure process, or not be reappointed. In unusual circumstances and prior to the final review year, a "Q" appointment may be renewed for up to three additional years with the approval of the Provost.

C. Non-Tenured Faculty/Appointments

Article II, Section 3a (2) of the University of Illinois ***Statutes***, provides that "the bylaws of a unit may grant specified faculty privileges to members of the faculty of the unit or of other units who are neither tenured nor receiving probationary credit toward tenure, and who have the rank or title of professor, associate professor, assistant professor, instructor or lecturer." The unit bylaws may further grant specified faculty privileges to faculty members with modified faculty titles under the terms "research," "adjunct," "clinical," "visiting," and/or "emeritus." Only academic staff with titles listed above may be extended faculty privileges. A brief description of the various non-tenured faculty appointments are listed below.

1. Clinical Faculty

Clinical faculty hold positions through which they contribute to the service and teaching missions of the University. A terminal degree is generally required and appointments with the clinical rank are appropriate for those who work primarily in a clinical setting. Ranks held by clinical faculty include instructor, assistant professor, associate professor, and professor. All titles of clinical faculty must contain the term "clinical" as a modifier to the title, for example, Clinical Associate Professor. Clinical faculty are not eligible for tenure, but are eligible for promotion in the clinical track based on procedures established by the University under their Campus Promotion and Tenure Guidelines. Salaried clinical faculty at 50 percent time or greater must be searched for and appointed through the hiring procedures established for non-tenure track faculty. While individual faculty members hired in a tenure-track probationary appointment may switch to a clinical appointment during the first four years of their probationary period (exceptions may be granted), such a switch requires appropriate documentation from the department head, endorsement by the dean, and approval from both the Provost and Vice President for Academic Affairs. Additionally, clinical appointments should not be used as a means of retaining tenure-probationary faculty members who are not successful in attaining tenure and promotion.

2. Research Faculty

Research faculty are appointed on a fixed-term basis to work on research projects either independently or in collaboration with other UIC faculty; they are members of the academic staff of UIC. A terminal degree is required with experience to develop a substantial research and publication record. Ranks held by research faculty include assistant professor, associate professor, and professor. All titles of research faculty must contain the term "research" as a modifier to the title, for example, Research Associate Professor. Research faculty are not eligible for tenure, but are eligible for promotion in the research track based on procedures established by the University under their Campus Promotion and Tenure Guidelines. Salaried research faculty at 50 percent time or greater must be searched for and appointed through the hiring procedures established for non-tenure track faculty. Additionally, research appointments should not be used as a means of retaining tenure-probationary faculty members who are not successful in attaining tenure and promotion.

3. Special Written Agreement for Definite Term ("W") Appointments

By execution of a "special written agreement," for definite term ("W" Agreement) a faculty member waives rights to all tenure provisions contained in Article X of the University of Illinois ***Statutes***. A "special written agreement" requires that the faculty member be paid partially (at least 50 percent time) or wholly from non-State funds.

The authority for a "special written agreement" is through the President and defined in the University of Illinois ***Statutes***, Article X, Section 1a(1). The President's designee is the Chancellor, who in turn has delegated this authority to the Provost.

The "W" agreement is necessary on occasion when the University's interest is best served by offering a rank of Assistant Professor (at 51% or greater), Associate Professor or Professor to a faculty member who either is not on the tenure track or has not been

reviewed for tenure. It should not be used to provide faculty, who are in the latter stages of the probationary period, an escape from the tenure track when an unfavorable tenure review is anticipated or has already occurred.

4. Lecturers and Instructors

Lecturers and instructors are appointed on a fixed-term basis for teaching duties, and for research and service that supports teaching. They generally have professional experience or expertise in the area of instruction and are generally not required to have a terminal degree.

5. Visiting and Adjunct in Faculty Titles

"Visiting" may be used in the title of a faculty appointment when the individual to be appointed is to be a temporary appointee of one year or less. Such appointments may be renewed for a period generally not longer than three years when the funding source is non-state. Appointments beyond one year (state funded) or three years (non-state funded) imply permanent status and if they are to continue should be converted to permanent appointments in accordance with established campus policies.

The use of "adjunct" as a prefix to a faculty rank indicates that the position is not the individual's primary position. Adjunct may be used in the title of a faculty appointment when the individual to be appointed is expected to have some sort of short-term, peripheral association with the University. The individual appointed should be recognized in his/her field and departments should exercise appropriate review procedures before making an adjunct appointment.

The use of visiting and adjunct as prefixes to faculty ranks excludes eligibility for tenure. Therefore, care must be taken to assure that the individual being appointed is a bona fide visitor or adjunct appointee; these titles cannot be used merely as a means of avoiding a tenure-track or tenured appointment.

D. Multi-Year Contact

At its November 2006 meeting, the Board of Trustees approved revised amendments to the University of Illinois ***Statutes*** to accommodate awarding of multi-year contracts to defined academic staff categories. Amended Articles IX and X authorize the University to enter into contracts with definite terms for not more than three years when offering appointments to non-tenured faculty and to establish appropriate notice of non-reappointment and dismissal for cause procedures for persons holding such multi-year contracts.

Multi-Year Contacts are applicable to non-tenured faculty positions holding at least a 50 percent time appointment under the following ranks: teaching associate, postdoctoral research associate, clinical associate, lecturer, instructor, and any regular professorial rank modified by the addition of "research" or "clinical" titles (e.g., research associate professor or clinical professor). Applicability does not extend to "adjunct" faculty or "visiting" faculty appointments. These amendments do not address contract provision for academic professional appointments.

Limits to the number of multi-year contracts per year will be set by the campus to a reasonable proportion of the overall faculty on the campus (e.g., X percent of the sum of

multi-year contract eligible staff plus tenure-track and tenured faculty).

E. Other Non-Tenured Appointments Associated with Faculty

1. Departmental or Institute Affiliate

Departmental/Institute Affiliate was established to provide greater flexibility in the sharing of services of faculty members. Less formal in nature than a regular joint appointment (which generally carries voting rights and tenure status in each department), the departmental/institute affiliate designation would not carry with it any tenure rights or voting rights in the affiliated department/unit. The designation would be available only to faculty members who otherwise have an academic position in the University in a "home department." The appointment would be made annually with the concurrence of the home department and the affiliated department/unit and acceptance by the individual and could be terminated either by the department/unit or the individual. The position authorizes the Affiliate to direct Masters and Ph.D. theses in the affiliated department in the normal manner of other members of that department (subject to the usual rules of the Graduate College).

The affiliated department/unit may wish to contribute temporarily to the salary of the affiliate. This can be done by either 1) a transfer of funds to the affiliate's home department, or 2) designating a percentage appointment in the affiliated department with a corresponding percentage reduction in home department. Arrangements should be made in advance between the departments and the individual regarding the length and funding arrangements for such an appointment. For purposes of promotion, only the home department will be involved since the title of Affiliate does not designate faculty rank per se or carry any implications for tenure.

2. Associates

Titles included in the academic ranks include teaching associate, clinical associate and postdoctoral research associate. Persons qualified for these ranks are appointed at a percent time and under the direction of a faculty member. Unlike associate appointments, the postdoctoral fellow is generally a zero percent time affiliation. Various types of fellowships exist at UIC either at the departmental level or at the campus level. Most fellowships are accompanied by a stipend and a tuition and service fee waiver.

F. Non-Salaried/Courtesy Appointments

Non-salaried or "courtesy" appointments are made by the department to recognize contributions by persons who are otherwise employed outside UIC, but contribute in some way to the teaching, research and service missions. The specific conditions of all these appointments are determined by each school and college, but usually these appointments are for one year or less and may be extended each year based on departmental/college review. Although these appointments carry faculty ranks, i.e., assistant, associate, or full professor, they are not tenure-track or tenured appointments. Criteria for a courtesy appointment to any faculty rank should be consistent with the criteria used for appointments to those for regular faculty to the extent applicable.

G. Faculty Appointments to the Graduate College

The faculty of the Graduate College shall be prescribed by the University of Illinois Statutes. Faculty membership in the Graduate College is granted by the Dean of the Graduate College or his/her designee on behalf of the Executive Committee of the Graduate College. Nominations for membership shall be made by the Executive Officer of the department of other equivalent unit and recommendations can be at the tenure-track assistant professor level or as tenured associate or full professor. In the College of Medicine this recommendation is limited to appointments in the Research Track. There are three categories of faculty membership: 1) Full membership, which is granted for the term of employment to those members of the faculty who have been recommended by the department or other teaching or research divisions, 2) Adjunct membership, granted for a term of up to five years upon recommendation of the Executive Officer of the department or equivalent unit to adjunct faculty who otherwise meet the standards of membership, and 3) Courtesy membership, granted for one year to visiting or adjunct faculty members who meet the standards for membership. Adjunct and Courtesy members have floor privileges but not voting rights in meetings of the Graduate faculty.

H. Named Chair/Faculty Appointments

In an era of acute competition for the best teachers and researchers, privately funded endowments furnish a flexible resource that the University can use to support a wide range of priorities. Creating an endowed fund allows the endowment to carry the name of the donor or the name of a person or organization to be honored by the donor. Named faculty appointments at the UIC result from these endowments and they vary in type and level, e.g., a named chair, a named professorship, a named research fund, etc. Providing support to faculty who are building a national reputation is one way to ensure the continued quality of the professorate at UIC. The income from an endowment may be used to augment the salary of the professor, as well as to support his or her scholarly and research needs, help fund specific teaching and research requirements, including laboratory equipment, support staff, graduate assistants, research materials and computer equipment.

Approval and endorsement of the named appointment is required from both the Provost and the Chancellor. If approved, the appointment will be forwarded to the Board of Trustees via the standard faculty appointment reporting process. Named appointments/titles, generally at zero percent (0%), must accompany an underlying faculty appointment and tenure resides in the professorial appointment, never in the named appointment. This applies even when a portion of the salary is paid from the endowment and a percent time must be assigned to the named appointment. The University of Illinois Foundation is the official private gift-procurement arm of the University. Since its formation in 1935 as a non-profit corporation, the Foundation has been a significant contributing factor in the success of the University's endowment programs.

I. International Faculty

The University of Illinois at Chicago provides assistance in obtaining temporary work visas (H-1B, TN, etc.) for international staff and will consult on procedures for obtaining permanent residency status. Hiring units are urged to contact the Office of International Services (OIS) prior to making an offer of employment. The potential employee is also responsible for contacting OIS directly to discuss their current immigration status.

It is important to address visa issues promptly in order to avoid situations where individuals cannot secure the necessary immigration documents in time to teach, conduct research, or fulfill other responsibilities because immigration status does not permit employment. Permanent resident status is necessary for permanent employees, since six years is the limit for

nonimmigrant status. If the prospective permanent employee does not have this status, a delay of approximately one to two years can be expected in obtaining the permanent residency, if it can be obtained at all.

J. Faculty Position Announcements

A list of faculty position announcements can be found under the "Working" section of the main UIC HomePage. Currently faculty position announcements are not required to be posted on-line so this list may not be all-inclusive. Since final review of faculty search documents are done in the Office of Access and Equity, entry of the faculty position openings online is currently done by OAE.

K. Termination of Employment

1. Notice of Nonreappointment for Non-Tenured Faculty [see also Section VI, I(5)]

There are two periods during the year when decisions regarding notice of nonreappointment must be made by the departments and colleges: before March 1 and before August 16. Assistant professors at more than 50% of full-time service in years two through six of the probationary period should be given notice of nonreappointment by the department before August 16, to be effective at the completion of the following appointment year. Assistant professors at more than 50% of full-time service in year one of the probationary period and full-time research associates, teaching associates, and faculty holding modified research titles (e.g., Research Associate Professor) on a non-tenured basis and paid from "hard" funds (i.e., state, auxiliary, and revolving accounts) must be given notice of nonreappointment by the department prior to March 1 to be effective at the completion of the current appointment year. Assistant professors at 50% or less of full-time service are not eligible for notice rights.

It is expected that the faculty listed above who require six months notice and are paid from hard funds will have appointment dates consistent with the academic/appointment year, i.e., August 16 through August 15 of the following year. Although the department and/or college must notify the faculty member of nonreappointment in writing, it is the Board of Trustees that gives the official notice. If notice is given later than six months before the end of the annual contract, or after March 1 in the case of an academic year appointment, it shall be accompanied by an offer of a terminal contract for one additional year of service.

Research faculty and research and teaching associates who are on "non-tenured" appointments and are less than full-time, or whose contracts indicate subject to the availability of funds do not require formal notice of nonreappointment by the Board of Trustees. Moreover, notice of nonreappointment is not required in the case of any appointment at the rank of instructor or lecturer, or for any appointment that includes in the title the term "adjunct," "clinical," or "visiting." Nevertheless, good personnel practice requires that such appointees be given as much notice as possible when a decision regarding nonreappointment has been made.

Although there is no statutory requirement, an associate or full professor in the final year of a "Q" appointment (who was not put forward for tenure review) and is not to be reappointed should be given adequate notice of nonreappointment by the unit.

Assistant, associate and full professors on a "W" contract must be given notice of nonreappointment by the Board of Trustees in accordance with the terms specified in the "Special Written Agreement to Accept Academic Appointment and Reappointment for Definite Terms." The notice of nonreappointment period is indicated in the special written agreement as agreed upon by the faculty member and the department head, and generally ranges from six to twelve months.

2. Resignation

Faculty resignations must be submitted in writing to the department head or other appropriate administrative officer. In accordance with state law, the health and life insurance coverage provided by the state and the benefits available to active employees under the State Universities Retirement System (SURS) cease as of the resignation date. Under federal legislation enacted in 1986, a continuation option via the Consolidated Omnibus Budget Reconciliation Act (COBRA) exists that permits resigning employees to continue insurance coverage. Employees are responsible for the premiums if coverage is continued. For University employees, COBRA applies to the State health, dental, and vision coverage. Continuation for COBRA-qualified dependents shall be identical to the employee's health, dental, and vision coverage under which they were covered at the time coverage was lost. For additional information, contact the Benefits Center.

Faculty members employed at UIC for the academic year (nine-month appointments) may continue their benefits through the summer only if they resign on and request continued payment through August 15.

3. Retirement

Faculty retirements must be submitted in writing to the department head or other appropriate administrative officer. Departments must notify Faculty Affairs Human Resources when a faculty member retires and the retiring faculty member should notify SURS as soon as possible regarding their pending retirement date. Retirement dates for nine-month faculty should occur on the following dates only: December 31 (end of fall semester), May 15 (end of spring semester) or August 15 (end of academic year or summer contract).

An employee's retirement annuity generally is based on years of service and average earnings during the highest four consecutive years – including summer session earnings, overtime pay, and up to 48 days of accrued vacation earnings for twelve-month faculty only that are paid at the time of retirement.

Pre-retirement planning conferences are held periodically to provide information and assistance on pre-retirement planning to all interested employees and their spouses. These conferences are generally held in March of each year and notices are sent to all employees via campus webmail.

The Annuitants Association is an organization to promote the individual and collective interests and welfare of its members and retirees of state universities. Membership is open to all participants in SURS who have retired or who are eligible for a retirement annuity, their spouses, and survivors.

4. Method of Final Payment/Service

Faculty members on an academic-year contract (nine-month) or ten-month contract do not earn vacation. Nevertheless they will be paid upon termination for the percentage of services completed in that contract year. That means a nine-month or academic-year appointee may receive the entire balance due for his/her appointment as of May 15 if all services have been provided during the preceding nine-month period (August 16-May 15). An academic-year appointee has the privilege of receiving his/her salary during the year prior to retirement over a nine-month period (rather than over a twelve-month period) so that the retirement annuity can begin June 1. Resignation dates for nine-month faculty should occur on the following dates only: December 31 (end of fall semester), May 15 (end of spring semester) or August 15 (end of academic year or summer contract).

The method of final payment for unused vacation time is subject to the approval of the department head. Faculty on twelve-month contracts who retire, resign, or otherwise terminate their employment with the university may be paid for accumulated vacation earned, but not taken, as of the date of termination up to a maximum of 48 working days, or they may wish or be asked to take their vacation before the completion of their contracts. However, terminating faculty on a twelve-month contract cannot use accumulated vacation to extend their termination date beyond their last day of actual employment. Department heads are advised to provide reasonable notice when asking a faculty member to take vacation before the completion of the employee's contract.

An employee who transfers from one position to another and remains on a twelve-month contract with continuing service may not be paid for accumulated vacation and sick leave. Any balance of vacation and/or sick leave will transfer to the new position.

5. Death and Survivors' Benefits

When beginning participation in the retirement system, university employees are given a beneficiary designation form. This information should be kept current by notifying the State Universities Retirement System (SURS) of such events as the birth of a child or the death of a beneficiary. The law governing SURS provides that divorce disqualifies the former spouse from receiving survivors' insurance benefits. A former spouse must be designated or re-designated as beneficiary after the date of the divorce to be eligible for any lump-sum death benefit that is not a survivors' insurance benefit. The beneficiary designation is for lump-sum death benefits and does not have any bearing on survivor benefits.

The SURS provides retirement, disability, death, and survivor benefits to eligible SURS participants and annuitants. As of April 1998, SURS active members must choose from one of three retirement options (see below) within the first six months from the date SURS receives their certification of employment from the employer. Employees who fail to choose within six months, will be permanently enrolled in the Traditional Benefit Package:

- Traditional Benefit Package: The historical SURS Defined Benefit retirement plan which until 1998 was the only SURS plan available.
- Portable Benefit Package: A Defined Benefit retirement plan that has much in common with the Traditional Benefit Package. However, it provides a more generous separation refund for those who leave the system.

- Self-Managed Plan (SMP): A Defined Contribution plan that establishes an account in the employee's name into which your contributions and the employer (State of Illinois) contributions are placed. You decide how your account balance will be invested, selecting from a variety of mutual funds, stable value funds, and variable annuities.

6. Emeritus/Emerita Status

The granting of emeritus status to retiring faculty and senior administrative staff members is based on merit. At UIC, the emeritus designation is regarded as an extraordinary title that is given for extraordinary service. Accordingly, emeritus status is bestowed on only those individuals who have contributed measurably to the University of Illinois at Chicago. Faculty eligible for emeritus status includes those in professorial ranks (professors and associate professors) and research and clinical faculty. Senior administrative staff are defined as chancellors and deans.

Ordinarily, emeritus status will not be granted to an individual who has served less than seven years. Exceptions to this policy may be considered for an individual who has made an outstanding contribution to the university during a briefer period of service. Emeritus status may be granted prior to retirement for those who have served the university in an eligible administrative position for at least five years and who resign such positions to return to the faculty.

To recommend emeritus status for a retiring faculty member or a senior administrator, the individual's immediate unit head should prepare a letter of justification with supporting documentation. The request should be reviewed by the appropriate person at each administrative level, with final review and recommendation in all cases at the level of Provost/Vice Chancellor for Academic Affairs. For example, a faculty member's application for emeritus status would ordinarily begin with the Department Head and be reviewed by the Dean and the Provost or his/her designee.

The provost shall appoint an Emeritus Review Committee to consider all requests for emeritus status and to ensure that uniform campus standards for extraordinary service are applied in each case. The Committee shall operate under rules established by, and will be advisory to, the Provost. The Provost's affirmative recommendations for the granting of emeritus status will be submitted to the Chancellor, who in turn will send his or her recommendation to the Board of Trustees for approval. The Office of the Board of Trustees will send a letter to the individual confirming the designation of emeritus status.

Approval at the campus level of the emeritus designation does not entitle the recipient to additional space, personnel, or equipment, unless a request is separately approved by the department, and the college when necessary. Requests for additional space, personnel, or equipment will not be granted for any emeritus academic administrator unless he or she is employed by the campus after retirement, i.e., receives a contract for pay from the Board of Trustees.

7. Retiree's Benefits

A retiree's identification card verifies the retiree's right to enjoy many of the privileges and services offered by the University. To obtain an I-Card, a retiree must have proof of retirement from their department, as well as a valid driver's license, passport or state ID

card. There is currently no charge for the first ID as long as the retiree turns in the previous faculty/staff card; however, there is a replacement fee for lost or stolen cards.

Retiree benefits include the following:

- library privileges to all retirees without restriction,
- retirees may enroll in courses or attend classes without payment of tuition or fees, assuming that other conditions governing enrollment in such courses are satisfactorily met,
- retirees may purchase a recreational facilities membership for the same price as faculty by showing their retiree I-Card,
- retirees may continue their personal listing in the staff directory by making arrangements with their home department, and
- other related services as outlined in the Chicago Retiree's Guide.

L. Re-Employment of University of Illinois Retirees

Re-employment of University retirees is a wise human resource practice for the University. Re-employing such retirees from time to time can help the University achieve quality and value objectives in serving students, conducting research, caring for patients, and managing exceptional circumstances and special needs. The University expects and requires effective succession planning and does not intend to use University retiree re-employment as a substitute for developing well qualified faculty and staff.

University retirees in the following categories may be re-employed for the purposes described without prior Board of Trustees approval: 1) retired faculty members who teach courses, advise students, and perform related duties on a part-time basis, 2) retired faculty or staff members who conduct research on appointments funded by grants and contracts, 3) retired clinical faculty members who are employed to provide patient care on a part-time or occasional basis, 4) retirees who are appointed as academic hourly employees on a temporary basis, and 5) retirees who are appointed on a temporary basis to perform staff functions when other options are not feasible.
Approved by the Board of Trustees, July 13, 2006

To Index

ROY J. AND LUCILLE A. CARVER COLLEGE OF MEDICINE

POLICIES AND PROCEDURES CONCERNING

FACULTY APPOINTMENTS AND EVALUATION

Approved by Provost 5/19/95
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Approved by Provost and faculty June, 2007 (tenure clock)

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ROY J. AND LUCILLE A CARVER COLLEGE OF MEDICINE
POLICIES AND PROCEDURES CONCERNING
FACULTY APPOINTMENTS, EVALUATION AND PROMOTION

I. Qualifications for Specific Ranks

A. Tenure Track Appointments

The College aspires to appoint and promote faculty in the tenure track who are committed to the achievement of excellence in teaching, scholarship, and service. Faculty in the tenure track have the responsibility to teach (see Appendix I), and may achieve promotion by emphasizing scientific inquiry or scholarship in their clinical or professional discipline (see Appendix II).

Tenure track faculty members who do not have patient care responsibilities have the same six-year tenure clock as most of the rest of the University faculty. Tenure track faculty members with patient care responsibilities have an eight year tenure clock. Faculty with patient care responsibilities are defined as faculty in clinical departments who are participants in the University of Iowa Physicians group (UIP).

1. Instructor

a. He or she must show promise of ability as a teacher (See Appendix I).

b. He or she must be working towards the completion of the doctorate or its equivalent.

c. He or she must be actively involved in scholarly research and other significant professional activities.

d. If the faculty member is responsible for the medical care of patients, he or she must have a license to practice medicine in Iowa and must demonstrate competence as a physician. Competence as a physician will be established by the hospital staff process of reviewing clinical credentials and granting hospital privileges. Individuals other than physicians involved in the care of patients should meet the criteria established by hospital bylaws and any relevant state licensure requirements.

e. The term of appointment is for one year. Reappointment is not automatic, but requires departmental review of the faculty member's performance and a recommendation based upon the member's performance in teaching, scholarship and service.

2. Assistant Professor without patient care responsibilities (approved by faculty June, 2007)

a. He or she must show promise of ability as a teacher. (See Appendix I).

b. He or she must hold the doctorate or its equivalent.

c. He or she must show promise of scholarly productivity. This can be accomplished by publications, clinical reports, presentations or other work of a professional nature (See Appendix II).

d. The initial term of appointment is typically for three years, although it may be for a shorter period of time. Reappointment is not automatic, but requires departmental review of the faculty member's performance and a recommendation based upon the evaluation of the faculty member's performance in teaching, scholarship and service. (See Review of Faculty, Section IV, #s A.1., B.1., and B.2.

e. Faculty members not to be promoted at the end of six years in the combined ranks of Instructor and Assistant Professor will be given a one-year terminal appointment.

2. Assistant Professor with patient care responsibilities (approved by faculty June, 2007)

a. He or she must show promise of ability as a teacher. (See Appendix I).

b. He or she must hold the doctorate or its equivalent.

c. He or she must show promise of scholarly productivity. This can be accomplished by publications, clinical reports, presentations or other work of a professional nature (See Appendix II).

d. If the faculty member is responsible for the medical care of patients, he or she must have a license to practice medicine in Iowa and must demonstrate competence as a physician. Competence as a physician will be established by the hospital staff process of reviewing clinical credentials and granting hospital privileges. Individuals other than physicians involved in the care of patients should meet the criteria established by hospital bylaws and any relevant state licensure requirements. The faculty member must be a participant in UIP.

e. The initial term of appointment is typically for four years, although it may be for a shorter period of time. Reappointment is not automatic, but requires departmental review of the faculty member's performance and a recommendation based upon the evaluation of the faculty member's performance in teaching, scholarship and service. (See Review of Faculty, Section IV, #s A.1., B.1., and B.2.

f. Faculty members not to be promoted at the end of eight years in the combined ranks of Instructor and Assistant Professor will be given a one-year terminal appointment.

g. Within the initial five years of appointment in the tenure track, a faculty member may request to be appointed in the non-tenure clinical track. The department may initiate the appointment by justifying to the Dean the non-tenure track faculty position, and by meeting University requirements. An individual may, as a rule, be appointed to the tenure track only once during his or her career in the Carver College of Medicine (See Appendix VI).

3. Associate Professor **(revised May, 2007)**

a. He or she must have a convincing record of teaching effectiveness, including a record of successful direction of the work of doctoral candidates, fellows or residents where applicable (See Appendix I).

b. He or she must show evidence of establishing a record of productive scholarship that can be supported by publications or the equivalent. (See Appendix II).

c. Departmental, collegiate, and/or University service and, if appropriate, professional service will be expected at an appropriate level (Appendix III and IV)

d. If the faculty member is responsible for the medical care of patients, he or she must have a license to practice medicine in Iowa and must demonstrate competence as a physician. Competence as a physician will be established by the hospital staff process of reviewing clinical credentials and granting hospital privileges.

e. Candidate must have shown such capacity that he or she will continue to strive for excellence in teaching, service, and scholarly pursuit with the clear expectation that he or she will be able to attain the rank of Professor. (See Appendices I, II, III, IV and V).

f. If a faculty member is promoted to the rank of Associate Professor from within the University of Iowa, tenure is granted automatically. However, initial appointments to these ranks offered to those not on the faculty of the University of Iowa should, whenever possible, be made as probationary appointments for three years.

g. When a potential faculty member holds a tenured rank at another university, an initial appointment with tenure may be made. In cases where a potential faculty member has not had previous academic experience, but on the grounds of distinguished professional or other scholarly contributions merits the rank of Associate Professor, the initial appointment without tenure should be for 3 years or less. Recognition is given to the fact that 3 years may not be enough time to establish a record of teaching and scholarship sufficient to grant tenure. Accordingly, reappointments without tenure at the Associate Professor rank may be given provided the total probationary period at this University does not exceed six years If the decision is made to withhold tenure after an evaluation in the sixth year of probationary service at this University as Associate Professor, the faculty member should be given a one-year terminal appointment.

h. In cases where a potential faculty member has not had previous academic experience and the faculty member will have clinical responsibilities, then the initial appointment without tenure should be for four years or less. Accordingly, reappointments without tenure at the Associate Professor rank may be given provided the total probationary period at this University does not exceed eight years If the decision is made to withhold tenure after an evaluation in the eighth year of probationary service at this University as Associate Professor, the faculty member should be given a one-year terminal appointment.

4. Professor **(revised May, 2007)**

a. He or she must be recognized as having a continued record of effective teaching success, including a record of successful direction of the work of doctoral candidates, fellows, or residents where applicable (See Appendix I).

b. He or she must have an established record of productive scholarship supported by substantial publication or the equivalent, with unmistakable evidence of recognition by peers at either the national level, international level, or both. (See Appendices II, III, and V).

c. Departmental, collegiate, and/or University service and, if appropriate, professional service will be expected at an appropriate level (Appendix III and IV)

d. If the faculty member is responsible for the medical care of patients, he or she must have a license to practice medicine in Iowa and must demonstrate competence as a physician. Competence as a physician will be established by the hospital staff process of reviewing clinical credentials and granting hospital privileges. Individuals other than physicians involved in the care of patients should meet the criteria established by hospital bylaws and any relevant state licensure requirements.

e. The rank of Professor will not be considered to be a reward for long and acceptable service (See Appendix VI).

f. If a faculty member is promoted to the rank of Professor from within the University, tenure is granted automatically. However, initial appointment to this rank offered to those not on the faculty of the University of Iowa should, whenever possible, be made as probationary appointments for three years. The individual must agree in writing to a three-year nontenured appointment.

g. When a potential faculty member holds a tenured rank at another university, an initial appointment with tenure may be made. In cases where a potential faculty member has not had previous academic experience, but on the grounds of distinguished professional or other scholarly contributions merits the rank of Professor, the initial appointment without tenure should be for three years or less. Recognition is given to the fact that three years may not be enough time to establish a record of teaching and scholarship sufficient to grant tenure. Accordingly, reappointments without tenure at the Professor rank may be given provided the total probationary period at this University does not exceed six years. If the decision is made to withhold tenure after an evaluation in the sixth year of probationary service at this University as Professor, the faculty member should be given a one-year terminal extension of appointment.

h. In cases where a potential faculty member has not had previous academic experience and the faculty member will have clinical responsibilities, then the initial appointment without tenure should be for four years or less. Accordingly, reappointments without tenure at the Professor rank may be given provided the total probationary period at this University does not exceed eight years If the decision is made to withhold tenure after an evaluation in the eighth year of probationary service at this University as Professor, the faculty member should be given a one-year terminal appointment.

B. Clinical Track Appointments (salaried) **(approved by Provost 6/10/02)**

The College aspires to appoint and promote faculty in the clinical track who are committed to the achievement of excellence in teaching, clinical service, and one or more other areas of professional productivity.

Clinical track faculty hold service positions through which they contribute to the clinical service, teaching, and/or outreach missions of the College, and hold faculty rank at instructor, assistant professor, associate professor, or professor. Clinical track faculty are not eligible for tenure.

Salaried clinical track faculty members are persons who have faculty career positions, and who make their primary contributions through clinical service and instruction in the context of this service. (See Appendices V and VI). No more than 35% of the total salaried College faculty may hold such appointments. The titles of these faculty members shall contain the modifier "clinical," preceding the rank [e.g. Clinical Professor].

Promotion in this track is based on accomplishments in three areas: the direct provision of clinical service , teaching in the context of clinical service , and professional productivity..

Professional productivity encompasses activities utilizing the faculty member's professional expertise, and that are in addition to the direct provision of clinical service and teaching in that context (see Appendix XI). The categories of activities to be considered include:

- Professional service (see Appendix IV),
- Teaching (Appendix I - all listed activities except #3, which is teaching in the context of clinical care),
- Academic service (Appendix III)
- Written scholarship (Appendix II)

Clinical track faculty are not eligible for tenure. (See Operations Manual Part III, Division I, Chapter 10.9.b, and Appendix VI and VIII.) Individuals with a clinical track appointment at any rank may apply for appointment to the tenure track following the usual appointment procedures (See Section II). An individual may, as a rule, be appointed to the tenure track only once during his or her career in the Carver College of Medicine.

These requirements should be interpreted using the following guidelines:

1) While written scholarship may help satisfy this requirement, it is not required for promotion in this track. The type of written scholarship that will be considered as evidence for promotion in this track is broad. In addition to peer reviewed research reports, it includes, for example, high quality review articles, case reports, clinical commentaries, textbook chapters, and policy documents prepared for the institution, the faculty member's discipline, or government bodies.

2) Promotion can be supported by a variety of professional productivity profiles. For example, some faculty will primarily be involved in a single area, such as education, clinical scholarship, or clinical administration. Other faculty will pursue activities in several of these areas. In all cases, a recommendation for promotion should be based on the quality of the activities, not just the quantity.

3) Although most faculty members in this track will continue to spend the majority of their effort throughout their career in direct clinical service and teaching, some individuals may not. These faculty members, by mutual decision with the institution, will focus their effort in a specific sphere of professional productivity (for example, as a clinical department, hospital or collegiate administrator, curriculum director, funded clinical investigator, etc). When such individuals are considered for promotion, these activities should be the primary focus of the evaluation as long as there has been demonstration of the appropriate level of expertise in direct clinical service and teaching since the original appointment.

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1. Instructor

   a. He or she must hold the doctorate or its equivalent, except in the Division of Associated Medical Sciences, where the master's degree or its equivalent is the minimum degree required.

   b. He or she must show promise of ability in service, to include clinical service.

   c. He or she must show promise of ability to contribute to teaching through the provision of service (See Appendix I).

   d. If the faculty member is responsible for the medical care of patients, he or she must have a license to practice medicine in Iowa and must demonstrate competence as a physician. Competence as a physician will be established by the hospital staff process of reviewing clinical credentials and granting hospital privileges. Individuals other than physicians involved in the care of patients should meet the criteria established by hospital bylaws and any relevant state licensure requirements.

d. The term of appointment is one year. Reappointment is not automatic, but requires departmental review of the faculty member's performance in teaching and clinical service, and a recommendation based upon that performance. Reappointment will be for two years.

2. Assistant Professor

a. He or she must hold the doctorate or its equivalent, except in the Division of Associated Medical Sciences, where the master's degree or its equivalent is the minimum degree required.

b. He or she must show promise of excellent clinical service, as judged by peers and/or supervisors (see Appendix V).

c. He or she must show promise of ability as a teacher (See Appendix I).

d. If the faculty member is responsible for the medical care of patients, he or she must have a license to practice medicine in Iowa and must demonstrate competence as a physician. Competence as a physician will be established by the hospital staff process of reviewing clinical credentials and granting hospital privileges. Individuals other than physicians involved in the care of patients must meet the criteria established by hospital bylaws and any relevant state licensure requirements.

e. The initial term of appointment is one to three years. Reappointment is not automatic, but requires full departmental review of the faculty member's performance and a recommendation based upon the evaluation of the faculty member's performance in teaching and clinical service. (See Review of Faculty, IV.A.).

Prior to reappointment or promotion, a full-scale departmental-collegiate review will be made. After a positive review, the faculty member will receive an appointment of 3 to 7 years. After a negative review, the department will generally recommend non-renewal of the contract. However, the department may in some cases choose to offer a contract of one year that is accompanied by specific performance requirements. If there is evidence of improvement, but not complete fulfillment of the performance requirement, one additional one-year contract may be given. If the defined performance requirements are met to the satisfaction of the DEO and the voting faculty, a new appointment of between 3 and 7 years should be offered. If the performance requirements are not met, the department may recommend non-renewal.

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Termination during the term of the appointment must be for failure to meet written standards of competence and performance (see Appendix X) established by departments and approved by the College. A decision not to renew an appointment may be for failure to meet the written standards of competence and performance, or for changed economic circumstances or program needs such that the position itself is terminated. Non-renewal may only occur at the conclusion of an appointment. Notice of non-renewal must carry appropriate notice, as defined in Operations Manual Part III Division I Chapter 10.9 h.1.c

f. There is no maximum period of time by which promotion must be achieved in this track (Appendix VII)

3. Associate Professor

a. He or she must hold the doctorate or its equivalent except in the Division of Associated Medical Sciences, where the master's degree or its equivalent is the minimum degree required.

b. He or she must have an acknowledged record ofexcellent clinical service, as judged by peers (see Appendix V).

c. He or she must have an acknowledged record of teaching success in the context of clinical service, including a record of successful direction of the work of students, fellows or residents where applicable (see Appendix I).

d. He or she must show evidence of progress toward a record of professional productivity that can be supported by clear documentation of the quantity and quality of activities, and as judged by peers.

e. If the faculty member is responsible for the medical care of patients, he or she must have a license to practice medicine in Iowa and must demonstrate competence as a physician. Competence as a physician will be established by the hospital staff process of reviewing clinical credentials and granting hospital privileges. Individuals other than physicians involved in the care of patients must meet the criteria established by hospital bylaws and any relevant state licensure requirements.

f. The term of appointment is1-3 years if the initial appointment was to this rank, or 3 to 7 years following reappointment or promotion. Reappointment is renewable based on departmental review of the faculty member's performance and a recommendation based upon the evaluation of the faculty member's performance in teaching and clinical service. After a negative review, the department will generally recommend non-renewal of the contract. However, the department may in some cases choose to offer a contract of one year that is accompanied by specific performance requirements. If there is evidence of improvement, but not complete fulfillment of the performance requirement, one additional one-year contract may be given. If the defined performance requirements are met to the satisfaction of the DEO and the voting faculty, a new appointment of between 3 and 7 years should be offered. If the performance requirements are not met, the department may recommend non-renewal.

Termination during the term of the appointment must be for failure to meet written standards of competence and performance (see Appendix X) established by departments and approved by the College. A decision not to renew an appointment may be for failure to meet the written standards of competence and performance, or for changed economic circumstances or program needs such that the position itself is terminated. Non-renewal may only occur at the conclusion of an appointment. Notice of non-renewal must carry appropriate notice, as defined in Operations Manual Part III Division I Chapter 10.9 h.1.c

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g. There is no maximum period of time by which promotion must be achieved in this track.

4. Professor

a. He or she must hold the doctorate or its equivalent except in the Division of Associated Medical Sciences, where the master's degree or its equivalent is the minimum degree required.

b. He or she must have an acknowledged record ofexemplary clinical service, as judged by peers (see Appendix V).

c. He or she must have an acknowledged record of continued teaching success, including a record of successful direction of the work of students, fellows, or residents where applicable (See Appendix I).

d. He or she must have an established record of professional productivity as demonstrated by clear documentation of the quantity and quality of activities, and as judged by peers. Evidence of successful leadership in one or more spheres of professional productivity is highly desirable (see Appendix VI). Finally, there must be unmistakable evidence of recognition by peers at the state, regional, national, or international level (see Appendix IV, VI and VII).

e. If the faculty member is responsible for the medical care of patients, he or she must have a license to practice medicine in Iowa and must demonstrate competence as a physician. Competence as a physician will be established by the hospital staff process of reviewing clinical credentials and granting hospital privileges. Individuals other than physicians involved in the care of patients must meet the criteria established by hospital bylaws and any relevant state licensure requirements.

f. At the rank of Professor, the term of appointment is 1-3 years if the initial appointment was to this rank, or 3 to 7 years following reappointment or promotion. Reappointment is renewable based on departmental review of the faculty member's performance and a recommendation based upon the evaluation of the faculty member's performance in teaching and clinical service. After a negative review, the department will generally recommend non-renewal of the contract. However, the department may in some cases choose to offer a contract of one year that is accompanied by specific performance requirements. If there is evidence of improvement, but not complete fulfillment of the performance requirement, one additional one-year contract may be given. If the defined performance requirements are met to the satisfaction of the DEO and the voting faculty, a new appointment of between 3 and 7 years should be offered. If the performance requirements are not met, the department may recommend non-renewal.

Termination during the term of the appointment must be for failure to meet written standards of competence and performance (see Appendix X) established by departments and approved by the College. A decision not to renew an appointment may be for failure to meet the written standards of competence and performance, or for changed economic circumstances or program needs such that the position itself is terminated. Non-renewal may only occur at the conclusion of an appointment. Notice of non-renewal must carry appropriate notice, as defined in Operations Manual Part III Division I Chapter 10.9 h.1.c

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C. Other Non-Tenure Track Appointments

1. Clinical Track Appointments (Nonsalaried)

Clinical track faculty with *nonsalaried* appointments are persons who are not employees of the University of Iowa, and who make their primary contribution through instruction in the context of their own medical practice (see Appendix VIII). These faculty hold the degrees of MD, DO, DDS or DMD. Individuals who hold other professional degrees and contribute to instruction hold adjunct ranks (see Section 2.) There is no limit on the number of such appointments that may be made by the College. The titles of these faculty shall contain the modifier "adjunct clinical," preceding the name of the rank. The Department shall be unmodified.

a. Adjunct Clinical Instructor

(1) He or she must be working towards the completion of the doctorate or its equivalent.

(2) He or she must show promise of ability in service, to include clinical service.

(3) He or she must show promise of ability to contribute to teaching through the provision of service (See Appendix I). Faculty with nonsalaried appointments must commit a significant portion of time to teaching (see Appendix VI and Appendix VIII).

(4) He or she must have a license to practice medicine in Iowa and must demonstrate competence as a physician. Competence as a physician will be established by evidence of staff privileges at a hospital in Iowa Individuals other than physicians involved in the care of patients should meet usual criteria for relevant state licensure requirements.

(5) The term of appointment is one to three years. Reappointment is not automatic, but requires departmental review of the faculty member's performance and a recommendation based upon the member's performance in teaching and service.

(6) There is no maximum period of time by which promotion must be achieved in this track. However, an Instructor may request consideration for promotion at any regular promotions cycle after, in general, the fourth year of appointment.

b. Adjunct Clinical Assistant Professor

(1) He or she must hold the doctorate or its equivalent.

(2) He or she must show promise of excellent clinical service, as judged by peers and supervisors.

(3) He or she must show evidence of ability as a teacher (See Appendix I). Faculty with nonsalaried appointments must commit a significant portion of time to teaching (see Appendix VIII).

(4) He or she must have a license to practice medicine in Iowa and must demonstrate competence as a physician. Competence as a physician will be established by evidence of staff privileges at a hospital in Iowa Individuals other than physicians involved in the care of patients should meet usual criteria for relevant state licensure requirements.

(5) The term of appointment is one to three years. Reappointment is not automatic, but requires departmental review of the faculty member's performance and a recommendation based upon the member's performance in teaching.

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(6) There is no maximum period of time by which promotion must be achieved in this track. However, an Assistant Professor may request consideration for promotion at any regular promotions cycle after, in general, the fourth year of appointment.

c. Adjunct Clinical Associate Professor

(1) He or she must hold the doctorate or its equivalent.

(2) He or she must have an acknowledged record of excellent clinical service, as judged by peers.

(3) He or she must have an acknowledged record of teaching success, including a record of successful direction of the work of students, fellows or residents where applicable (see Appendix I). Faculty with nonsalaried appointments must commit a significant portion of time to teaching (see Appendix VIII).

(4) He or she must show evidence of progress toward a record of professional productivity including professional service (see Appendix IV). Scholarship (see Appendix II) may help satisfy this requirement, but is not required.

(5) He or she must have a license to practice medicine in Iowa and must demonstrate competence as a physician. Competence as a physician will be established by evidence of staff privileges at a hospital in Iowa Individuals other than physicians involved in the care of patients should meet usual criteria for relevant state licensure requirements.

(6) The term of appointment is one to three years. Reappointment is not automatic, but requires departmental review of the faculty member's performance and a recommendation based upon the member's performance in teaching.

(7) There is no maximum period of time by which promotion must be achieved in this track. However, an Associate Professor may request consideration for promotion at any regular promotions cycle.

d. Adjunct Clinical Professor

(1) He or she must hold the doctorate or its equivalent.

(2) He or she must have an acknowledged record ofexemplary patient care, as judged by peers.

(3) He or she must have an acknowledged record of continued teaching success, including a record of successful direction of the work of students, fellows, or residents where applicable (See Appendix I). Faculty with nonsalaried appointments must commit a significant portion of time to teaching (see Appendix VIII).

(4) He or she must have an established record of professional productivity, and unmistakable evidence or recognition by peers at the state, regional, national, or international level (see Appendix IV and VI). Scholarship (Appendix II) may help satisfy this requirement, but is not required.

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(5) He or she must have a license to practice medicine in Iowa and must demonstrate competence as a physician. Competence as a physician will be established by evidence of staff privileges at a hospital in Iowa Individuals other than physicians involved in the care of patients should meet usual criteria for relevant state licensure requirements.

(6) For faculty with nonsalaried appointment, the term of appointment is one to three years. Reappointment is not automatic, but requires departmental review of the faculty member's performance and a recommendation based upon the member's performance in teaching.

2. Adjunct Appointments

Adjunct appointments are made principally for contributions to teaching and/or research, and are made instead of clinical appointments, for individuals who do not hold an M.D./D.O./D.D.S. degree.

a. Adjunct Instructor

(1) Promise of ability as a teacher and/or investigator (See Appendices I and II).

(2) Working towards the completion of the doctorate or its equivalent.

(3) Commitment of a significant portion of time to teaching and/or research.

(4) Involvement in a patient care setting if appropriate.

(5) The term of appointment is one to three years. Reappointment is not automatic, but requires departmental review of the faculty member's performance and a recommendation based upon the member's performance in teaching.

(6) There is no maximum period of time by which promotion must be achieved in this track. However, an Adjunct Instructor may request consideration for promotion at any regular promotions cycle following the initial three years at this rank.

b. Adjunct Assistant Professor

(1) Promise of ability as a teacher and/or investigator (See Appendices I and II).

(2) Holder of the doctorate or its equivalent.

(3) Commitment of a significant portion of time to teaching and/or research.

(4) Demonstration of good clinical skills in the care of patients if appropriate.

(5) The term of appointment is one–three years. Reappointment is not automatic, but requires departmental review of the faculty member's performance and a recommendation based upon the member's performance in teaching.

(6) There is no maximum period of time by which promotion must be achieved in this track. However, an Adjunct Assistant Professor may request consideration for promotion at any regular promotions cycle following the initial three years at this rank.

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c. Adjunct Associate Professor

(1) Acknowledged record of teaching success and/or research (See Appendices I and II).

(2) Unmistakable evidence of recognition by peers.

(3) Commitment of a significant portion of time to teaching and/or research.

(4) Demonstration of excellent clinical skills in the care of patients, if appropriate.

(5) The term of appointment is one–three years. Reappointment is not automatic, but requires departmental review of the faculty member's performance and a recommendation based upon the member's performance in teaching.

(6) There is no maximum period of time by which promotion must be achieved in this track. However, an Associate Professor may request consideration for promotion at any regular promotions cycle following the initial three years at this rank.

d. Adjunct Professor

(1) Acknowledged record of teaching success and/or research (See Appendices I and II).

(2) Unmistakable evidence of recognition by peers.

(3) An established record of professional or scholarly productivity (may include papers, reports, seminars, etc.).

(4) Commitment of a significant portion of time to teaching and/or researcj.

(5) Demonstrates outstanding clinical skills in the care of patients, if appropriate.

(6) The term of appointment is one–three years. Reappointment is not automatic, but requires departmental review of the faculty member's performance and a recommendation based upon the member's performance in teaching.

(7) There is no maximum period of time by which promotion must be achieved in this track. However, an Associate Professor may request consideration for promotion at any regular promotions cycle following the initial three years at this rank.

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3. Other Non-tenure Track Instructional Appointments

Appointments to these positions may be made to individuals with academic degrees as listed below. However, individuals with higher academic degrees also may be appointed to these ranks. Appointments are made on an annual basis and may be renewed. Those with M.D./D.O. or Ph.D. degrees ordinarily should not occupy these positions for extended periods, and in the case of the rank of Associate, should not exceed 3 years.

If the individual to be appointed is to be responsible for the medical care of patients, he or she must have a license to practice medicine in Iowa and must demonstrate competence as a physician. Competence as a physician will be established by the hospital staff process of reviewing clinical credentials and granting hospital privileges. Individuals other than physicians involved in the care of patients should meet the criteria established by hospital bylaws and any relevant state licensure requirements.

a. Associate

(1) He or she must show promise of ability to contribute to teaching through the provision of service (See Appendix I).

(2) At a minimum, holds a Master's degree or the equivalent.

(3) Appointed to fill a specific service. Individuals properly qualified may have patient care responsibilities and engage in research.

For individuals with M.D./D.O. or Ph.D. degrees, individual shows potential for appointment to the tenure track on the basis of promise in teaching, research and service. However, appointment to this rank does not guarantee eventual appointment to the tenure track. Individuals in this rank with appropriate qualifications are not precluded from applying for a position in the salaried clinical faculty track.

(4) Appointments at this rank are made on an annual basis. For individuals with M.D./D.O. or Ph.D. degrees the total time in this rank should not exceed three years.

c. Lecturer

(1) He or she must show promise of ability to contribute to teaching. (See Appendix I).

(2) Holds a Master's degree or the equivalent.

(3) May be actively involved in scholarly research.

(4) May be engaged in other significant professional activity. Individuals properly qualified may have patient care responsibilities.

(5) Appointments at this rank are made on an annual basis. Reappointment is not automatic, but requires departmental review of the faculty member's performance and a recommendation based upon the faculty member's performance in teaching, scholarship, and service as appropriate. The annual review process must be described in each unit's policies and procedures, and the results must be shared with the faculty member in writing. Units are encouraged to use a process similar to that described in Section IV.

4. Visiting Faculty

Visiting faculty are appointed with the same criteria as Adjunct or Nonsalaried Clinical Faculty (see I. C. 1).

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II. Procedure for Appointment

A. The procedure of appointment is as follows:

1. The position is deemed necessary by the Dean, Department Head, and the Faculty of the Department.

2. The affirmative action process of the University has been carefully satisfied at each step throughout the process.

3. After consultation with the faculty of the department concerning the best qualified person in the pool of such persons and the receipt of letters of recommendation from persons who have been invited in writing to comment by

the Department Head or his/her designee, the Department Head recommends a candidate to the Dean.

4. If the decision of the Department Head differs from the majority view of the appropriate faculty, the Head is expected to explain the reasons for the differing recommendation to the Dean and to the appropriate faculty members of the department.

5. For appointment of faculty members at the levels of Assistant Professor and above there is a second level of review at the college level. This is conducted by the elected Executive Committee of the Faculty, which is advisory to the Dean. The documents and supporting materials recommending appointment are transmitted from the Department Head to the Dean. These materials are then sent to the Executive Committee where the Officers assign each candidate's dossier to two members for detailed review. The Executive Committee meets with the Dean, discusses the candidates, seeks further information if necessary, and then advises the Dean by vote according to the procedures established in the Carver College of Medicine *Manual of Procedures*.

   After receiving the advice from the Executive Committee concerning the departmental recommendation, the Dean makes a final determination of the recommendation to be sent to the Provost along with the appropriate documentation.

   The Dean is not bound to accept the recommendation of the department or the advice of the Executive Committee. If the Dean's final decision differs from the majority opinion at any of these three levels, the Dean is expected to explain the reasons for the action to the Department Head, the Executive Committee, the Medical Council, and the Provost.

6. Following the Regents Policy on Oral Communication Competence (1/29/91), all new faculty members will be evaluated for communication skills within the first eight weeks of the assignment of teaching duties (see Appendix IX). Completion of TOEFL fulfills this requirement.

III. Joint/Secondary Appointment

The specified term of each joint/secondary appointment, the periodicity of the review, and the criteria to be applied in conducting the review must be clearly stated in writing at the time of the appointment. This document will also include: (a) a description of duties and responsibilities of the appointee in both the primary and the secondary department; (b) the financial obligations of each department; (c) factors other than quality of performance (e.g., changes in interests or programs) that may be considered in determining future status of the appointment; and (d) provision for periodic review and reappointment of the individual using guidelines similar to his or her rank.

The Collegiate process for review of a joint or secondary appointment is identical to that of a primary appointment, if the appointee is not already a member of the Collegiate faculty, but affirmative action processes have already been completed.

This document must be completed and approved by all parties (primary and secondary Department Heads, the Collegiate Deans, and the appointee) prior to the joint appointment.

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IV. Review of Faculty

All faculty members are evaluated periodically.

A. Tenure Track

1. **Probationary Tenure Track Faculty**

Probationary tenure track faculty should be reviewed annually, with the results reported by the Collegiate Dean to the Provost on the appropriate form. Initiation of the annual review is the responsibility of the Department Head. It is expected that the annual review will be performed in consultation with the individual faculty member. All probationary tenure-track faculty members must also be reviewed by the tenured departmental faculty members of higher rank during the third and sixth years of service or one year prior to the termination of the appointment period when the appointment or reappointment period is for less than three years.

2. **Tenured Associate Professors**

Individuals holding the rank of Associate Professor with tenure will be reviewed at least once every two years by the Dean and the Department Head.

3. **Tenured Professors**

To assure a faculty of optimal effectiveness and productivity, and to provide one basis for allocation of resources, tenured professors and Department Heads in the Carver College of Medicine will be reviewed periodically by their colleagues. Such reviews may be used to guide faculty to sustain productivity as their priorities and personal directions change over their career cycle. The review will evaluate performance, identify ways to improve performance if it has been less than optimal, and stimulate continued academic or administrative growth.

Tenured full professors will be reviewed at least every five years by a committee appointed by the department head. The committee may include tenured professors in the Carver College of Medicine whose primary appointments are outside the department of the reviewed faculty member as well as tenured professors in the same department. This review should include an interview with the reviewed faculty member unless waived by that faculty member. A written report of the evaluation of the teaching, scholarly, and service activities will be submitted to the department head and to the faculty member under review. The Head and the faculty member will discuss the findings of the review committee. Department heads will submit to the Dean a brief summary of the review process each year that review of tenured professors occurs, the written review report on the candidate, and the response of the Department Head to the career plan of the faculty member for the next five years (See Section IV, D, 1b).

B. **Clinical Track (Salaried)**

Members of the clinical track faculty undergo two separate types of review, academic and contract. If the academic and contract renewal reviews are scheduled for the same academic year, they may be combined into one document.

1. Academic reviews

Academic reviews are performed for the purpose of assessing the faculty member's academic achievements, progress toward promotion, and future career plans. The criteria to be assessed are those described in the appropriate rank criteria.
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All salaried clinical track faculty members at any rank should be reviewed annually during the first three years after the original appointment to the Carver College of Medicine.

Initiation of the academic review is the responsibility of the Department Head. It is expected that the review will be performed in consultation with the individual faculty member. These reviews should be performed in consultation with both the clinical track and tenured departmental faculty members of higher rank.

After the first three years of appointment, the following schedule should be followed: Assistant Professors should continue to be reviewed annually until they are promoted, or for 9 years, whichever occurs first, and after that only at the time of contract renewal. The results of these reviews should be reported by the Collegiate Dean to the Provost on the appropriate form. Associate Professors should be reviewed every two years, and Professors should be reviewed every 5 years. Reviews for Associate and Full Professor should be reported to the Dean.

2. Contract reviews

Contract reviews are performed in the final year of a contract period, and are for the purpose of determining if a new contract will be extended, and if so, for determining the length of the new contract. The criteria to be assessed are the faculty member's effectiveness in teaching and clinical service, compliance with the department's written standards of performance, and the department's need for continuation of the position. The review is conducted by the DEO, after consultation with both the clinical track and tenure track departmental faculty members of higher rank. The eligible faculty group must vote on the decision to renew. The results of all contract renewal reviews should be reported by the Department to the Collegiate Dean and to the Provost on the appropriate form.

C. Department Heads

Department heads will be reviewed concurrently with the review of their respective departments as specified in accordance with Article II, Section 4.6 and Article V, Section 5.0 in the *Manual of Procedure of the Carver College of Medicine*.

D. Materials to be Reviewed

1. Materials that must be reviewed include:

a. Current curriculum vitae and supporting documents (see below).

b. Career plan for the next five years that covers teaching, scholarship (for individuals in the tenure track), service, and professional growth.

c. Other materials the faculty member believes are relevant to the review.

d. A verifiable personal assessment of teaching, scholarship or professional productivity, as appropriate for the faculty track, and service activities since the last review, as described in D below.

e. Reports of evaluations by the faculty member's division director if the department is so organized.

f. Statement by department head that describes circumstances under which the faculty member has functioned during the reviewed period.

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2. Other materials that may be reviewed at departmental discretion include:

a. Letters of evaluation from persons at other institutions that were solicited for appointment or promotion consideration during the review period.

D. Personal Assessment

Each candidate shall prepare a document assessing his or her progress toward achieving or maintaining the standards of teaching, service, and scholarship or professional productivity appropriate for the academic rank and track (See Appendices I through VIII), together with

The Schumacher Model: Fostering Scholarship and Excellence in Nursing and for Recruiting and Grooming New Faculty

Gretchen Schumacher, PhD, CRNP; Kerry Risco, MSN, CRNP, NP-C; and Alice Conway, PhD, CRNP, BC

ABSTRACT

In 2004, U.S. nursing schools turned away 32,797 qualified nursing applicants. One contributing factor was an insufficient number of nursing faculty. Projected retirements will require nursing faculty units to work in smaller numbers and actively recruit new faculty. The Schumacher model provides a framework for fostering scholarship and excellence in nursing and for recruiting and grooming new faculty. It articulates methods for nurse educators to capitalize on each other's strengths to work together to address the current shortage. This article describes the Schumacher model, its application to mentorship among nursing faculty, and the current nursing faculty climate.

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The nursing faculty shortage directly affects the current shortage of nurses overall. With too few nursing faculty, nursing programs will not be able to educate adequate numbers of nurses. According to the American Association of Colleges of Nursing (AACN) (2005), in 2004, U.S. nursing schools turned away 32,797 qualified applicants from baccalaureate and graduate nursing programs. One of the contributing factors was an insufficient number of nursing faculty. The current shortfall in the number of nurse educators needed is 12% and the average age of doctorally and master's prepared nursing faculty is older than 50. In addition, the projected nursing faculty retirements exceed 500 in the next decade (AACN, 2005). Many nurses have been reported to leave academia due to the stress and high expectations associated with the career (Berlin & Sechrist, 2002). The expectation to be independently proficient in many aspects, including grant writing, publication, and teaching, is overwhelming to both novice and seasoned nurse educators.

In a time of a critical nurse educator shortage with statistical indication of future dwindling numbers, it is imperative that nursing faculty work smarter, not harder, and prioritize efficiency and methods to recruit and retain nurse educators. It has been said that nurses "eat their young." Both novice and seasoned faculty bring strengths to nursing education. To preserve our profession, it is time for novice and seasoned nursing faculty to celebrate each other's differences and capitalize collaboratively on individual strengths and contributions to a faculty unit. The environment needs to change to one of nurturing and caring, the essence of the profession itself.

The Schumacher Model

The Schumacher model (**Figure 1**) is a linear framework in which novice faculty and seasoned faculty work together in a circular feedback environment using each faculty member's individual gifts. The environment is founded on a shared vision and commitment to the university or institution and profession, along with trust and respect. Working together in this way, the faculty unit as a whole strategizes to break through perceived or actual barriers to the ultimate goal of fostering nursing scholarship, excellence, and faculty recruitment and development (**Figure 1**).

The model begins with the identification of novice and seasoned faculty. Novice faculty are new to the academic role or teaching setting, whereas seasoned faculty are experienced in the role and setting. Novice faculty may be younger, and seasoned faculty are probably closer to retirement, but this is not a rule. Novice faculty may or may not bring teaching experience

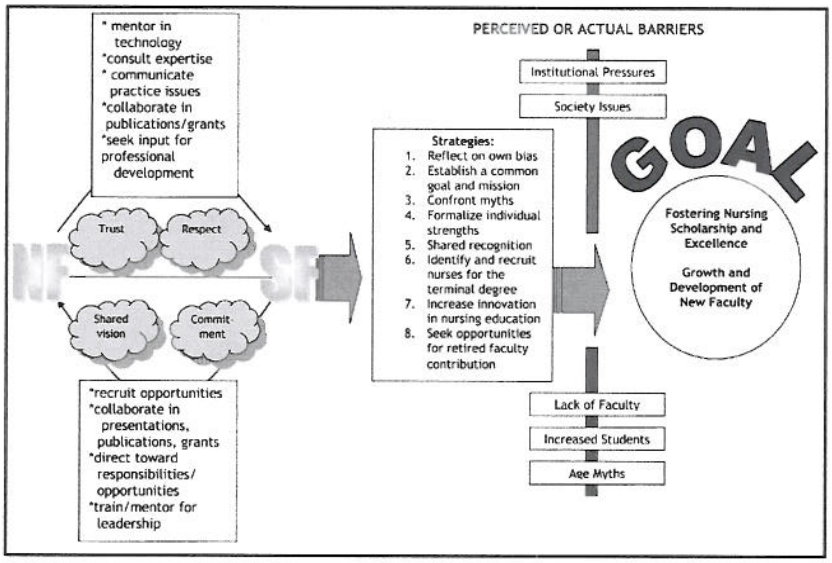

Figure 1. Schumacher nursing faculty organizational model.
Note. NF = novice faculty; SF = seasoned faculty.

or expertise to the faculty unit. It may be probable that novice faculty have recent clinical experience and will bring current practice issues to the group. Some younger generation novice faculty may also offer technological expertise. Seasoned faculty have institutional knowledge pertaining to faculty development and securing promotion and tenure. They are aware of the need for visibility within the institution, which is paramount for novice faculty. A seasoned faculty member probably possesses expertise in teaching and pedagogical approaches and may also be savvy in securing publications, presentations, and grant opportunities.

Of note, the model's success depends on the faculty unit's foundational philosophy and environment. For successful implementation, it is important for faculty to identify themselves and others in the novice and seasoned roles. The nursing faculty unit's shared vision and commitment must be written, posted, stated, and continually professed by all members. To facilitate cohesiveness, it is important to regularly reiterate the documented and posted common mission, goal, and direction of the group at meetings and in relationships. A commitment to looking at each individual for the strengths he or she brings to the whole helps the group celebrate each member's differences and reminds them of each individual's strengths.

After identifying and documenting the faculty unit's individual, institutional, professional, and global missions and goals, members must actively embrace their responsibility of commitment to the whole unit. Novice faculty are expected to consult the expertise of seasoned faculty, seek input for professional development, collaborate in publications and grants, and possibly communicate practice issues and mentor in technology. Seasoned faculty are expected to recruit and communicate professional development opportunities, assist and coauthor grants and publications with novice faculty, and train and mentor the new peers in using their strengths for leadership. Working in this way, novice and seasoned faculty capitalize on each other's strengths to break through perceived or actual barriers to scholarship, excellence, and growth and development of new faculty (**Figure 1**).

Faculty Roles and Relationships

How do faculty members know what skills they bring to the table? In its current developmental state, the Schumacher model identifies 12 essential roles necessary for fostering scholarship and excellence within a nursing faculty unit (**Figure 2**). The **Table** offers a description of the characteristics associated with each role.

The networker points other faculty and staff to beneficial connections. A faculty member proficient in this area is keenly aware of opportunities for establishing collaborative connections formally and informally. The networker gravitates to gatherings and arenas that potentially bring direct resources and opportunities to the faculty unit. The networker naturally returns from local and national meetings with substantial new reports and contacts for faculty unit developments and goal attainment.

The researcher is not only well-versed in research methods and current literature, but has a natural gift for critically analyzing and offering feedback to peer research works and agendas. The researcher is energized by using literature to guide process and is gifted in reporting findings related to individual and faculty unit goals.

The gold miner is frequently found submitting grant application after grant application with ease and is eager to point out financial resources to other members for specific individual and faculty unit projects. Typically, the gold miner is experienced in reviewing grant applications and knowledgeable about funding trends.

The light bulb is a visionary and generates directional pathways for the faculty unit's strategic plans and future directions. The light bulb is known for seeing the gaps and future potholes and generates ideas for implementation for future planning.

The techy effortlessly implements the latest teaching-learning technology. Most faculty immediately turn to the techy for a quick fix when encountering a technological problem. The techy delivers faculty development workshops helping the faculty unit's learning curve with new technologies in teaching.

The PR person is intensely aware of the faculty unit's reputation and visibility. The PR person is drawn to promoting visibility in publications

and magazines and on local and national levels, informing the world about the faculty unit's happenings.

Every successful faculty unit maintains a thriving CEO. The CEO is gifted administratively and naturally facilitates the faculty unit's missions and goals related to budget and fiscal affairs. The CEO is organized and directive and facilitates efficient and goal-oriented meetings.

The taskmaster is called when there is a need to get the job done. The taskmaster is focused, pays attention to detail, and successfully implements ideas for individuals and the faculty unit.

The ombudsman is naturally gifted and stimulated by advocacy. The ombudsman may be a good listener and allows those in need to sit and talk for hours. The ombudsman may fight and advocate with mighty strength and determination for students, peers, or the faculty unit as a whole.

The editor is specially gifted in writing styles and editorial endeavors. The editor plays a vital role in enhancing publications and scholarly works for individuals and the faculty unit.

The campaigner is energized by political dialogue and discourse. The campaigner comfortably maneuvers through political arenas and seeks involvement and visibility in the political areas related to nursing and the faculty unit institutionally, professionally, and nationally.

Finally, the philosopher has a special bent toward relating the faculty unit's goals, missions, actions, and directions toward the meaning of health and what it means to be human and caring. The philosopher actively seeks connections between the philosophical underpinnings of the institution and faculty unit and nursing foundations, theory, and practice.

One faculty member may serve the unit in more than one role; however, it is unlikely that even the most seasoned nurse educator is proficient in all roles. In this critical time, there is a need to work efficiently in potentially dwindling numbers, and nurse educators must release the need to be good at everything and instead actively identify, seek out, and use the strengths of their peers.

Perceived or Actual Goal Barriers

Faculty members using their individual gifts and capitalizing on the strengths of others must work together as a whole to break through perceived or actual barriers to the goal of fostering nursing scholarship, excellence, and growth and development of new faculty. Although each faculty unit may face other obstacles, the model recognizes five barriers to the goal:

- Institutional pressures.
- Society issues.
- Lack of faculty.
- Increased students.
- Age myths.

Institutional pressures are a barrier to the model's goal. Financial pressures and dwindling federal and state dollars for higher education often force institutions to offer low salaries and rank to fill faculty positions. This trend needs to be addressed by the entire nursing faculty. Deans and other administrators need to be educated about nursing salaries and become allies in securing better salaries for nursing faculty. The CEO, networker, or campaigner might offer to work with administration to look at ways of offering more competitive salaries, which may influence this very real barrier.

Societal issues related to the myth of doing it all need to be confronted. Faculty members have other roles and responsibilities. Those who are new mothers and fathers may need some alterations in their workload to meet new personal obligations. The same strategies may need to be considered for a seasoned faculty member who is caring for an elderly parent. Some members of the faculty unit may choose life experiences outside of work rather than working morning and night, 52 weeks per year. Efforts to avoid time commitment comparisons among faculty members are necessary to facilitate collective focus on individual and faculty unit goals. Creative scheduling and willingness to consider ways to assist each member experiencing multiple-role pressures can help the retention of valued faculty members.

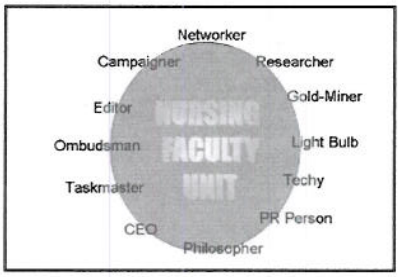

Figure 2. Individual faculty roles.

Lack of qualified faculty is another barrier. Strategies need to be developed to grow our own. Faculty hired with all but a dissertation may also require creative scheduling and peer support to complete the degree requirements. Although this may increase work by others in the short term, it becomes a win-win situation for everyone in the long run because new doctorally prepared faculty helps the university and the department meet the requirements of accrediting bodies. As faculty identify potential undergraduate students, they need to help these students consider careers in nursing education. Early mentorship of these students can produce future faculty. The ombudsman and networker are gifted to lead the faculty in this task.

Increased student numbers can be a mixed blessing. Although, as faculty, we are encouraged to foster an increase in students seeking entry into nursing, we need to make sure that these applicants will embrace the professional standards and values intrinsic to our discipline. The creation of admission procedures that facilitate this embrace should be addressed by all programs.

Another perceived or actual barrier is that of age myths. Two common age myths that need to be dispelled are the beliefs that one is too young to have enough experience to have contributory information and that one is too old to really understand what is going on in nursing. We all need to honestly reflect on our own biases regarding age. We live in a society that values youth and discards anything old, but we often do not acknowledge

TABLE

Essential Roles for Fostering Scholarship and Excellence

Faculty Role	Characteristic
Networker	Points people to the right connections; can see and articulate the benefits to both parties when helping them merge together in a common interest
Researcher	Conducts and guides research that is scholarly and excellent
Gold-miner	Writes and receives grant funding
Light bulb	Generates ideas for future directions and identifies global influences in tasks at hand; may not be a great implementer, but generates numerous ideas and provokes everybody else to think
Techy	Knowledgeable about technology (informatics, software, online modules, innovative pedagogies); provokes implementing advances in technology
PR person	Seeks publications and presentations institutionally, locally, and nationally that will bring visibility to nursing and promote career development
CEO	Serves as chair for the department or administrates the business of the stated missions and goals; manages the budget and fiscal affairs
Taskmaster	Gets the job done and quickly turns around tasks that others may place on the back burner; meets deadlines and is often ahead of them; may not create ideas, but can help implement them
Ombudsman	Advocates for students and peers in need; has a gift for listening; naturally encourages others
Editor	Attends to written details and submits written work that is scholarly; dots all I's and crosses all T's
Campaigner	Maintains a thumb on the political pulse institutionally, professionally, and nationally; seeks out opportunities for advancement; comfortably maneuvers through political arenas
Philosopher	Evaluates, articulates, and generates the faculty unit's mission, goals, and actions for congruency and relevance regarding nursing foundations, theory, and practice

that the young have insights and expertise. Novice faculty may come with great expertise that will enhance the work of the faculty and goals of the model. Seasoned faculty have expertise in not only surviving in an academic environment, but also thriving in one.

Nurse educators must develop strategies to achieve the model's goal. There will always be barriers to achieving the goal, but it is crucial at this time for nursing faculty units to proactively address those barriers. If a faculty unit is smaller, it must work toward being small but mighty by capitalizing on each individual's gifts that contribute to the whole group.

Strategies to Address Perceived and Actual Barriers

The model depicts 8 strategies for breaking through perceived or actual barriers to the goal. Faculty units should brainstorm, identify, and prioritize those strategies or additional strategies necessary for breaking through barriers. It is essential to establish a common goal and mission, both for individuals and the group as a whole. Formalizing each individual's strengths can be done by putting them in writing, visibly posting them, and frequently reviewing them. One novice faculty member may have the individual goal of completing doctoral work; another doctorally prepared faculty member may seek to establish large grant funding. Yet another member may seek to pass the torch effectively and move into retirement. As a whole, the faculty unit may set a goal of increasing visibility on campus to promote collaboration with other disciplines. Whatever the missions and goals may be, it is important for each member's individual goals and the common group goals to be identified, documented, and shared.

Another strategy for addressing barriers is to reflect on one's own bias and confront myths. Seasoned faculty should be committed to helping novice faculty meet both their professional goals and the department's needs. This can be done by formal mentoring or role modeling and includes encouraging novice faculty to serve on appropriate university committees. Conversely, novice faculty's acknowledgement of seasoned faculty's contributions to the functioning of the department's goals is a reinforcing positive strategy for all.

Faculty also need to identify and recruit nurses for terminal degrees. Nursing faculty should actively seek out students with advanced or terminal degree potential and point them in the direction of opportunities. They should be mentored into programs that will help them attain the advanced or terminal degree in the most expeditious way. Nursing faculty should take the role of guidance counselor or career counselor as they steer students into settings with the greatest number of opportunities for growth.

Another strategy for goal attainment is sharing recognition. Novice and seasoned faculty need to pair together in projects, presentations, and publications, with each individual

sharing the recognition. Often, an idea leads to a presentation and later, to publication. Sharing the position of first author, placing one person first on the presentation and another first on the publication, brings first author recognition to each contributor. This is particularly relevant in a tenure and promotion setting. A faculty unit is stronger when more members are tenured and promoted. Using all opportunities to develop each faculty member's reappointment or promotion materials will lead to benefits for the entire faculty unit. In addition, full-professor faculty can decline first authorship and help novice faculty complete presentations and publications and promote the novice faculty as first author.

Nurse educators should strategize by seeking opportunities for retired faculty to contribute to the goal of fostering scholarship, excellence, and growth and development of new faculty. Retired faculty are often an unused resource. Bringing back retired faculty for special projects, teaching a course, or guest lecturing can capitalize on a resource often overlooked, ignored, or discarded. Helping with manuscript development, grant writing, or curriculum revision and development are some activities at which retired faculty excel. Fostering emeritus status for retired faculty often keeps them involved and is another win-win situation. We need to capitalize on this resource in facing the nursing faculty shortage.

Innovation in nursing education is critical if faculty are to help students to develop critical thinking skills. Forcing more information into an already packed curriculum does not foster critical thinking, nor does it prepare our graduates for the ever-changing and uncertain work environment. Helping faculty to help students learn new strategies to foster critical thinking is essential. These strategies can include the use of art museums, poetry, and story telling to teach physical assessment skills and concept mapping, or the use of the 1-minute case study. Establishing an environment that cultivates innovation is also part of the faculty's commitment to meeting the goal of the model.

The Schumacher Model as a Guide for Mentorship

Mentoring is relevant across the entire career continuum of an educator and encompasses orientation to the faculty role; socialization to the academic community; development of teaching, research, and service skills; and facilitation of the growth of future leaders in nursing and nursing education (National League for Nursing, 2006). The Schumacher model provides a framework for a one-on-one mentorship relationship and also mentorship of new faculty provided by the entire faculty unit.

In a mentorship relationship between novice and seasoned faculty, the Schumacher model can be used to identify and publicize the specific gifts novice faculty add to the faculty unit. The model encourages novice faculty to actively share expertise and seek input from both individual mentors and entire faculty units as mentor. When a faculty unit has identified the specific strengths all individuals contribute, new educators possess a list of individuals who serve as specific resources to help them meet career objectives in teaching, excellence, and scholarship. In addition, the Schumacher model can help seasoned faculty mentors begin a working relationship with new faculty. Discussion related to documented-shared vision, trust, respect, and commitment provides unified underpinnings for the mentorship relationship. Finally, the Schumacher model offers a stated and unified goal of fostering scholarship and excellence for the mentorship relationship. The new faculty member and protégé can work backward from the model's goals of fostering scholarship and excellence to identify which are the most influential barriers for the new faculty member and then prioritize the strategies needed to address them. Mentors and novice faculty can then collaborate regarding which specific actions are most important for promoting new faculty's success.

Conclusion

At a time when nursing academia is experiencing a severe shortage of faculty, it is imperative that steps be taken to work more efficiently and to retain new faculty. The Schumacher model provides the framework for relationships between novice and seasoned faculty to help them work together toward fostering excellence in nursing education by capitalizing on each individual's specific strengths for both individual and faculty unit goal achievement. The Schumacher model may also be used to guide an established mentorship relationship between novice faculty and seasoned faculty or a novice faculty member and an entire faculty unit.

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Nursing Education Research—How to Use It to Build Your Promotion and Tenure Case

Research tends to be the first criterion that comes to mind as a requirement for achieving promotion and tenure in academia. Traditionally, the kind of research necessary for promotion and tenure in many higher education institutions has been primary nursing research (e.g., nursing phenomena, nursing interventions, nursing administration). This can be particularly true of institutions classified as high or very high in research intensity according to the Carnegie Foundation for the Advancement of Teaching (2007b).

Educational research had previously been reserved for faculty who teach in schools of education; however, with growing internal and external demands for the demonstration of teaching efficacy, schools in the arts and sciences have become more engaged in studying the outcomes of pedagogies implemented in their respective disciplines. Nursing education, as a discipline, has been a leader in the study of educational strategies—this is evidenced by the proliferation of journals publishing nursing educational research over the past 2 decades.

Along with the emergence of nursing education research is the scholarship of teaching and learning initiative, also promoted by The Carnegie Foundation for the Advancement of Teaching (2007a). Defined (Thompson, 2001), the *scholarship of teaching and learning* refers to the engagement in systematic assessments and evidence gathering to investigate the effectiveness of specific teaching strategies. Key features of the scholarship of teaching and learning involve using data for informing future teaching, using peer review, and submitting scholarship of teaching and learning work in a public forum (Pace, 2004).

There are similarities between nursing education research and scholarship of teaching and learning initiatives—systematic inquiry and the intent to make work available for peer review. The key difference is that nursing education research obligates researchers to develop or contribute to a generalizable knowledge (Office of Human Subjects Research, National Institutes of Health, 2005). In this sense, the scholarship of teaching and learning serves as an umbrella term that includes a broad range of teaching inquiry methods, including nursing education research.

So how can a program of nursing educational research become a basis for promotion and tenure? For research-intensive universities, building a promotion and tenure case along the lines of nursing education research can be a tenuous process. Part of the reason nursing education research may not count as a program of research is the general lack of large grants for such research. Before a nursing education research program is presented as a case for promotion and tenure, faculty members must determine whether their peers, department, and university are agreeable to a promotion and tenure case on the basis of this kind of research. In some cases, a department may accept a nursing education research program as fully satisfying promotion and tenure requirements, whereas in other departments, educational research may be one part of the dossier that also contains another research program directly related to advancing nursing practice or clinical outcomes. Therefore, it is incumbent on the faculty member to determine the expectations of the department and university from the outset when building a promotion and tenure dossier related to nursing education research.

There are ways to extend a nursing education research program to one that advances either nursing practice or clinical outcomes in addition to student outcomes. Service-learning, which involves designing a mutually agreeable program that benefits both students and the community, is a key example. Because service-learning involves both student and community benefit, each benefit is amenable to a separate program of research. In another example, systematic investigation of clinical decision making models may be tested in student clinical settings, as well as in nursing practice settings.

Finding an institution that fits your passion is critical to your success. If an institution does not value nursing education research, it is unlikely that support (infrastructure) and reward systems will be available to you—clearly, this would result in an unfulfilling professional career. Using resources dedicated to the promotion of nursing education, such as the National League for Nursing and the American Association of Colleges of Nursing, will help you find the right institution for you.

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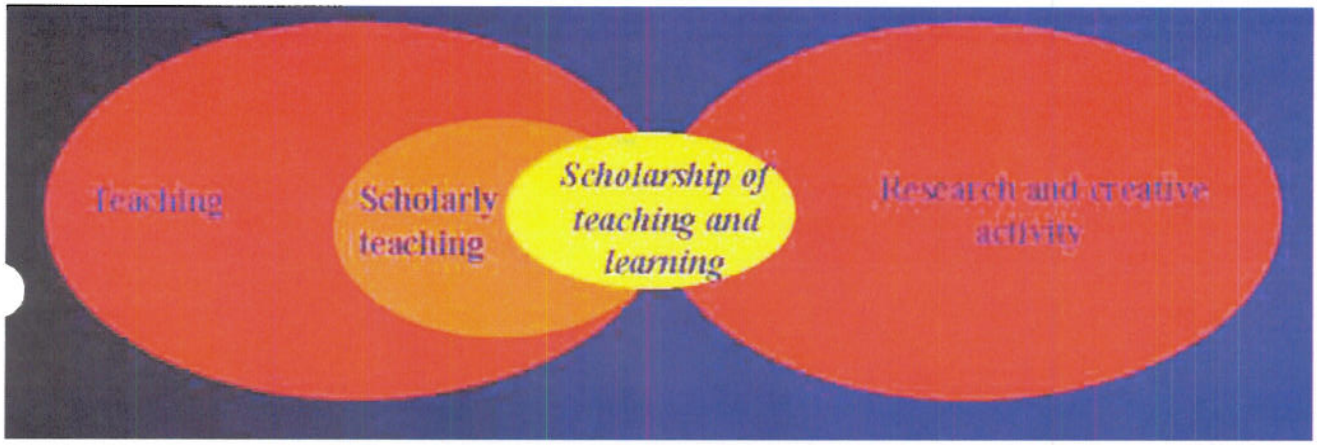
SOTL as Academic Activity vs. Campus Initiative

Distinction between scholarship of teaching and learning as a domain of academic activity and as a campus program:

-SOTL as academic activity (yellow ellipse)
-SOTL as a campus program can span all teaching-related activities (leftmost three ellipses).

A SOTL program provides support to faculty for movement toward the yellow ellipse; that is momement in their teaching-related activities toward the right and movement in their research-related activities toward the left.



Into what realm beyond teaching does scholarship of teaching extend? The rightmost ellipse is the set of points representing deeds that scholars perform in the name of research and creative activity. Though research-based activity to advance knowledge is the prevailing notion of scholarship, *scholarship is not precisely synonymous with research* .

Walker discussing idea that scholarship is not synonymous with research.

Scholarship is reflective and creative. It can result from reflecting on the processes and outcomes of research or personal teaching experience and creating something new.

Boyer's notion that scholarship of teaching and learning

In other words, a SOTL initiative may include all teaching related activities of faculty. Thusly conceived, a SOTL initiative can provide a resource-rich and opportunity-laden home to faculty members who aspire SIMPLY to teach excellently as well as to those who perceive themselves primarily as scholars (i.e."researchers"). In fact, there is evidence that faculty who have not been

spans the "tired teaching vs. research debate" is naturally depicted in the position of the yellow ellipse (with italicized text) between the two big red ellipses.

We can distinguish between SOTL as an academic activity and as a campus initiative.

Walker discussing SOTL as an academic activity.

As an academic activity, what scholarship of teaching and learning means in your institution defines the boundary of the yellow ellipse. As a campus initiative, what SOTL means may encompass the entire 3 leftmost ellipses.

attracted to previous teaching improvement initiatives can be attracted to a SOTL initiative because of its research orientation. This phenomenon may be visualized in the diagram as faculty converging to SOTL not only from the big red ellipse on the left but also from the one on the right.

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Title:	Evidence for promotion of nontenured faculty.
Authors:	Sorrell JM; Cangelosi PR; Black PL; Bunty K; Filak C; Hobbs DL; Sookratree M
Affiliation:	Professor, School of Nursing, George Mason University, Fairfax, Virginia, Jsorrell@gmu.edu
Source:	Nurse Educator (NURSE EDUC), 2008 Nov-Dec; 33(6): 263-7 (18 ref)
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Major Subjects:	Faculty, Nursing Promotion and Tenure
Minor Subjects:	Goals and Objectives; Research, Nursing; Scholarship; Schools, Nursing -- Virginia; Virginia
Abstract:	An increasing number of faculty members are choosing the nontenured path in academia. These faculty members bring expertise in teaching that must be recognized and valued. With the shortage of nurse educators, procedures to attract and retain these faculty members are needed. To address this problem, guidelines for promotion of nontenured facility were developed. The authors describe the development process and the final criteria for promotion.
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Determinants of tenure in allied health and nursing education

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Determinants of tenure in allied health and nursing education

Aim. This paper presents a prospective cross-sectional study that investigated the tenure rate and the primary criterion use in granting tenure in nursing and allied health education in the United States of America.

Background. Given the recent trend by highly skilled professionals to seek employment in other countries, a clear understanding of the conditions of service in higher education is important to educators contemplating the relocating to another country. The preponderance of the published literature on academic tenure is from the United States of America, where educators continue to debate the value of the tenure system and the criteria to be used in tenure decisions.

Method. We surveyed the deans of National League for Nursing accredited programmes ($n = 187$) and deans of allied health programmes belonging to the association of schools of allied health professions ($n = 75$) in the United States of America. The questionnaire sought demographic and institution-related information, tenure rate and weightings attached to teaching, scholarship and service in tenure decision. The data were collected in 2002.

Findings. Allied health and nursing educators had 47% and 35% tenure rates, respectively. The overwhelming majority of the deans in our study, 77%, ranked teaching as the primary criterion used in tenure decisions in their institutions. On the other hand, fewer than 25% rated scholarship and fewer than 5% rated service as the most important criterion used for tenure in their institution. The responses of the deans were modulated by the type and ownership of the institution in which they were employed and the characteristics of the educators.

Conclusion. The implications for preparing future educators in the United States of America for long-term careers in allied health and nursing professions are that: (1) teaching is less highly valued in research-oriented universities; and (2) heavy teaching workloads may be detrimental to the chances of obtaining tenure. Replication of the study in other countries would have the potential to facilitate the employment mobility and educator exchange.

Keywords: health education, multidisciplinary education, nurse education, questionnaire, survey, tenure, United States of America

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Introduction

The world is increasingly becoming a global village, with many highly skilled professionals in recent years crossing national boundaries in search of better opportunities in other parts of the world. The alluring destination for such emigration has been countries in Europe, Australia, Canada and the United States of America (USA). For educators planning to relocate to another country for better career opportunities, it is important to be familiar with the educational system and conditions of employment in the institution of higher learning around the world.

Academic appointment contracts in higher education often specifies among other things the academic status, salary and benefits, requirements for retention, criteria for promotion and tenure. The concept of tenure in academia is unknown or poorly understood in different parts of the world (Walker *et al.*, 1983). Academic tenure represents the expectation of continued employment conferred on an educator working for a certain number of years on probationary status. Promotion and tenure are usually discussed together in the literature, but they constitute two independent events that may or may not occur simultaneously depending on the institution.

Tenure is the expectation of continued employment conferred on an educator working for a certain number of years on probationary status and is generally linked to academic freedom and property rights of the individual concerned. Promotion serves as a reward for past accomplishments that convey distinctions among academic ranks. Tenure represents the vital and long-term contributions of the educator to the institution, and it is conferred upon attaining the rank of associate professor or higher status. In the USA, tenure is usually earned through a rigourous evaluation process and not granted automatically. Academic tenure is different from the employment 'protection', which is provided in British and New Zealand universities.

In the USA, the traditional criteria used for granting tenure in academia are categorized into three broad domains: scholarship, teaching and service. *Teaching* is traditionally considered the primary duty of educators. *Scholarship* represents publication of research findings in peer-refereed journals, presentation of research in scientific fora, authorship of books/chapters and submission of grant proposals. *Service* is the contribution to the development of the department/college and the institution at large, as well as professional/community organizations and government agencies. In both nursing and allied disciplines, scholarship is increasingly becoming a highly valued activity considered for tenure (Flanigan *et al.* 1988, Holcomb *et al.* 1990, Melland 1995, Angstadt *et al.* 1998, Akroyd *et al.* 2001).

In the USA, many institutions of higher learnings are consolidating and restructuring allied health and nursing disciplines into the same college or division. This change is being made because of economic reasons and perceived similarities between nursing and allied health professions (AHPs). Allied health and nursing disciplines share a similar history as 'helping professions' that moved their education from hospital settings into universities milieu. These disciplines, in earlier years, awarded certificates, associate degrees and later baccalaureate degrees to their graduates. Over the years, the number of institutions offering the doctoral degrees in nursing has grown from zero prior to 1951 to 87 in 2005 (http://www.aacn.nche.edu/education/doctoral.htm). There are growing numbers of postdoctoral research opportunities, which are designed to produce the next generation of nursing scholars and advance the quality of nursing care. Some allied health disciplines such as physiotherapy, occupational therapy, speech and language therapy and audiology are moving to an entry-level doctoral degree qualification. However, the overwhelming majority of the allied health disciplines have no doctoral programme.

Despite the similarities between AHPs and nursing, there are obvious differences. Nursing is a more homogeneous group; on the other hand, AHPs are more diverse with over 200 specialty disciplines with varying levels of education leading to the award of a certificate, an associate degree, a baccalaureate degree, a master's degree, a doctoral degree or postbaccalaureate training in a science relating to healthcare (http://www.bhpr.hrsa.gov). In academia, both nursing and allied health disciplines continue to face similar challenges with respect to the policies and practices surrounding tenure.

Background

Following an exhaustive search of the literature on the MEDLINE and CINAHL data bases by using the terms 'tenure', 'allied health' and 'nursing', we found several published studies that shed light on the tenure system, but the preponderance of these was from the USA. To obtain a global perspectives, we used the Google search engine. This produced large numbers of 'hits', but the articles were primarily from the lay press and were promotional stories, which lacked the rigour required by peer-reviewed journals. Only articles published in peer-reviewed journals were cited in this study.

We expanded the scope of our literature review to include other disciplines by consulting other search engines (Eric, PsycInfo and Faculty Development) by using the terms, 'tenure', 'academic appointment', 'faculty contract', 'confirmation of appointment' and 'foreign'. We obtained limited

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'hits' from these searches, and the articles were limited in scope and predominantly essays (non-evidence-based manuscripts) on tenure legislation, historical reviews and critiques of the usefulness of the tenure system in academia. The identified articles were from Britain (Dnes & Seaton 2001), Canada (Campbell 1986, O'Neill & Sachs 1994, Hum 1998), Australia (Allen 1988, William 1989, Moses 1990), Italy (Biggins 2005), and Germany (Abbot 1999).

Dnes and Seaton (2001) examined the impact of academic tenure on the performance of educators in the United Kingdom. They found that the 1988 Education Reform Act, which was designed to soften (but not remove) the tenure, has not had the adverse effect on efficiency that was predicted by many educators.

Campbell (1986) reviewed the history of judicial/arbitral review of decision-making, confidentiality and the function of tenure and promotion in institutions of higher learning in Canada. O'Neill and Sachs (1994) investigated the relative importance of refereed and non-refereed publications in tenure and promotion decisions at 26 English-speaking Canadian institutions of higher learning. Their findings revealed that publication in refereed journals was statistically significantly more important than publication in non-referred journals in tenure and promotion decisions. Hum (1998) published a monograph that compared the tenure, promotion, hiring practices, wage structure and incentive structures at Canada universities with the process in Germany. The monograph discussed the need for major educational reforms and the implications of such a reform on the Canadian higher educational system.

Moses (1990) examined differences in the use of performance indicators (number of publications, research grants and number of doctoral graduates) in four disciplines (chemistry, engineering, English and law) at Australian universities. He found that the use of these performance measures have a negative impact in the Humanities. In a literature review paper, Allen (1988) discussed the procedures for promotion and tenure in Australian institutions of higher learning from the view point of costs, declining recruitment, federal restrictions and legislation. The author shed light on the increasingly uneven distribution of appointment ranks across the age spectrum of educators in Australian universities.

In another review article, William (1989) described the condition of service of educators at an Australian university focusing among other things on academic ranks and promotion and tenure criteria. The report addressed institutional governance and policy on sabbatical leave, conditions of service and remuneration for the different academic cadres and the status of educators in the community.

Abbot (1999) critiqued the proposal of the German university rectors to create short-term appointments with a view to lowering the age at which lecturers could be tenured. The author offered an alternative model to the previous (long-term appointment) system for tenure and discussed the advantages and disadvantages of both the old and new systems of granting academic appointments in German universities.

In a recently published article, Biggins (2005) discussed the legislation enacted by the Italian parliament to eliminate by 2013 the tenure-track position introduced in 1980. The new legislation granted universities in Italy the autonomy to embark on contract research projects and make *ad hoc* academic appointments. Although this autonomy was well received within the academic community, the long-term impact remains unknown given the infancy of the legislation.

There is no national (federal) legislation on academic tenure in the USA because education is a free enterprise venture, subject to regulation by local (state, county or city) governments. Public and private institutions of higher learning exist side by side and many local governments have enacted legislation that has curtailed or eliminated the basic tenets of the tenure system in public universities. Educators in the USA have over the years debated the value of the tenure system and the primary criterion used in tenure decisions (Perry 1982, Conine *et al.* 1985, Kruger & Washburn 1987, Messmer 1989, 1991, Moore 1989, O'pt Holt 1991, Sullivan 1996, Gropper 1998, Balogun *et al.* 2006).

The rate of tenure for AHP and nursing educators in comparison to other disciplines is unknown. However, it is often speculated that the tenure rate for AHP and nursing educators is generally low compared with other disciplines. For example, Walker *et al.* (1983) investigated the personal characteristics, educational and professional activities of physiotherapy educators in Australia, Britain, New Zealand, Nigeria and South Africa. They found that tenure was held by 45% of the study participants in five countries. Only 36% of the samples have publication experience, while 61% have made presentations at national or international conferences.

O'pt Holt (1991) assessed the tenure policies and tenure rate in the USA and found that only 36% of allied health educators are tenured, compared with 58% for other disciplines. In another US study, Waller *et al.* (1990) found that 50% of laboratory science educators are nationally tenured. In a contradictory finding to the earlier studies, Gropper (1998) found that the tenure rate for the USA nursing educators ranged from 80% to 92% (mean = 89%), depending on the type and mission of the institution. Research-oriented private universities had the highest tenure rate at 95%.

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In a more recent study, Pohl *et al.* (2002) found that only 37% of nursing educators in the USA were tenured. The predictors of tenure included the clinical competence and institutional support for clinical practice. The tenure rate for allied health educators was statistically and significantly higher than for nursing educators. The low tenure rate reported in the last 5 years for allied health and nursing educators is often attributed to their underperformance in the scholarship domain.

Moore (1989) surveyed educators in five disciplines (physics, psychology, sociology, nursing and management) in the selected USA universities to assess their perceptions on tenure decisions. The educators believed that there were many influencing factors, but achievement criteria were identified by members of all disciplines as the most important determinants used.

Given the shortage of qualified educators in both nursing and AHPs (http://www.bhpr.hrsa.gov), having a clear idea of the tenure rate is important to new educators entering higher education. Similarly, as a result of recent trends among educators to seek employment in other countries, it is important for an individual planning to relocate to another country to understand the conditions of service in higher education in the host country. An investigation of the primary criterion used in granting tenure in nursing and allied health education is therefore urgently needed.

The study

Aims

The aims of the study were to: (1) determine the proportion of nursing and allied health educators who are tenured, (2) identify the primary criterion most highly valued in tenure decisions in nursing and allied health education. We hypothesized that: (1) the tenure rate for nursing and allied health educators would be comparable, (2) productivity in the scholarship domain would be more valued than teaching and service in tenure decisions in nursing and AHPs.

Design

A prospective cross-sectional design was adopted, using a questionnaire survey. The data were collected in 2002.

Participants

Five hundred and sixty-two nursing deans and 110 allied health deans employed in various institutions throughout the USA were contacted to participate in this project. Of the 562 nursing deans contacted, 187 completed the questionnaire, representing a 33% response rate. Of the 110 allied health deans contacted, 75 completed the questionnaire, representing a response rate of 68%. Allied health deans comprised 29% of the sample and nursing deans represented 71% of the sample. A combined total of 262 deans responded to the survey. The overwhelming majority (82%) of the deans were females; only 18% were males. The age of the deans ranges from 34 to 74 years (mean = 54·4, SD = 6·2 years) and their years of experience as dean ranges from 1 to 31 years (mean = 7·6, SD = 6·4 years).

Questionnaire

We designed a questionnaire that sought demographic and institution-related information as well as the criteria used for tenure. The initial draft of the questionnaire was reviewed by a panel of experts to ascertain its face and content validity. The panel consisted of three nursing, three allied health educators and three administrators (two deans and programme director). The educators' teaching experience ranged from 5 to 20 years, and the administrators' work experience ranged from 6 to 12 years. As a result, the clarity of the questionnaire improved.

The questionnaire contained open-ended questions on items such as age, number of years of experience as dean, number of undergraduate students, number of graduate students, number of full- and part-time educators, number of tenured educators, number of educators on tenure track and clinical track appointments. In addition, the questionnaire contained closed-ended questions on matters such as: gender; type of institution (research, doctorate-granting, comprehensive and liberal arts); ownership of institution (private, public and state-related); percentage of tenured educators (tenure rate); percentage of educators on tenure track and clinical track appointments. Respondents were asked to rate from the highest to the lowest the decision criteria (teaching, scholarship and service) used for tenure in their institutions.

Data collection

The research questionnaire was accompanied by a covering letter stating the purpose of the study and requesting the cooperation of the deans in completing it. Participants were assured of the confidentiality of all information provided. To improve the response rate, a self-addressed stamped envelope was enclosed with each questionnaire. A month later, a reminder letter and another questionnaire were mailed to those who did not respond to the first mailing.

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Ethical considerations

The study was approved by a university ethics review board, and return of a completed questionnaire was taken as consent to participate.

Data analysis

The data were analysed by using the STAT VIEW 513+ statistical software and the Web Calculator developed by Georgetown Linguistics. Institutional and participant profile data were analysed by using descriptive and inferential statistics. Pearson's product moment correlation coefficients were calculated to establish the relationship between tenure rate and selected-dependent variables. Multiple and stepwise regression models were used to determine the contribution of the dependent variables towards the tenure rate (criteria variable). The tolerance level was set at a probability of 0·01 ($F > 4·00$).

We ascertained statistically significant differences between groups for ratio data with a Bonferroni's adjusted Student's *t*-test and ANOVA. For the ANOVA, statistically significant main effects were probed with Scheffe's *post hoc* comparison test. The Scheffe means group comparison test uses the *F*-sampling distribution and, similar to ANOVA, is robust concerning non-normality and heterogeneity of variance. We explored statistically significant difference between groups for all categorical data with chi-squared tests. Statistical significance level was fixed at 0·05.

Results

Profiles of study participants and institutional characteristics

The profile of the institution where the deans were employed is presented in Table 1.

We found statistically significant differences in the responses of the allied health and nursing deans according to type of institution ($\chi^2 = 46·581$, d.f. = 3, $P = 0·001$) and ownership of the institution ($\chi^2 = 14·521$, d.f. = 2, $P = 0·001$) at which they were employed. The majority of allied health deans were employed in research and doctorate-granting institutions. However, the majority of the nursing deans were employed in comprehensive and liberal arts institutions. Statistically significant differences were found between the characteristics of the educators in nursing and allied health disciplines (Table 2).

Compared with the nursing deans, allied health deans reported statistically and significantly higher numbers of undergraduate ($t = 5·408$, $P = 0·001$) and graduate ($t = 9·049$, $P = 0·001$) students in their institutions (Table 2). Similarly, allied health deans reported higher number of full- ($t = 8·006$, $P = 0·001$) and part-time ($t = 5·947$, $P = 0·001$) educators than nursing deans.

Table 1 Profile of the institution at which the deans were employed

	Allied health deans (%)	Nursing deans (%)	χ^2
Type of institution			
Research	38	17	46·581*
Doctorate-granting	25	11	
Comprehensive	36	35	
Liberal arts	1	36	
Ownership of institution			
Private	24	50	14·521**
Public	69	45	
State-related	7	5	
Is the faculty in your institution unionized?			
Yes	19	21	0·125 NS
No	81	79	

NS = $P > 0·05$, *$P < 0·01$, **$P < 0·001$.

Tenure rate

The tenure rate for allied health educators was statistically and significantly higher ($t = 3·436$, $P = 0·001$) than for nursing educators. More allied health educators had tenure track appointments than nursing educators ($t = 2·852$, $P = 0·05$). The teaching workload (contact hours/week) for nursing educators was statistically and significantly higher ($t = 4·101$, $P = 0·001$) than that of allied health educators.

Primary criterion for tenure

The overwhelming majority of allied health and nursing deans, 77%, ranked teaching as the primary criterion used in tenure decision in their institutions. On the other hand, fewer than 23% rated scholarship as the most important criterion used for tenure. Only 1% of allied health deans and 4% of nursing deans considered service as the most important criterion used in tenure decision.

A priori analyses

To shed further light on some of the findings, we performed several additional *a priori* analyses to explore the influence of institution type (research, doctorate-granting, comprehensive and liberal arts) and ownership of institution (private, public and state-related) on tenure rate. The summary of the three

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Table 2 Educators and student profiles of the college at which the deans were employed

Dependent variable	Allied health deans		Nursing deans		
	Range (Min–Max)	Mean (SD)	Range (Min–Max)	Mean (SD)	*t*-calculated
Enrollment data					
Number of undergraduate students enrolled	35–20,000	1233 (2467)	15–2,000	249 (244)	5·408**
Number of graduate students enrolled	0–2,000	299 (337)	0–400	60 (81)	9·049**
Total number of students	35–20,000	1544 (2499)	15–2,000	309 (288)	81·693**
Faculty characteristics					
Number of full-time faculty	7–720	93 (123)	3–85	20·0 (14)	8·006**
Number of part-time faculty	0–570	54 (100)	0–100	10 (14)	5·947**
% of educators tenured	0–90	46·6 (24·2)	0–90	35·2 (24·3)	3·436*
% of educators on tenure-track	0–100	60 (35)	0–100	47 (34)	2·852*
% of educators on clinical-track	0–100	18 (20)	0–98	22 (25)	1·260 NS
Educators teaching work load (contact hours/week)	3–30	13 (6)	2–45	16 (6)	4·101**

NS = $P > 0.05$, *$P < 0.01$, **$P < 0.001$.
Mean (SD) = Mean (SD); % = Percentage.

(ownership of institution) by four (type of institution) ANOVA for tenure rate is presented in Table 3. The two factor ANOVA revealed a statistically significant *F*-ratio for ownership of institution main effect ($F = 6.241$, $P = 0.0132$), but not for type of institution ($F = 0.344$, $P = 0.7096$) or the interaction effects ($F = 0.745$, $P = 0.5908$). The result of the Scheffe *post hoc* analysis of the main effect showed that the tenure rate in public institutions was statistically and significantly higher ($P < 0.05$) than in private institutions.

Although not a part of the research objectives for our study, *a priori* analyses were done to explore the link between tenure rate and selected-dependent variables (Table 4). The findings revealed a weak but statistically significant positive correlation between tenure rate and number of undergraduate students ($r = 0.216$, $P < 0.05$), total student population ($r = 0.218$, $P < 0.05$) and percentage of full-time educators on tenure track appointments ($r = 0.256$, $P < 0.01$). A negative but weak link between tenure rate and teaching workload ($r = -0.13$, $P > 0.05$) was obtained.

Further analyses were performed to determine the combined and relative contribution of the selected variables towards prediction of tenure rate (Table 5). The multiple regression analysis revealed that the eight-dependent variables combined contributed statistically and significantly to the prediction of tenure rate ($F = 3.867$, $P < 0.0003$). However, the dependent variables combined contributed only 16·3% to the variance in tenure rate.

The stepwise regression analysis revealed that only four of the eight selected-dependent variables contributed statistically and significantly to the prediction of tenure rate (Table 5). The percentage of educators on tenure track appointments contributed 6·8% of the variance; number of undergraduate students accounted for 3% of the variance;

Table 3 Summary of the two factor ANOVA for tenure rate

Source	d.f.	SSQ	MS	*F*-test	*P* value
Ownership of institution (A)	1	3588·6	3588·6	6·241	0·0132
Type of institution (B)	2	395·1	197·5	0·344	0·7096
Interaction effect (A × B)	5	2140·6	428·1	0·745	0·5908
Error	221	127065·8	575·0		

	Type of institution				
Ownership of Institution	Research	Doctorate-granting	Comprehensive	Liberal arts	Total
Private	38 (10)	27 (13)	32 (21)	30 (15)	31 (89)
Public	44 (10)	41 (23)	48 (57)	35 (10)	44 (128)
State-related	36 (7)	– (0)	52 (5)	56 (3)	46 (15)
Total	41·6 (55)	35·9 (36)	44·1 (83)	32·3 (58)	39·3 (232)

Average tenure rate in percentage (%) by type and ownership of institution and sample size indicated in parenthesis in each cell.

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Table 4 Relationship between tenure rate and selected-dependent variables

Dependent variable	Tenure rate, Pearson's product moment correlation coefficient (r)
Enrollment data	
Number of undergraduate students	0·216*
Number of graduate students	0·074 NS
Total number of students	0·218*
Staff Characteristics	
Number of full-time staff	0·095 NS
Number of part-time staff	0·081 NS
Percentage of staff on tenure track	0·256**
Percentage of staff on clinical track	−0·177 NS
Staff teaching workload	−0·130 NS

NS = $P > 0{\cdot}05$, *$P < 0{\cdot}05$, **$P < 0{\cdot}01$.

Table 5 Summary of stepwise regression analysis for tenure rate, showing changes in multiple regression coefficient (r) and coefficient of determination (R^2) with addition of different variables

Stages of analysis	r	R^2	R^2 change	F
Percentage of staff on tenure track	0·262	0·068	0·068	12·205
Number of undergraduate students	0·313	0·098	0·030	8·929
Staff-teaching workload	0·350	0·123	0·025	7·642
Percentage of staff on clinical track	0·387	0·150	0·027	7·198
All eight variables	0·404	0·163	–	

teaching workload and percentage of educators on clinical track contributed 2·5% and 2·7% of the variance.

Discussion

Tenure rate

The trend among highly skilled professionals to seek employment in other countries that offer the possibility of more rewarding career opportunities as well as upward social mobility has increased in recent years. For educators contemplating such relocation, a clear understanding of the differences in conditions of service and prospects for promotion and tenure is essential. Our study was designed to provide empirical data on the conditions of service for nursing and allied health educators in the USA. Specifically, we determined the proportion of nursing and allied health educators in the USA who are tenured. We hypothesized that the majority of nursing and allied health educators would be tenured. Paradoxically, we found that only 35% of nursing educators were tenured, while allied health educators had a tenure rate of 47%.

The 47% tenure rate for allied health programmes in our study is slightly higher than that reported in previous studies (O'pt Holt 1991, Pohl *et al.* 2002). O'pt Holt (1991) reported a 35·5% tenure rate for allied health educators, while Pohl *et al.* (2002) reported a rate of 37% for practising the nursing educators. The 47% tenure rate obtained in our study for allied health educators is consistent with the findings of Waller *et al.* (1998), who reported a rate of 50% for clinical laboratory science educators. Similarly, our tenure rate is similar to the 45% reported by Walker *et al.* (1983) for physiotherapy educators in five countries around the world. Based on our results, it is reasonable to speculate that, as more allied health and nursing educators in the USA earn doctoral degrees and become more involved with research, the tenure rate in both fields will increase and their institutions' policies for tenure will more closely conform to those of other disciplines.

The results of the *a priori* analyses shed light on the influence of institution type and ownership on tenure rate. The two-factor ANOVA revealed that the tenure rate in public institutions was statistically and significantly higher than in private institutions. Our findings suggest that allied health and nursing educators relocating to the USA may wish to select their place of employment by matching their individual academic strengths in teaching, scholarship and service with the mission (type and ownership) of the host institution. This recommendation should be treated with caution, however, because of the unequal representation of deans from the two disciplines: 187 nursing deans as against 75 allied health deans. There was a limited number of deans from liberal arts institutions; only 15 were from liberal arts institution when compared with 128 and 89 from public and private institutions, respectively (Table 3). It is conceivable that the value systems and attitudes of deans from private and public institutions towards tenure might be different from that of those in state-related institutions.

In the USA, institutions with tenure systems are increasingly faced with the need to reconsider the criteria used to award tenure (Gignac *et al.* 2000, Balogun & Sloan 2006). The result of the *a priori* analyses was helpful in understanding the factors that may determine the award of tenure. We obtained a weak negative correlation between tenure rate and teaching workload. This suggests that heavy teaching workload may be detrimental to the chances for obtaining tenure, and poses a dilemma for many allied health and nursing educators who have high classroom/clinical teaching workloads and have not been socialized for academic survival. However, given the

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tenuous correlation coefficients obtained in our study, the findings should be interpreted with caution.

The stepwise regression revealed that the percentage of educators on a tenure track accounted for 6·8% of the variance in tenure rate; number of undergraduate students accounted for 3% of the variance; teaching workload accounted for 2·5% of the variance; and percentage of educators on clinical track accounted for 2·7% of the variance in tenure rate. Although the *a priori* analysis revealed that tenure rate can be reliably predicted from the eight selected variables in our study, the low coefficient of determination (16·3%) obtained suggests the need to investigate other plausible factors that are predictive of tenure in allied health and nursing education.

Primary criterion for tenure

Our findings on the most important factor considered for tenure is discordant with previous studies (Baird *et al.* 1985, Conine *et al.* 1985). Baird *et al.* (1985) reported that scholarship was considered highly important for tenure by 50% of the nursing schools surveyed. Conine *et al.* (1985) found that the most important predictor of career advancement in allied health was scholarship, even though educators preferred teaching. As we demonstrated, teaching was valued more than scholarship and service activities in the tenure-granting process for allied health and nursing educators. This is inconsistent with the core values used in awarding tenure in the medical and dental professions (Adderly-Kelly 2003). The relatively recent development of doctoral education and the remnants of hospital-based traditions of the nursing and many of the AHPs in the USA are responsible, in part, for the second tier value attached to scholarship in this study (Balogun *et al.* 2006).

The deans in our study ranked scholarship second and service as the least important criterion in granting tenure, and our findings corroborated the results of previous studies (Henry 1981, Flanigan *et al.* 1988, Messmer 1989). Because of the low priority given to service in the award of tenure, it is tempting for educators to devote less attention to service on university committees, in professional organization and in the community.

Although service was rated low, it is reassuring to note that the majority of our respondents recognized that service is 'important' and valued. The literature suggests that in research and doctorate-granting institutions, scholarship is the major yardstick for tenure decisions, while teaching, service and clinical competence are not highly valued (Messmer 1989). Despite the evolving trend towards recognition of productivity in the scholarship domain in nursing and AHPs, many institutions do not have a well-developed cohort of staff members who have the knowledge and skills to engage competently in a research programme of their own or to guide and inspire students to pursue a research career (Holcomb & Roush 1988, Schiller *et al.* 1988, Messmer 1991, Adderly-Kelly 2003).

A conundrum facing allied health and nursing disciplines is the need to find creative and measurable standards to gauge scholarship and ways to incorporate these effectively into the tenure guidelines. In 1998, Boyer proposed a broader and more inclusive paradigm for scholarship that includes '*discovery, integration, application and teaching*' *(p. 16)*. The model has gained wide acceptance and is currently used in fashioning the criteria for tenure in nursing and allied health education (Angstadt *et al.* 1998, Adderly-Kelly 2003).

Study limitations

There are several design issues that affect the external validity of our study. Our findings can only be generalized to the nursing and AHPs in the USA. For wider external validity, replication of our study in other parts of the world is recommended. Our questionnaire did not request information on the geographical location of the institution, nor did it ask about the presence of other health professions such as medicine, dentistry or podiatry programmes in the institution. It is plausible that the criteria used in granting tenure may be influenced by regional differences and the existence of other highly esteemed health professions in the institution. Although the deans serve a very critical role in tenure decision, it should be recognized that, depending on the governance structure of the institution, other committees may review educators' portfolios and make recommendations to the provost/president (vice-chancellors) of the university.

Our findings should also be interpreted with caution because the relationship between deans and tenure committees was not investigated. It would be helpful in follow-up studies to determine how many deans have the power independently to grant tenure, and what other committees are involved in tenure decision. The composition of the tenure committee may have a major impact on the expectations and outcomes of tenure reviews. For example, in a liberal arts institution, if other science departments (such as biology, physics and chemistry) are represented on a tenure committee it is often more difficult for allied health or nursing educators to receive tenure without research, grant-winning and publication accomplishments. We did not investigate the specific disciplines within allied health. It is plausible that the nature and development of the professions in an allied health school will influence the opinion of the deans on many of the issues investigated in this study.

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What is already known about this topic

- In the last decade, there has been a trend for educators to migrate to affluent and developed countries in search of better professional satisfaction.
- Apart from the United States of America, there is a dearth of empirical studies on the tenure system in allied health and nursing education.
- Low tenure rates for allied health and nursing educators are often attributed to their underperformance in the scholarship domain.

What this paper adds

- The tenure rate for allied health educators was higher than for nursing educators.
- The values attached to teaching, scholarship and service are highly dependent on the type of institution, with teaching being more highly valued in those mainly concerned with education compared with research-oriented universities.
- Heavy teaching workloads may be detrimental to the chances of obtaining tenure.

Conclusion

The world has become a global village, with opportunities for educators to carry their knowledge and skills from one country to another, but there is a dearth of empirical studies on the tenure system from other countries outside the USA. Our findings have implications for preparing future educators for long-term careers in allied health and nursing disciplines. The findings suggest that allied health and nursing educators immigrating to the USA might select their place of employment based on their academic strengths in the domains of teaching, research and service and the mission of the university. Replication of our study in other countries is warranted. The findings of such studies would provide better understanding of the similarities and differences in conditions of service in higher education around the world and might have the potential to facilitate the international educator exchange and employment mobility across countries.

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Author contributions

JAB was responsible for the study conception and design and drafting of the manuscript. PES and MG performed the data collection and data analysis. PES and MG provided administrative support. JAB provided statistical expertise. PES and MG made critical revisions to the paper.

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Chapter 20

Mentoring Program for Tenure-Track Faculty: One School's Experience

Pamela R. Cangelosi

> I don't believe in tenure. Tenure lets a lot of dead wood stay. Tenure is a flawed system—it divides faculty and is outdated. Our university does not use the tenure system—thank goodness! I strongly believe in tenure. Scholarship in its many forms should be recognized. Tenure singles out the scholarly faculty, and that is good. Why shouldn't they be rewarded?

These statements from faculty suggest that the practice of tenure is a controversial issue in higher education. The one remnant of tenure that stayed with me after graduate school was that no one seemed to agree if tenure should be retained or eliminated. Not until I accepted a tenure-track position at a university that highly valued tenure did I come to understand and appreciate the concept of tenure. As with other disciplines, nursing struggles to define what constitutes scholarship, and in turn, what type of scholarly activity is suitable for achieving tenure (Quill, 2003). For many years, traditional research was valued as the only activity that would increase the knowledge base of a profession and the only way to gain recognition for scholarly pursuits. Boyer (1990) challenged this when he encouraged academia to move beyond traditional research as the sole measure of scholarly work. Perhaps the question around which the dispute over

tenure centers is what is scholarship? Is it necessary for excellence in higher education? More specifically, is it necessary for excellence in nursing education?

The purpose of this chapter is to describe one school's experience with assisting faculty in understanding, pursuing, and achieving tenure. Background information related to tenure and scholarship and the role of mentoring in this process are presented; potential barriers and aids to developing the scholarly writing so necessary for tenure is discussed; and the new mentoring program for tenure-track faculty in my institution is described using my experience with the program as a new tenure-track faculty member. Finally, the potential challenges and rewards of the mentoring program are addressed.

TENURE AND SCHOLARSHIP

Criteria for promotion and tenure are based on the mission of the institution of higher learning. Faculty are appointed to a position depending upon their education and experience, which is evaluated in terms of how they meet the mission and goals of the institution. When faculty achieve the prescribed criteria, promotion and tenure are granted (Glassick, Huber, & Maeroff, 1997). With tenure there is a reciprocal responsibility between the institution and faculty (Billings & Halstead, 2004). Faculty are to continue productivity and professionalism in teaching, scholarship, service, and in some institutions, clinical practice. In return, academic freedom and career stability are provided by the institution. Booth (1988) summed up the goals and values of tenured faculty best when he asked, "Is this candidate *still curious*, still inquiring . . . and is thus probable that at the age of forty, fifty, or sixty-six, he or she will still be vigorously inquiring?" (p. 329).

The Controversy Surrounding Tenure

The process of tenure, however, is not without its critics. Tenure has been present in academia for approximately 100 years and during this time been shrouded with controversy (Quill, 2003; Sedgwick, 2002). Proponents of tenure cite employment stability, career advancement, and protection of academic freedom as the main draws of tenure. However, those opposed to tenure believe that today's world is different

from the world in which tenure was developed. This, they say, makes the relevancy of tenure highly questionable. The economy is causing an increased need for the justification of tenure because many legislators, trustees, and administrators are now closely scrutinizing public expenditures (Brennan, 1997). When corporate America downsizes, bureaucrats question why academia is immune (Sedgwick, 2002).

In 1996, Trower reported on the tenure practices of 1200 4-year institutions. Among these colleges, 15% had no tenure process while 31% had the traditional tenure process. Only 2% of these institutions reported any change in their tenure criteria since 1992. As the criteria for tenure and promotion are based on institutional mission, a change in the criteria could signal a major shift in focus for an institution. Trower observed that although most institutions of higher learning did not formally change tenure criteria, they did offer programs such as early retirement, financial incentives, tenure quotas, performance criteria, and long-term contracts, all of which continue to fuel the controversy surrounding tenure.

A greater number of adjunct nontenured faculty are employed by universities today, which many believe brings the "real world" to students (Sedgwick, 2002). However, adjunct faculty lack decent pay, benefits, and academic freedom. Therefore, because of financial constraints, they often cannot afford the commitment and loyalty of tenured faculty (Thompson, 2003). Unfortunately, in some settings, this leaves too few tenured faculty to perform the work of the college and the university as a whole. Academic advising, faculty governance, and collegial involvement all suffer without sufficient tenured faculty (Sedgwick, 2002; Thompson, 2003). Despite the controversy, tenure continues to be a viable way to ensure commitment to the mission of the university.

The Essence of Scholarship

Until the mid-19th century, teaching was the main focus of scholarship in academia (Glanville & Houde, 2004). According to Boyer (1990), research and scholarship became linked when Cambridge and Oxford claimed to be institutions of teaching as well as centers for the attainment of truth and the expansion of knowledge. This concept spread to academia in America. Subsequently, a significant part of the faculty role in higher education today is the scholarship of research, which is closely associated with promotion and tenure (Adderly-Kelly, 2003).

In *Scholarship Reconsidered: Priorities of the Professoriate,* Boyer (1990) questioned the notion that to be scholarly, one must emphasize research and publications. Boyer (1990) strongly supported the idea that teaching should be valued and rewarded in academia and introduced the term, "scholarship of teaching" (p. 23). According to Boyer,

> Scholarship means engaging in original research. But the work of the scholar also means stepping back from one's investigation, looking for connections, building bridges between theory and practice, and communicating one's knowledge effectively to students . . . the work of the professoriate might be thought of as having four separate, yet overlapping, functions. These are the scholarship of *discovery*; the scholarship of *integration*; the scholarship of *application*; and the scholarship of *teaching*. (p. 16)

Based on these beliefs, Boyer urged a more inclusive definition of what constitutes a scholar. Traditional research and publications alone did not adequately portray the complete range of scholarly endeavors. Boyer claimed that knowledge is obtained through the four areas of scholarship he identified—discovery, integration, application, and teaching. As scholarship forms the foundation of the promotion and tenure processes, to recognize only one type of scholarship in decisions involving promotion and tenure does not give a true vision of the diversity and intellectual contributions of faculty. According to Atkinson (2001), Boyer's work caused a paradigm shift in academia, by elevating the role of teaching to a scholarly activity.

Scholarship in Nursing

In nursing, professional organizations such as the American Association of Colleges of Nursing and the National Organization of Nurse Practitioner Faculties recognize the demanding nature of teaching and practice and support their inclusion in the assessment of scholarly work (American Association of Colleges of Nursing, 1999; National Organization of Nurse Practitioner Faculties, 2000). Boyer (1990) suggested that the scholarship of teaching and practice requires peer review as rigorous as the review associated with research activities. Although Boyer's seminal work has prompted academia to begin to recognize the scholarship of teaching, many academic settings are still reticent to grant tenure based on it (Atkinson, 2001).

Boyer proposed the scholarship of teaching as one part of the integrated whole of scholarship. As with research, teaching or practice unto themselves does not constitute scholarship. As Glassick et al. (1997) are quick to state, "Knowledge, for all the glory and splendor of the act of pure discovery, remains incomplete without the insights of those who can show how best to integrate and apply it" (p. 10). Although nursing is a leader in promoting the scholarship of teaching (Glanville & Houde, 2004), no discipline should take a myopic view of what comprises scholarship. The scholarship of teaching should embody a focused research problem, systematic inquiry, peer review, and dissemination of findings. The scholarship of teaching also implies that findings will be integrated and applied. In this way, the scholarship of teaching can provide an important part of the foundation on which to base tenure decisions.

MENTORING AND THE TENURE PROCESS

The nursing literature is replete with references to the value of mentoring at all levels of the profession. Fawcett's (2002) definition of mentors as being "people who help those less experienced in their field learn about the field and advance their careers" (p. 950) suggests the many roles mentors may play. Mentors have been described as teachers (Spouse, 1996); preceptors (Andrews & Wallis, 1999); advocates and role models (Fawcett, 2002); nurturers and advisors (Allen, 2002); motivators and communicators (Gray & Smith, 2000); and leaders (Wieck, Prydun, & Walsh, 2002). Even Florence Nightingale as a "mentor of matrons" is well documented (Lorentzon & Brown, 2003, p. 266).

Unfortunately, the mentoring of new faculty is not as well documented as the mentoring of clinical nurses. Academia is different from the world of clinical or administrative practice. New faculty struggle "to figure out how to live an academic life—that is, how to teach well, produce fruitful research, earn tenure, pay attention to a partner and children, lead an examined life, and make plans for the future" (Sorcinelli, 2004). New faculty may be experts in clinical nursing or administration, but they are novices in the "academic life." In an effort to avoid the "triple threat of evaluation, isolation, and overwork" (Sorcinelli, 2004), new faculty need mentors experienced in the practices and ways of the tenure process, or an "academic life."

Both peer-to-peer and expert-to-novice models of mentoring are evident in the literature related to faculty mentoring. Jacelon, Zucker, Staccarine, and Henneman (2003) and Lewallen, Crane, Letvak, Jones, and Hu (2003) described a mentoring program in which tenure-track faculty themselves help each other learn the role of faculty scholar. In contrast, Records and Emerson (2003) clearly indicated that one important role of a mentor with novice faculty was to ensure research skill development. Brown (1999) and Snelson et al. (2002) also used the expert-to-novice model in their programs of mentoring for new faculty; however, their emphasis was not on research skill development. For Brown's program, the emphasis of the mentoring relationship was on the pragmatic aspects of teaching and orientation to university policies. The program Snelson and colleagues described also stressed the day-to-day aspects of the faculty role, but they emphasized the need for a caring relationship between mentor and novice faculty. Cangelosi (2004) described an expert-to-novice model of mentorship as well, but that model was specifically for faculty seeking tenure. The model is described later in the chapter.

SCHOLARLY WRITING

Research related to writing has identified the importance of teaching writing as a scholarly discipline (Johnstone, Ashbaugh, & Warfield, 2002; Whitehead, 2002). Diekelmann and Ironside (1998) identified the "practices of scholarship" as reading, writing, thinking, and dialogue.

The previously described mentoring programs that focus on research skill development emphasize the need to gain expertise in scholarly writing as one of the most important elements in being successful in the tenure process. For many new faculty, including myself, writing is the most difficult aspect of the job. Several barriers to scholarly writing that I have encountered are also noted in the literature: lack of large blocks of time to write, limited self-confidence in writing, and minimal instruction about how to write for publication (Adderly-Kelly, 2003; Sorcinelli, 2004). Unfortunately, many schools of nursing do not have sufficient faculty competent in research and publication skills to support a research program of their own or to mentor graduate students pursuing a career in research or a career as academic faculty (Adderly-Kelly, 2003). This greatly hinders the development of future

nurse researchers. Not only do students frequently lack instruction in scholarly writing, but also once they have graduated, too few are able to find mentors qualified to guide them in the scholarship of writing.

As a new faculty member, my only experience was writing papers for graduate school, which I quickly discovered was poor preparation for writing for publication. I wrote my dissertation with great reservation, convinced that what I discovered in my research would be of interest to the larger community of scholars, but fearful that I would never be able to effectively communicate my findings in writing. As Glassick et al. (1997) would say, I lacked "the courage to risk disapproval in the name of candor" (p. 65). My dissertation was my first experience with having others mentor my scholarly writing. My committee guided me in the research process—every aspect of it—including the writing of the dissertation. As new faculty, it is the collaboration with a faculty mentor skilled in scholarly writing that has helped me gain the confidence and beginning skills necessary for writing for publication. The accessibility of a network of faculty members competent in scholarly writing to review manuscripts is also invaluable.

Finding large blocks of time to write is a challenge for faculty. Balancing the responsibilities of research, teaching, and service with a personal life takes commitment on the part of faculty members and others with whom they associate. I have been told by other faculty that true scholarship takes time and solitude. I too can now attest to the amount of time it takes to think and write in a scholarly fashion. As one tenured faculty member told me, "You have to work weekends and evenings, otherwise tenure won't happen. You just can't accomplish the work of tenure between nine to five." Without mentoring to help new faculty learn how to achieve a satisfying balance between professional and personal lives, and without the commitment of the university to allow time for scholarship, fewer new faculty will succeed in achieving tenure.

THE NEW FACULTY MENTORING PROGRAM AT GEORGE MASON UNIVERSITY

As a result of various organizational changes and retirement of senior faculty, the College of Nursing and Health Science (CNHS) at George Mason University had an increasing percentage of term (nontenure-track)

faculty. This helped to meet the needs of teaching large numbers of undergraduate students, particularly in clinical practica, but did not facilitate development of faculty research and scholarship. A sufficient number of tenured faculty on college, university, and doctoral dissertation committees was becoming increasingly more difficult to achieve. It was also a struggle to have enough tenured faculty acting as advisors to graduate students. Increased responsibility for these activities, in addition to performing their own teaching and research, was creating an intolerable workload for the remaining tenured faculty. With a large doctoral program and increasing numbers of senior faculty nearing retirement, it was evident that new tenure-track faculty needed to be hired. It was also essential that programs be put in place to help these new faculty members succeed in obtaining tenure. If faculty members arrive at the end of their 6-year probationary period unprepared for tenure, the cost is great not only for the faculty member but also for the organization.

To address this problem, the CNHS Faculty Matters Committee, in collaboration with the Associate Dean for Academic Programs and Research, met to plan a mentoring program for new tenure-track faculty to help to retain and prepare them for obtaining tenure. Previously, several faculty unsuccessful in attaining tenure either left the college or opted out of the tenure-track to take term, or nontenure-track, contractual appointments. New faculty guidelines now prevented faculty from moving from tenure-track to term. Therefore, to retain faculty, it became even more important to help ensure success in the tenure process. This meant that the often-cited problems of lack of time and support to pursue the scholarship and service activities required of tenured faculty needed to be addressed.

The Faculty Matters Committee, in collaboration with the senior faculty, designed a mentoring program for both new and more seasoned faculty pursuing tenure. New, doctorally prepared, tenure-track faculty were hired with the understanding that transfer to term appointments was not an option. The mentoring activities involved in the program did not require significant expenditures, but they did provide essential support and guidance to faculty in achieving tenure. It was the hope and ultimate goal that faculty would be stimulated to remain and contribute to the future of the college (Cangelosi, 2004).

EXPERIENCING THE MENTORING PROGRAM

As a new tenure-track faculty, fresh out of a doctoral program, I was one of the first to experience this program. I found that the program mentored me in both short- and long-term activities that fostered success in my first 2 years as a faculty member in the college. Short-term mentoring focused on the day-to-day activities of teaching while long-term mentoring encompassed the activities for scholarship and tenure.

Short-Term Mentoring

The first part of the mentoring program involved pairing every new faculty with an experienced faculty member who taught similar classes or at least the same level of students within the college. This assignment was intended to be of short duration and usually lasted for only one academic year. The day-to-day policies and procedures specific to the college and university, the location of required services, and assistance in meeting new people were facilitated through these partnerships.

My assigned short-term faculty mentor taught the same level of students that I taught. We met for lunch, and she was helpful in assisting me in the organization of a clinical course. However, for me, the most productive short-term mentoring occurred with my "informal mentor," who was a faculty member not officially assigned as a mentor. Because of the proximity of our offices, and her reaching out to me, she assumed the actual role of my short-term mentor. Through this informal partnership, I learned the intricate policies of the college. Specific necessities, such as which forms to complete, whom to notify, and where to go for selected services were all provided for me by my informal short-term mentor. Not only did she ease my transition into the daily operations and administrative responsibilities of teaching, but we also discovered, discussed, and grew in our mutual philosophies of teaching and nursing. Perhaps this relationship, formal or informal, was intended to be short term, but our connection continues. Only it is now based more on collegiality and friendship. This is just one example of how the mentoring program fostered mentoring by all faculty and not just by those who were "officially appointed."

Long-Term Mentoring

The second aspect of the mentoring program was intended to be of longer duration, and it consisted of assigning each tenure-track faculty member to a tenured faculty member for guidance in the tenure process. This process was viewed as vital in facilitating the tenure process and in convincing the new faculty that attaining tenure was a feasible and valuable endeavor. Each mentor/new faculty member established academic goals and timelines for the next year, and on many occasions, the mentor provided encouragement and moral support.

My relationship with my long-term mentor has become the most valuable and rewarding experience in my professional career. The tenured faculty member I have been primarily associated with has shown me how to turn my dissertation into a published article, how to apply research to my teaching, and how to derive research from my teaching. Through frequent meetings over coffee or lunch, email messages, and telephone conversations, my long-term mentor has shared her expertise and has guided me in scholarly activities. Her caring interest, enthusiasm, and knowledge have opened professional doors for me that I previously did not know existed.

Perhaps one of the most helpful outcomes of this relationship has been the ability to observe how my long-term mentor incorporates a life of scholarship into a satisfying, personal life. Or as Sorcinelli (2004) phrased it, "to figure out how to live an academic life." Knowledge of how to perform scholarly work does not ensure commitment to the performance of scholarship. Without the ability to integrate scholarship into a satisfying professional and personal life, few faculty will stay long enough to achieve tenure.

Components of the Mentoring Program

Three components of the mentoring plan were especially well received by the tenure-track faculty: a day-long faculty workshop that focused on teaching innovations and the tenure process; a weekly "scholarship day"; and a tenure support group.

Faculty Workshop

The goals of the faculty workshop were to assist tenure-track faculty in developing a program of scholarship and research and to foster

excellence in teaching. The Director of the University's Center for Teaching Excellence presented helpful techniques for teaching. The most dynamic part of this presentation for me was the focus on evaluation strategies, such as peer evaluation of teaching, individualized formative evaluations for use by students at midterm, and university-designed faculty evaluations for students at the end of the semester.

As an important aspect of the tenure process is the development of a professional portfolio, documentation required for portfolios at George Mason University was also reviewed in the workshop. The need to begin collecting these materials in an organized fashion as each semester progresses rather than wait until the end of the 6-year probationary period was stressed. Many nursing programs and colleges—George Mason University is no exception—are encouraging broader and more creative evidence supporting teaching, research, and scholarship in the professional portfolio (Atkinson, 2001; Glanville & Houde, 2004). In agreement with a broader view of scholarship, tenure-track faculty were encouraged to decide on a teaching or research focus for their scholarly portfolios based on their primary interests and professional activities.

Although traditional research is valued at George Mason University, it is not the only measure of scholarship. Publications in peer-reviewed journals are considered vital to the attainment of tenure, but peer reviews of teaching expertise, personal statements about teaching and research, acquisition of grants, and requests for presentations at professional conferences are also highly valued. I found the review of exemplary portfolios most valuable, because it cultivated a sense of organization and realistic possibility to the entire process. The Provost's meetings, in which the tenure process is outlined, and the resources of the Center for Teaching Excellence were also promoted throughout the workshop, both of which I have since found to be extremely beneficial to my understanding of the tenure process.

In keeping with the tenure requirement to publish in peer-reviewed journals, the workshop provided a forum for tenured faculty to discuss strategies they found useful in writing for publication. Faculty with expertise in scholarly writing paired with tenure-track faculty to identify at least two manuscripts the tenure-track faculty member could complete with mentoring from their assigned long-term mentor and from faculty present at the workshop. Although long-term mentors usually guided the manuscripts

through completion, this exercise was instrumental in the development of mentoring across the college and not just between the faculty members assigned to mentoring pairs.

Scholarship Day

A second important component of the mentoring plan was the establishment of a scholarship day for each tenure-seeking faculty member. This day was intended for scholarly activities such as writing manuscripts, conducting research, literature reviews, and other activities supportive of faculty research and scholarship. Teaching assignments were carefully designed to allow tenure-track faculty a scholarship day, which sent a clear message that scholarship is valued and requires planning and discipline. In concert with the long-term mentor, tenure-track faculty set realistic, weekly objectives to be accomplished during the scholarship day. Over the past 2 years, I have discovered that prudent use of this day is essential for me to find sufficient time to write. By consistently avoiding telephone interruptions, by not scheduling meetings on that day, and by restricting the day to actual scholarship activities, I have been able to engage in scholarship.

Tenure Support Group

A third unique component of the mentoring plan was the formation of a tenure support group. Collectively, the nine tenure-track faculty met with one or two tenured faculty members every month to provide frequent guidance in meeting the requirements of tenure. Suggestions for manuscript topics and moral support were the primary activities of the group as a whole, but smaller groups began to form and meet as well. Based on research areas of interest, these smaller groups shared data, coauthored manuscripts, and revised and resubmitted manuscripts if one was rejected. To date, four manuscripts from these smaller groups have been accepted for publication, while three more are in process. The expertise that is shared within these groups is perhaps one of the most enriching aspects of the mentoring plan. Several tenure-track faculty are not nurses who teach in the Health Science branch of the CNHS which makes for an eclectic group with broad expertise. One tenure-track faculty member summed up this experience the best when she stated, "I feel intellectually stretched when we meet. I just love that!"

Future plans for the mentoring program include monthly meetings of individual tenure-track faculty with a consultant skilled in the publication process for the purpose of manuscript review and identification of target journals. Expansion of the smaller tenure-track research groups into research teams with experienced faculty to share grant-writing experience is another future objective for the mentoring plan.

CHALLENGES AND REWARDS OF THE NEW MENTORING PROGRAM

Although mentoring relationships are regarded as essential to professional development, challenges do exist in these relationships. Effective mentors must embody generosity, competence, self-confidence, openness to mutuality, and commitment to the goals of the relationship (Vance, 2000). To be effectively mentored, one must possess an openness to critique, the ability to set goals, and the motivation to seek guidance as needed. A sense of failure prevails when the objectives of the relationship are not accomplished, regardless of the energy expenditure and dedication of those involved in the relationship. Despite the challenges associated with mentoring, Klein and Dickenson-Hazard (2000) are quick to note that growth in personal and professional satisfaction gained from the mentoring process is a reward that greatly overshadows the challenges.

Challenges

The mentoring program in the CNHS gave new recognition to the value of obtaining tenure and this created some tension between term- and tenure-track faculty. Some term faculty saw tenure-track faculty as receiving special privileges, such as the scholarship day, even though the teaching workload was the same. The perception seemed to be that tenure-track faculty were being given extra time for their scholarship.

Another challenge is that not all tenure-track faculty perceive the effectiveness of the mentoring plan in the same way. Although the mentoring plan has been very effective for me and others in our school, some tenure-track faculty did not find the mentoring

process supportive. Valuable mentoring is available and generously provided within the framework of the mentoring program in the CNHS, but tenure-track faculty must seek out the amount of guidance they personally require to meet their individual needs. From my experience in the program, no one has ever refused or denied the role of mentor when guidance was requested. I have come to believe it is the intrinsic value of scholarship that effectively fuels one's perseverance to seek out mentoring that can aid the pursuit of tenure.

Rewards

Despite the challenges associated with the mentoring program, the immediate rewards related to teaching are remarkable. Among all faculty in the CNHS there is an increased sharing of course materials, more dialogue about teaching strategies, and a greater awareness and desire to assist new faculty in the mechanics of teaching at George Mason University. One of the unanticipated benefits of the mentoring program for me was the difference it made in my perceptions of the tenure process. Despite previous negative images, my faculty mentors are actually making a tenure-track lifestyle feasible for me. I feel like I have greater direction for my research and a real plan as to how to carry it out. In the first 2 years of my tenure-track experience, I have had six articles accepted for publication, made six presentations at regional, national, and international conferences, and obtained two small grants for new research projects. I have come to view the tenure process not as a black hole or a barrier to jump over, but as a systematic process that rewards the scholarship I have come to value.

On the other hand, I have found this building of a program of research and scholarship to be incredibly hard work that is often invisible to term faculty. There is no time to do it during the 5-day work-week. I use the scholarship day granted by the mentoring program and weekends to do the reading and writing related to my scholarship. Through my long-term mentor, I have learned to balance research and scholarship with my other commitments. I think my most valuable insight is that the scholarship is not something separate from my life. Rather, scholarship is a part of both my academic and personal life.

LOOKING AHEAD

I have often wondered why my mentors have taken the time to mentor me. They too need to make time in their own very busy lives to work with me. One mentor provides an explanation:

> We have all been there. Tenure is a hard-earned distinction, and I feel a professional responsibility to help others achieve that distinction. After all, isn't that why we are here—to help our students learn? Well, I think that extends to the ranks of faculty too. I want to help faculty continue to learn and grow. Their growth stimulates student growth, and I grow in the process as well. It has a real ripple effect, which is such a positive experience!

The long-term goals of the mentoring program in the CNHS will not be met until the nine tenure-track faculty attain tenure. However, in the short term, the increased responsiveness of all faculty to mentoring, regardless of tenure status, has prompted informal discussions about each other's scholarly endeavors over lunch, increased email exchanges, and promoted a "we are in this together" atmosphere.

Mentoring plans, like the one at George Mason University, cannot promise qualified faculty success in the promotion and retention process. However, the potential rewards can motivate and inspire all who are formally and informally involved in the mentoring process. The care that faculty members show for each other and the cultivation of the future leaders for the profession make the challenges of this mentoring program worth the time, effort, and risk involved.

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Evaluation of Clinical Faculty: Gender and Minority Implications

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Abstract

Background: Learner ratings are an important source of data regarding teaching effectiveness. We examine ratings of faculty teaching for the effects of faculty-resident gender and underrepresented minority (URM) status concordance.

Method: Factorial ANOVAS and *t* tests were used to examine gender and

- Method
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- Table 1

URM status in 10,443 teaching effectiveness evaluations for 720 faculty members, provided by 516 residents across 18 clinical departments.

Results: Significant interaction effects were found for gender ($P < .001$) and URM status ($P < .05$) on the individual evaluation record level. Analyses of faculty-level data showed effect sizes were small except for large positive effects for URM faculty evaluated by URM residents (ES = 0.61).

Conclusions: Overall, gender and minority status seem to have a negligible role in residents' evaluations of clinical faculty. However, the apparent beneficial effects for URM-URM pairs need more study.

Evaluations of faculty teaching performance are widely used for decisions regarding promotion and retention. Although there are many new evaluation instruments to measure teaching effectiveness, such as 360-degree evaluation and peer review,[1,2] trainee ratings remain the most common source of evaluative data. Fortunately, several studies have shown that learner ratings are robust and valid assessments of teaching skills.[3] These favorable measurement characteristics, combined with factors such as accessibility and affordability, likely mean that learner ratings will remain a popular source of data regarding teaching effectiveness. Therefore, it is important to look critically at these data to understand the nuances that lead to variability in ratings.

Gender and race—of teacher and learner—are two issues that merit further study. Outside of the teacher-learner arena, there are suggestions that gender and race concordance are important for building trust and communication.[4] In the scant literature about the influence of race in faculty evaluation, minorities received lower ratings than nonminorities, although the race of the evaluator was not considered.[5] There is a slightly larger literature regarding gender effects in faculty evaluation. In one ambulatory clerkship, female students rated the ability to teach problem solving among male faculty as significantly higher than female faculty, whereas male students rated female faculty as significantly higher than male faculty on the same ure.[6] Other literature suggests the existence of a significant faculty-student gender interaction among select disciplines.[7] The simple existence of a difference does not necessarily mean bias—it may be that the female—or male—faculty were better teachers in the samples studied. However, there is an abundant literature to suggest that women have stronger communication and clinical skills than do men.[8] On the other hand, clinical teaching effectiveness also depends on a strong knowledge base and procedural skills, areas where men often perform better, at least on testing.[9]

Accordingly, the purpose of this study was to examine how ratings of clinical faculty teaching effectiveness vary according to teacher (faculty attending) and learner (resident) gender. We hypothesized that overall, we would observe the highest ratings for gender-concordant pairs. Secondly, we asked how ratings of teaching effectiveness varied by faculty and resident underrepresented minority (URM) status, and we hypothesized that race-concordant pairs would result in the highest ratings. Within both hypotheses, we look at individual record data and subsequently explore how ratings vary by gender and URM status when data are aggregated to the level of an individual faculty person. Discovering significant race or gender effects could have implications for how ratings of faculty are used. Moreover, much of what is known about teaching evaluations comes from classroom settings rather than the extended and intense clinical settings that exemplify many residencies.

Method

Between July 2005 and June 2006, 10,443 evaluations of teaching effectiveness were collected for 720 faculty members by 516 residents across 18 clinical departments. The evaluations were completed confidentially via a Web-based system at the end of a training period, usually a two- to four-week period as identified by the program director. The clinical teaching effectiveness instrument consisted of eight items and a global item rated on a scale, where 1 = poor, 2 = fair, 3 = good, 4 = very good, and 5 = excellent. Questions were phrased as two statements, one summarizing behaviors of the effective teacher and one the ineffective teacher. The scale was developed and pilot tested over several months using consensus-building processes with representatives from multiple clinical departments. A scale score was computed for each evaluation response as the mean of all items except the global item. Cronbach's alpha was estimated at 0.96. According to the office of faculty affairs, there were 82 Asian, 24 black, 600 Caucasian, and 14 Hispanic faculty members; and 197 females and 523 males in ata set. According to definitions provided by the graduate medical education office, there were 131 Asian, 18 black, 340 Caucasian, 12 Hispanic, 10 other-non-URM, and 5 other-URM residents; and 211 females and 305 males represented in the

data set. All faculty had gender information, and 30% of faculty did not have race information; 32% of residents did not have race and gender information. Faculty received an average of 11 evaluations (range 1-89). This study was reviewed by the institutional review board and classified as exempt.

For gender and then for minority status, we conducted a series of four analyses. First, on the level of individual evaluation records, we examined average teaching effectiveness scores according to faculty and resident gender or URM status using a factorial ANOVA. As defined by the faculty affairs office, Hispanic and black faculty were included in the URM category for faculty. For residents, the Association of American Medical Colleges *underrepresented in medicine* definition was used and includes black, Hispanic, Middle Eastern, and native Hawaiian trainees. Second, factorial ANOVAs were repeated, using records of the subset of faculty evaluated by both male and female residents (N = 7,321) or by both URM and non-URM residents (N = 5,230). The reanalysis with the smaller sample was intended to guard against any possible selection effects. Selection effects are thought to be minimal because residents are usually assigned to services, but nevertheless it is important to rule out as a source of potential bias. Third, with factorial ANOVAs we looked at item-level data to see whether there were differences related to item content (e.g., women receive higher ratings for the communication item). Finally, using data aggregated to the faculty level, we created means for evaluations by male and female residents, and URM/non-URM residents, and we compared means within gender/minority subgroups with *t* tests and computed effect sizes (Cohen's *d*).

Results

In the total data set, the main effect for faculty gender was not significant ($P = .06$); mean ratings of female and male faculty were 4.49 (SD = 0.66) and 4.46 (SD = 0.74), respectively. Similarly, the main effect for resident gender was not significant ($P = .13$); mean ratings by female and male residents were 4.47 (SD = 0.72) and 4.48 (SD = 0.72), respectively. However, there was a significant interaction effect ($P < .001$). Female faculty were rated highest by female residents (mean = 4.56, SD = 0.60; versus mean = 4.44, SD = 0.70 by male residents). In contrast, male faculty were rated highest by male residents (mean = 4.49, SD = 0.73; versus mean = 4.43, SD = 0.76 by female residents). As shown in the left panel of Figure 1, when the analysis was repeated with the subset of faculty rated by both men and women, the interaction effect remained significant: means ratings of female faculty by female residents = 4.55 (SD = 0.61), female faculty by male residents = 4.43 (SD = 0.70), male faculty by male residents = 4.49 (SD = 0.73), and male faculty by female residents = 4.41 (SD = 0.78; $P < .001$). There were significant interactions for all items ($P < .05$). Females consistently rated female faculty highest, and s consistently rated male faculty highest, with no apparent differences related to item content (data not shown).

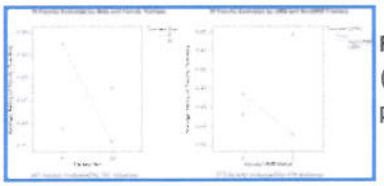

Figure 1 Interaction effects in faculty-resident gender and underrepresented minority (URM) status on evaluations of clinical teaching effectiveness. Ratings are on a five-point scale, where 1 = poor, 2 = fair, 3 = good, 4 = very good, and 5 = excellent.

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In the total data set, the main effect for faculty URM status was not significant ($P = .23$). The overall mean ratings of URM faculty and non-URM faculty by all residents were 4.46 (SD = 0.71) and 4.48 (SD = 0.72), respectively. Main effects for resident URM status and the interaction were not significant ($P = .69$ and $P = .10$, respectively). However, when we repeated the ANOVA including only those faculty evaluated by both URM and non-URM residents, there was a significant interaction term ($P = .04$). As shown in the right panel of Figure 1, mean ratings were: non-URM faculty, URM residents = 4.38 (SD = 0.82), non-URM faculty, non-URM residents = 4.44 (SD = 0.75), URM faculty, URM residents = 4.60 (SD = 0.68), and URM faculty, non-URM residents = 4.33 (SD = 0.76). Significant interactions were observed for three items: *ability to teach critical thinking*, *communication*, and *professionalism* ($P < .05$). Consistently, the highest scores were for URM-URM pairs.

On the level of the faculty, all of the findings favoring gender or minority concordance remained, but the effects were mostly small. As shown in Table 1, gender concordance still benefited female faculty (ES = 0.07) and male faculty (ES =). On average, non-URM faculty received slightly higher ratings from non-URM residents (ES = 0.05). However, there was a large observed difference in rating given to URM faculty between URM residents (mean = 4.66, SD = 0.43) and non-URM

residents (mean = 4.40; SD = 0.40; ES = 0.61).

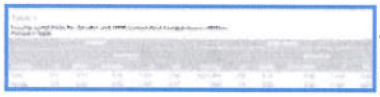

Table 1 **Faculty-Level Data for Gender and URM Concordant Comparisons--Within-Person *t* Tests**

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Discussion

With data for 720 faculty from 18 clinical departments who were rated by 516 residents, we asked questions regarding the importance, if any, of gender and URM status concordance on observed teaching evaluations. Few studies in medical education have asked this question, particularly in the graduate medical education setting, where interactions often last for weeks and teaching can be at the bedside and/or regarding patients in very intense situations. This study is novel in that it used data from multiple departments. Moreover, the large amount of data enabled subanalyses for faculty rated by both male and female residents and URM and non-URM residents, thus reducing the likelihood that selection by residents of similar preceptors influence the results. In short, we observed significant race and gender interactions, supporting our concordance hypotheses overall, but the effect sizes were small in all but URM faculty. In the latter, there seems to be a very large, positive effect of ratings by URM residents.

Our findings are limited in several ways. Only data submitted by residents for clinical faculty are included. Learners at different points in their training or in different teaching venues might have different perspectives. Moreover, analyses were restricted to evaluations where race and gender information were available about the faculty and resident. Some programs could not provide the data. Third, the URM definitions were not the same for residents and faculty. It will likely be several years until faculty data are aligned with resident data. Finally, as is reflective of academic medicine in general, there were very small numbers of URM faculty.

The sizable literature suggesting the importance of concordance in patient-physician interactions 4 comes from a setting that allows freedom to choose one's physician. In a more restrictive training environment, a trainee typically cannot choose his or her faculty preceptor. Additionally, the learning environment focuses on multiple skills in addition to communication. Overall, the significant interaction effects observed in the total data set largely disappear when data were aggregated to the faculty level. We interpret this to mean that residents are very knowledgeable consumers—they desire, appreciate, and recognize good precepting, and they rate it accordingly. In fact, the average of 11 ratings per faculty is more than enough to capture true score. The good news is that gender and race are largely irrelevant. This parallels studies reporting that race and gender concordance are not important in mentoring of junior faculty,10 when the situation may more closely resemble the resident-attending relationship.

The take-home meaning of these results is not so clear. Although the effects were significant, they were also small. The impact is potentially much larger if current recruitment efforts of URM residents and faculty are successful. It is certainly reasonable to think that faculty communicate in different ways with gender- and race-concordant residents. It may be that URM faculty are better teachers to URM residents. Future research to examine faculty and resident attitudes regarding gender and minority status may help us determine whether our results are related to teaching at all, a function of preexisting demographic conditions, or simply a halo effect. Additionally, including time of year in the analysis may produce different results. As faculty and resident nonconcordant pairs become acquainted with each other, comfort may increase, reducing any effect.

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Does the Consistent Application of Criteria for Faculty Promotion Lead to Fair Decisions?

Author(s): Kanter, Steven L. MD

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A recent survey of medical school faculty asked whether criteria for promotion are consistently applied to faculty across comparable positions. Only one third of survey respondents indicated agreement or strong agreement that this was so.1 A colleague asked me if this finding helps me think about what to do at my own institution. I said, "No, not at all!" But the question does.

Let me explain.

The question was part of an important survey aimed at developing an improved understanding of faculty vitality. The Association of American Medical Colleges (AAMC) in cooperation with the Collaborative on Academic Careers in Higher E[illegible]ation (COACHE) developed the Medical Faculty Job Satisfaction Survey to better characterize the issues that influence [illegible]y well-being. The findings of this survey have the potential to provide valuable information to medical schools and teaching hospitals about faculty members' satisfaction with their work environments, including factors such as quality of the

institutional milieu, governance, opportunities for collaboration, usefulness of feedback from unit heads, compensation and benefits, and promotion policies.

However, does it make sense that criteria for promotion should be applied consistently to faculty across comparable ...ions? Certainly, an institution that values faculty vitality strives to ensure a rational and fair process for making decisions about promotion and tenure. So, it does make sense to include questions that ask faculty members to gauge their satisfaction with the promotion process. But does the *consistent* application of *criteria* for promotion lead to *fair* decisions?

Before we can answer this question, we must explore three of its subtexts.

First, does the term *criteria* refer to rules or goals? Is there a set of rules that should be applied in the same way to each candidate for promotion to measure his or her suitability for advancement (e.g., number of peer-reviewed papers, number of courses developed, number of invitations to speak at national conferences)? Or should a candidate's accomplishments be evaluated in the context of an overarching set of goals (e.g., innovative accomplishments, intellectual leadership, creative approaches to difficult questions)? If you think about decision making for appointment, promotion, and tenure (APT) on a "decision continuum," with rule-based decisions as one anchor and goal-based decisions as the opposite anchor, a quick review of institutional APT documents reveals that most institutions tend toward the latter.2 That is why documents describing institutional policy for APT generally are titled "guidelines" or "principles" or the like, and not "rules."

Faculty who have served on APT committees have struggled with the dilemma of rule-based versus goal-based decision making. For example, Matusov and Hampel describe this phenomenon at the University of Delaware School of Education by contrasting a procedural model and a judgment model.3 And I can attest that each of the dozens of APT committee members with whom I have been acquainted over the years has attempted, usually about halfway through his or her term of service, to write a set of rules (as defined earlier) for promotion on the back of an envelope or on a napkin. These faculty members quickly realized that they were driven to try to devise a set of rules after experiencing the frustration of wrestling with difficult promotion decisions and the discomfort of grappling with the intricacies of the notion of fairness. But rules did not alleviate the frustration or relieve the discomfort. Ultimately, each came to the conclusion that APT decision making is a complex task that requires expert deliberation and professional judgment based on one or more sets of overarching goals (e.g., traditional goals of scholarship, institution-specific goals). A single set of rules cannot capture the full range of complexity involved in judging accomplishments in cutting-edge research, state-of-the-art clinical care, and current e... ...ational practice.

Second, to whom or to what does the term *fair* refer? Should promotion decisions be fair to the faculty member under consideration? To all faculty as a group? To the dean? To the medical school? To society as a whole? The easy response is to answer "yes" to all of these questions, but sometimes it is not possible to reach a decision that is perfectly fair to all parties. For example, if most faculty who are awarded tenure at a given medical school have demonstrated that they can renew their first grants, or compete successfully for second ones, but a faculty member comes up for consideration who has not yet done so but whose work holds great promise, is it fair to award tenure? Is it fair to the faculty member in question? Is it fair to his or her colleagues who had to clear a higher hurdle? Is it fair to the school, which has a financial investment in this individual and his or her lab, to decide not to award tenure and risk losing the individual? Is it fair to the institution as a whole to risk losing the ability to reap the rewards when the individual is successful in the near future? The expert and seasoned judgment of a wise and experienced committee, which can appropriately weigh this set of complex issues, offers the best chance to reach the best decision.

Third, does *consistent* mean to apply a set of predefined rules without exception? Or does it mean to make decisions within the context of a set of coherent, integrated goals? If an institution aims to cultivate a broad-based group of faculty who possess a diverse set of talents, the consistent application of predefined rules will not lead to the best decisions about career advancement. A promotion process must aim to reward originality, creativity, and intellectual leadership, recognizing that different criteria may be relevant for different individuals. A promotion committee should evaluate each faculty candidate for promotion by exploring all relevant information and working to understand a candidate's professional trajectory.

A risk of using the phrase "criteria are consistently applied" in a survey question is that it easily can be interpreted to infer "making a fair decision." But subjecting a promotion decision to a predetermined set of criteria, without latitude for judgment, is not fair to most faculty and likely will result in poor decisions both for individuals and schools.

If faculty promotion decisions could be captured in an algorithm, medical schools would no longer need promotion co...mittees, faculty would save time and energy (service on promotions committees consumes significant time and effort), ...niversities would save administrative costs, because deans and provosts would not need to review dossiers in detail. However, good faculty promotion decisions require the deliberation of a seasoned and thoughtful group of physicians and scientists who can assimilate diverse goals, attend to nuances and subtleties, and reach rational, balanced, and fair decisions.

And so, let us return to the original question: Does the consistent application of criteria for promotion lead to fair decisions? The preceding careful consideration of the three subtexts in this question reveals that the answer is *not* *sarily*, because the question does not capture adequately the complexities that are vital to making the best decisions ... faculty advancement.

If that is the case, then what are the important questions to ask faculty to assess their level of satisfaction with promotion decisions? Important survey questions are ones that will provide to institutional leaders valuable information that can be translated easily into meaningful reform. These questions should elicit from faculty whether or not they have access to good information about promotion policies, mentoring on career advancement, and an environment that fosters creativity and intellectual risk-taking with appropriate safety nets. For example, questions might take this form: How satisfied are you that

* your school's promotion process fosters creativity over conformity?
* your school's promotion process rewards original thought, innovative ideas, and intellectual leadership?
* your school's promotion committee is composed of experienced, dependable, and wise members of your faculty?
* your school makes available sufficient information about the promotion process, including a program for junior faculty to observe a promotion committee meeting?
* you have access to adequate mentoring within your department about promotion policies and procedures?
* your school's promotion process helps cultivate the broad range of talent necessary to advance knowledge in medicine and biomedical science?

Questions such as these reflect critical issues that faculty should understand about their departments and schools, that chairs and deans should understand about their faculty, and that all of us must understand to cultivate faculty well-being. It is important for AAMC-COACHE to continue to develop and refine the Medical Faculty Job Satisfaction Survey. I recommend that this survey delve further into questions of faculty satisfaction with the promotion process to illuminate the most important values of career advancement. Survey questions must capture both the complexities and the subtleties that are vital to making the best decisions about faculty APT. And we must use this information in a timely manner to implement meaningful change at medical schools and teaching hospitals to foster faculty vitality.

Steven L. Kanter, MD

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Post-Tenure Review at the University of Louisville School of Medicine: A Faculty Development and Revitalization Tool

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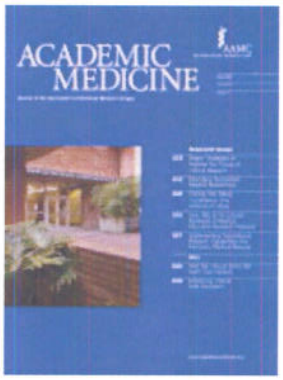

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Abstract

In 1994, the University of Louisville board of trustees mandated that each school develop a methodology for post-tenure review. Ten years after implementation, this article provides an update on the process and its outcomes.

In the case of an unsatisfactory evaluation, a faculty member is re-reviewed two years later. Failed reviews trigger the creation of a faculty

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development plan. The plan includes specific and measurable requirements to be met within one year, with an additional year to demonstrate success. The plan must clearly state objective goals related to the area of deficiency, development activities that the faculty member will engage in, and resources the institution will provide for the faculty member to achieve the stated goals.

Soon after implementation, an increase in retirement rates was observed. Since then, more than 250 post-tenure reviews have been completed in the school of medicine, and over 95% of faculty reviewed received ratings of *satisfactory*. Outcomes for faculty receiving ratings of *unsatisfactory* vary. Overall, results suggest that post-tenure review at the University of Louisville School of Medicine has facilitated faculty revitalization not only for those who failed, but also for others as they prepare for the evaluation process. The key to the success of this program is its nonpunitive nature. The focus on faculty development and the resulting reinvigoration of the careers of faculty put a positive spin on what otherwise would have been perceived as a top-down measure to increase faculty accountability.

In 1940, the American Association of University Professors (AAUP) issued their historical *Statement on the Principles of Academic Freedom and Tenure*.1 Perhaps the most notable excerpt from this document is as follows: "Tenure is a means to certain ends; specifically (1) freedom of teaching and research and of extramural activities; and (2) a sufficient degree of economic security to make the profession of teaching attractive to men and women of ability." Tenure stands today as the basis for most long-term contractual arrangements between faculty and their institutions. U.S. courts have fairly consistently upheld tenure as a legally binding contract that protects the property interests of the tenured faculty member. Tenure, as defined by the AAUP, is the guarantee of due process and can only be terminated for cause or under some other specific conditions; the most common condition for the termination of tenure is retirement. At the time that the AAUP statement was issued, the mandatory retirement age was 65.

The landscape changed at our universities when the Federal Age Discrimination Acts of 1986 and 1992 were issued. Termination of employment on the basis of age (mandatory retirement) in all but a few select professions (such as airline pilots) is now prohibited. Since the enactment of these laws to the present, the median age of medical school faculty has increased by about 10 years, and the percentage of medical school faculty over 65 years old has grown from near zero to over 12%.2

Whereas tenure is a property interest, and termination of tenure falls within the due process clause of the 14th Amendment, routine assessment of faculty performance and using those evaluations to determine whether a faculty member will be retained is not prohibited.3 Indeed, post-tenure review began to be discussed at most institutions when mandatory retirement was eliminated in the mid-1980s. By the 1990s, a significant number of legislatures, boards of trustees, and university administrators were making such reviews mandatory. This movement was fueled, in part, by the national cessation of tenure in Great Britain in 1988.4 By 1999 in the United States, post-tenure review was gaining such rapid momentum and widespread acceptability that the AAUP's committee on academic freedom and tenure issued a formal response that was endorsed by its membership at its 85th annual meeting 5:

The Association believes that periodic formal institutional evaluation of each postprobationary faculty member would bring scant benefit, would incur unacceptable costs, not only in money and time but also in dampening of creativity and of collegial relationships, and would threaten academic freedom .... The Association emphasizes that no procedure for evaluation of faculty should be used to weaken or undermine the principles of academic freedom and tenure. The Association cautions particularly against allowing any general system of evaluation to be used as grounds for dismissal or other disciplinary sanctions.

Although on main campuses a faculty member's entire salary is often guaranteed by tenure, the more limited financial guarantee associated with tenure in medical schools has often been challenged.6 In 1996, these challenges triggered a report e AAUP on compensation and tenure in U.S. medical schools in which there was acknowledgement that it was acceptable to modify the salaries of tenured medical school faculty, especially clinicians, on the basis of productivity.7 Two national

conferences by the American Association of Medical Colleges (AAMC) on tenure 8,9 further explored the relationship between tenure and compensation guarantees.

Whereas the AAUP statement and AAMC meetings focused on salary, the concept of tenure also addresses the right to hold an academic position and title. Post-tenure review is directed at this facet of tenure. In 1997, a survey was conducted by the AAMC, showing that 17 schools had put post-tenure review in place and that about 50% of all U.S. medical schools either had enacted or were considering some form of post-tenure review.10 As a result, a plenary session on the topic was planned for the 1998 national AAMC Faculty Affairs Development Conference in Annapolis, Md. This plenary involved a panel of faculty deans who had implemented post-tenure review, and it included the first author (L.S.). The results of the plenary, including the methodologies adopted and the preliminary outcomes, were summarized in the May/June issue of the AAMC's publication, *Academic Physician and Scientist*.10 A January 2007 survey that we conducted of faculty affairs deans through the AAMC Faculty Affairs listserve with e-mail follow-up requests to dean's offices showed that about 40% of 113 responding institutions (90% of the 125 U.S. medical schools) reported some form of post-tenure review, exclusive of annual merit reviews. Several medical schools no longer offer tenure, and these data must be interpreted in the context that for those schools, post-tenure review is not relevant. Therefore, currently about half of all medical schools with tenure mandate post-tenure review. Public schools are more likely to have post-tenure review than private schools. Regional differences are observed as well (Table 1).

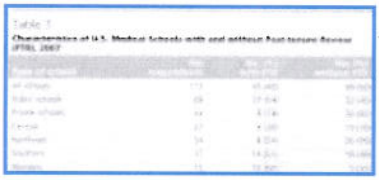

Table 1 **Characteristics of U.S. Medical Schools with and without Post-tenure Review (PTR), 2007**

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Introduction of Post-Tenure Review at the University of Louisville

At the University of Louisville, post-tenure review was mandated in 1994 by the board of trustees.11 The unconfirmed rumor that circulated was that a trustee had observed a tenured professor mowing his lawn in the middle of a work day and took the issue to the board along with some literature on post-tenure review as an emerging national trend. The implementation of these reviews followed a longstanding tradition (since the mid-1970s) of annual reviews that served as the basis for merit raise considerations. All raises at the University of Louisville were based on merit.

Initially, the reviews were for all paid faculty, including those without tenure (term faculty, contract faculty with no defined term, part-time faculty) and were called *periodic career reviews*. Although their name hasn't changed, five years after initiation the reviews were limited to tenured faculty and thus took on the form of true post-tenure reviews.12 The reviews for all university faculty occur after every five years of service for every tenured faculty member, with the review cycle reset should a promotion action intervene. Reviews involve the multitiered system of all University of Louisville career (tenure and promotion) reviews, with the exception of requiring intramural rather than extramural letters of evaluation. In the school of medicine, the faculty member's portfolio, made up of a curriculum vitae, reprints (if applicable), and intramural or extramural letters, is reviewed first by all members of the faculty member's department, then by the department chair, the faculty affairs dean, and, finally, the school's promotions, appointments, and tenure committee, for recommendation ultimately to the dean. Unlike promotion and tenure, which involve the provost, president, and board, the dean is the final decision-making authority on satisfactory or failed reviews. Anticipating approximately 35 reviews per year, and the required administrative structure to provide oversight for that, in 1996 the first author (L.S.) was asked to serve as the first associate dean for faculty affairs in the school of medicine, with the task of putting post-tenure review in place. This was not a popular mandate among the faculty, and to increase its palatability, a focus on faculty development was adopted.

Ten years after the initiation of the post-tenure review process at the University of Louisville, this paper provides an update on the process and its outcomes in the school of medicine.

Post-tenure Review Criteria and Methodology

Unlike promotion and tenure reviews in the school of medicine, which require excellence in the greatest area of effort (teaching, research, or clinical service) and proficiency in all other areas of involvement, post-tenure review requires only proficiency in each area of involvement. Whereas pretenured faculty are required to carry an assignment in all three areas, once tenure is achieved, the only required area of involvement is teaching. Criteria for proficiency in each area are explicitly defined in school documents.

All post-tenure reviews originate in the faculty member's home department after notification by the dean's office that a review is required. Although all faculty in the department review each case and vote, the binding pass/fail vote is restricted to tenured professors for full professors under review, and to tenured associate professors and professors for associate professors under review. Portfolio materials reviewed include at least four letters of recommendation, which, as noted, may be from intramural sources; a current curriculum vitae; annual work assignment letters issued by departmental chairs; annual merit evaluations; teaching evaluations; reprints; and separate recommendations by the department chair and the faculty committee. All votes and administrative recommendations are cast in terms of either *satisfactory* or *unsatisfactory*. Faculty undergoing post-tenure review may examine any substantive material in their personnel file at any time, although the identity of the evaluators, with the exception of the chair, is kept confidential to the extent permitted by law. Once departmental recommendations are made, the school's promotion, appointments, and tenure committee reviews the dossier and makes a recommendation to the dean. Due process procedures are in place to address disagreements at different levels of the review and to offer protection for academic freedom.

In the case of an unsatisfactory evaluation by the dean, a faculty member is re-reviewed two years later as a special career review. Within 30 days after the negative review, the chair and the faculty member under review, with the assistance of the dean's office, collaboratively prepare a development plan, which must ultimately be approved by the dean. The plan includes specific and measurable requirements to be met within one year, although in special cases the dean may approve a longer remediation period. Although a university-wide faculty development approach was taken in response to failed reviews, the medical school in particular mandated that the plans meet four criteria. First, the plan must clearly state objective goals related to the area of deficiency to be met. Second, the faculty member must participate in specified developmental activities. Third, the institution commits to providing agreed-on resources and opportunities for the faculty member, and fourth, the month of the follow-up special career review must be specified.

Considerable effort is made to provide resources to the faculty member to meet the requirements of a successful review. For example, faculty members whose research productivity received poor marks might be given funds to attend seminars on how to write grants and papers and might enter a formal mentoring relationship with a funded investigator. For instance, an endowed chair was one such mentor, and the faculty member experienced an increase in publication rate from less than one publication a year before the review (the rate required to demonstrate proficiency in research) to between two and seven publications per year after the review, and this faculty member eventually received independent National Institutes of Health (NIH) funding. Others established long-term collaborative arrangements with their mentors. We observed that these faculty often brought with them classical lab skills and techniques that were no longer in vogue among junior faculty but that were, nonetheless, useful to the funded investigator's research program. These skills often brought to bear unique approaches to contemporary research problems.

After the first year, the faculty member has an additional year to demonstrate satisfactory performance, and then he or she undergoes the follow-up special career review. If the follow-up review is satisfactory, the next five-year review cycle begins. If the review is again evaluated as unsatisfactory, the career record of performance is forwarded to the dean for appropriate disciplinary action, which may, according to university guidelines, include proceedings for termination.

Termination of tenure at the University of Louisville can occur for the following reasons: incompetence, neglect of or refusal to perform one's duties, or immoral conduct. The basis for termination following a failed special career review would be incompetence. Procedures for pursuing this option are laid out in detail in university documents that preexisted post-tenure review and did not change with its adoption. They include discussions between the faculty member and appropriate administrative officers to seek resolution; the preparation of a written recommendation for dismissal from the dean to the university president and copied to the faculty member, laying out the reasons for the recommendation, with reasonable particularity; and a full set of appeals procedures that the faculty member may follow, including an appeal before the university board of trustees. Fortunately, the option of termination for cause has never been pursued after a failed post-tenure review. This does not mean, however, that faculty have not left, as detailed below.

Outcomes

The first analysis of the periodic career review program took the form of a report to the provost during the second year nplementation. The report noted that several faculty resigned or retired *before* their review, which was attributed to r desire to avoid the rigors of the post-tenure review process.13 It was further reported that 3 of the 23 faculty (13%) who did participate received ratings of *unsatisfactory*. One of these subsequently opted to retire, and the other two prepared faculty development plans in accordance with university guidelines as described above.

Subsequent experience was similar to these early years, although with fewer failures as faculty perhaps either increased their efforts or left the university. From 1999 through mid-2006, 240 regular five-year post-tenure reviews and six special reviews were completed. Among the five-year reviews, 96.3%, or 231, were satisfactory. Of the nine faculty (3.7%) who failed, six subsequently passed the special career review, indicating successful remediation. Of the remaining three, one resigned before the special review; one gave up tenure and switched to a clinical service track, thus precluding a special career review; and one special review is currently pending. One faculty member who failed the five-year review before 1999 also failed the special review, and he declared his intent to relinquish tenure two years hence for phased retirement.

Several indicators suggest that the faculty of the school of medicine have a high degree of satisfaction with the process that was put in place, given the realities of a mandated post-tenure review. General acceptance is demonstrated by the excellent compliance we have with the program, and the lack of opposition to it. Senior faculty who had not undergone a regular career (promotional) review in many years reported that "it felt good to get positive feedback and professional validation from other colleagues."10 Other faculty with unsatisfactory initial reviews, like those described above, demonstrated success and believe their careers were revitalized. Indeed, an analysis of the publication record of faculty who underwent remediation in research shows an increase in publication rate that has been stable in the years after their reviews (Figure 1). Years later, these faculty also express gratitude despite an initial feeling of failure. It is generally thought that the process we put in place and the standards that we have established are fair and equitable, benefitting both faculty and the institution.

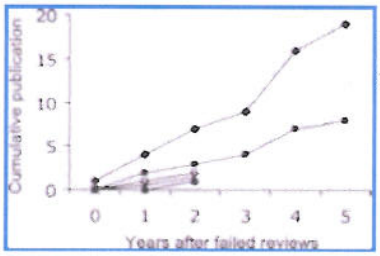

Figure 1 Publication records of faculty who underwent remediation in research after failed post-tenure review, University of Louisville School of Medicine.

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Observations and Conclusions

Overall, the post-tenure review process in the school of medicine at the University of Louisville has had several positive outcomes. Some of these are listed above for those faculty members who initially failed but later succeeded, as well as the reaffirmation felt by other faculty when their departments and the school gave, in effect, a "stamp of approval" for a job well done. Other less tangible positive outcomes also resulted. Faculty with waning research careers stepped up to the plate and took on heavier teaching and administrative responsibilities, reporting that they did not want to be perceived as not carrying their weight. According to reports provided by chairs,12 the departmental peer-review component of the reviews significantly contributed to the phenomenon of non-research-intensive faculty volunteering for increased teaching and administrative responsibilities and releasing research-productive faculty to engage in scholarly pursuits. The general research productivity of the faculty rose in the decade after implementation of post-tenure review (a tripling of the extramural funding, a threefold increase in the number of funded NIH grants, a 60% increase in publication rate, and an improvement in NIH rankings by more than 20 places among the 125 U.S. medical schools, from 95th to 73rd)14 because of several factors

along with that, the self-esteem that came with being busy and making a contribution. Contributions were then recognized in a formal way every five years.

The manner in which the post-tenure review process at the University of Louisville School of Medicine was implemented, for every tenured faculty member, every five years, is time- and resource intensive. Out of the 182 career reviews (post-tenure, promotion, and tenure) done in the last two years in the school of medicine, 78 (43%) were post-tenure reviews. The ol of medicine promotion and tenure committee meets monthly, and promotion/ tenure actions are processed after September each year and forwarded to the provost in January. Between February and August, the committee's work is dominated by post-tenure reviews. A comparable increase in workload is also borne by departmental committees and by the individual faculty members, staff, and chairs who are involved. Because of the magnitude of this effort, many schools at the university chose to do a triggered review that occurred only if a faculty member had a specified number of poor annual merit review evaluations. This triggered type of review is more in line with the recommendations from the AAUP 5 to address the reality that "some tenured faculty members may, nonetheless fail to fulfill their professional obligations because of incompetence, malfeasance or simple nonperformance of their duties."

We, however, believe there are benefits to the nontriggered, uniform way that we implemented post-tenure review in the medical school. The formal peer-generated reaffirmation of productive faculty would not have occurred if the triggered model of review had been adopted. In the triggered model, the review itself is a negative, punitive process, whereas in our model, post-tenure review is a routine, expected event that everyone goes through every five years. By mandating that all faculty undergo review, the process gently encouraged faculty to seek opportunities to become more involved in the school of medicine in whatever ways they could be actively engaged.

We believe that the key to the success of this program is its nonpunitive nature and the way the mandate to implement post-tenure review was executed. The focus on faculty development and the resulting reinvigoration of the careers of key faculty who had deficiencies put a positive spin on what otherwise would have been perceived as a top-down measure to increase faculty accountability. Indeed, even the AAUP response to post-tenure review 5 acknowledges the value of post-tenure review as a means toward faculty development as long as academic freedom is protected in the process.

Is academic freedom undermined by post-tenure review at the University of Louisville? Chairs at Louisville have for decades provided annual work assignments to their faculty that detail involvement in teaching (for all faculty), research, and service (including clinical service). The requirement that faculty demonstrate proficiency in all areas of academic involvement formally demonstrate it every five years was the major incremental change in scrutiny with the onset of post-tenure review. Due process precautions during the reviews and termination-for-cause processes have not been altered, and they still allow for robust protections. Accordingly, we believe that academic freedom has been preserved.

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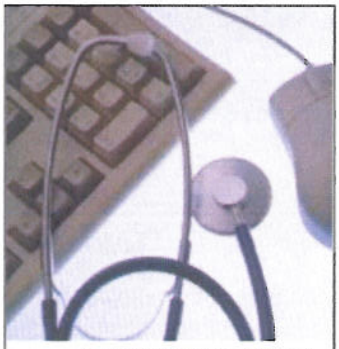

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Redefining Tenure at Medical Schools

Tenure-track? Yes/no.

"It's not true that tenure equals support." --Roy Silverstein

It's a common field on application forms for medical research grants, says Maryrose Franko, senior program officer at the **Howard Hughes Medical Institute (http://www.hhmi.org/)** (HHMI). In many cases, "no" means disqualification. But a few years ago, HHMI noticed that more and more top applicants for their early-career award were not tenure-track. "There were so many people who weren't tenure-track yet who were exactly who we wanted to support," Franko says. So, last year, they decided to expand the award's tenure-track requirement. Now, they also accept applicants who don't have the tenure-track label but can prove an equivalent level of tutional support. HHMI's decision followed on the heels of a similar one made by the **Burroughs Wellcome Fund** .p://www.bwfund.org/) (BWF) for its **translational research award (http://www.bwfund.org/pages/177/Clinical-Scientist-Awards-in-Translational-Research/)** . "Our guidelines did say you have to have a tenure-track position," says Nancy Sung, a senior program officer. "And now we say tenure-track or equivalent."

Those changes reflect a shift in the role of tenure in academic medical institutions. Traditional tenured and tenure-track research positions are still common, but they are becoming a smaller proportion of the total medical school faculty. These days, new faculty members are increasingly likely to be hired in nontenure-track positions, a better match for the short-term grant funding the institutions rely on. And many of those who do manage to land a coveted tenure-track position face reduced financial guarantees and a challenging funding environment.

As a result, today's early-career job seekers in academic medicine must look beyond the tenure-track label and look closely at the details: a position's specific financial guarantees, the institution's commitment to its nontenured young researchers, the value of the experience they will gain, and the contribution they will make to society. And while checking the nontenure-track box used to imply a tremendous disadvantage on grant and job applications, the gap seems to have narrowed. "What does tenure mean anymore?" Franko asks.

Shifting choices for Ph.D.s

What, indeed? Medical faculties are roughly divided into two parts: clinical faculty members who hold M.D.s or dual degrees and basic-science faculty members who hold Ph.D.s. Many medical schools offer tenure to only their basic-science faculty--an attempt to be consistent with the benefits offered to Ph.D.s throughout the university. But some medical centers are not part of a university and so don't offer tenure to anyone.

The relative decline of tenure at medical schools is largely a result of the rapid expansion in the numbers of clinical faculty being hired, usually, but not always, without tenure; the proportion of tenured and tenure-eligible faculty declined even as their numbers increased, according to **a 2007 article in Academic Medicine**

Courtesy, Andrea Ladd

Andrea Ladd

(http://journals.lww.com/academicmedicine/Fulltext/2007/03000/The_Continued_Evolution_of_Faculty_Appointment_and.12.aspx) by Sarah Bunton and William Mallon of the **Association of American Medical Colleges (http://www.aamc.org/)** (AAMC) in Washington, D.C. But a similar, though less dramatic, trend has also affected nonclinical faculty. Over the same period, the percentage of Ph.D. basic-science faculty with tenure or on the tenure track fell from 83% to 76%--right in line with the numbers from nonmedical college and university departments.

These trends can lead to difficult choices for Ph.D.-holding job candidates familiar with the traditional tenure model. When **Andrea Ladd (http://www.lerner.ccf.org/cellbio/ladd/)** , who has a Ph.D. in cell biology and anatomy, did her first faculty job search in 2004, one of her top choices was the **Cleveland Clinic (http://www.lerner.ccf.org/)** : It's strong in both heart disease and RNA biology, and her research is at the intersection of those two fields. "It's a really great fit for my science," she says. She also found the atmosphere congenial and collaborative. But the Cleveland Clinic did not offer tenure, whereas some of her other choices did. She had always envisioned herself in a tenure-track position, but she started to wonder whether tenure was important after all.

"It's not true that tenure equals support," **Roy Silverstein (http://www.lerner.ccf.org/cellbio/silverstein/)** , chair of Cleveland Clinic's **Department of Cell Biology (http://www.lerner.ccf.org/cellbio/)** , tells recruits like Ladd. "What the clinic has done is develop a series of systems, processes, and benefits which turn out to be more important than tenure." That includes in-depth coaching and mentoring programs, as well as bridge funding to carry people through rough periods. They also have an up-or-out review that resembles the tenure review, which helped convince Ladd that her colleagues would be of the same--or higher--caliber as those at an institution that offers tenure.

Ultimately, Ladd agreed with advice her postdoc adviser gave her: "What I really need to look at, more than whether or not there's tenure, is what the environment's going to be like," she says. More than 3 years later, now assistant staff (the equivalent of assistant professor in other institutions) in the cell biology department at the Cleveland Clinic, she's pleased with her choice. "Not having tenure means everybody has to stay productive and keep working really hard, and it keeps the whole environment really competitive," Ladd says.

Tweaking the tenure clock

Even at medical schools with tenure, institutions' increasing flexibility has given scientists the freedom to opt for unconventional paths. As a postdoc, **Steven Wendell (http://www.dental.pitt.edu/oral_biology/StevenWendell.php)** , who has a Ph.D. in genetics, had become active in the **National Postdoctoral Association (http://www.nationalpostdoc.org/)** , at which he discovered a love for science policy and administration. So for his first faculty position at the University of Pittsburgh, he split his time between administrative responsibilities in the **career development office (http://www.oacd.health.pitt.edu/index.html)** of the **Schools of the Health Sciences (http://www.health.pitt.edu/)** and research responsibilities in the **School of Dental Medicine (http://www.dental.pitt.edu/index.php)** , where he was a rare Ph.D. among physician-scientists.

Courtesy, Steven Wendell

Steven Wendell

Although he ultimately wanted tenure, he did not want his first few years in this unusual arrangement to count because his research accomplishments would be limited. A dual role is "not optimal for making progress on your tenure," he says, but "it was enormously fulfilling." So his supervisors agreed that he would spend the first several years in a nontenure-track position and then transition to a tenure-track position, which he is doing now. That means giving up his administrative responsibilities and focusing on research and teaching. "Pitt's very good at developing from within and very supportive of people in that category of nontenure-track," he says.

Physician-scientist **Tony Moody (http://humanvaccine.duke.edu/modules/moody/index.php?id=1)** , an instructor at Duke University School of Medicine, is also on the cusp of a track switch. After finishing his bachelor's degree at Duke, Moody worked for several years as a chemist, eventually joining the laboratory of Duke HIV researcher **Barton Haynes (http://humanvaccine.duke.edu/modules/haynes/index.php?id=1)** . Moody then decided to attend medical school, again at Duke, so he could run his own laboratory. After Moody finished his training, Haynes recruited him again to join the newly created **Center for HIV/AIDS Vaccine Immunology (https://chavi.org/)** at Duke, where Moody now runs his own lab. He spends 90% of his time in his cellular immunology lab and the rest treating patients.

Like Wendell, Moody negotiated a nontenure-track position followed by a transition to a tenure-track position when he felt ready. "Getting independent grants right now is so tough that making that jump ... didn't seem to be a particularly wise move," Moody says. To make grant-writing easier for people off the tenure track, Duke's medical school recently changed the nomenclature of its faculty tracks, moving from coded names such as associate clinical professor to a more neutral numbering system, such as Track V professor. Both titles denote nontenure-track status. The medical school's administration hopes this will combat the prejudices of the grant reviewers, as well as help do away with the "class system" common at many medical schools, says Ann Brown, the associate vice dean for faculty development at the medical school.

Now on the cusp of his transition to the tenure track, Moody is optimistic about his chances of success at earning tenure, but circumspect. "Tenure isn't necessarily the only goal," he says. He wonders whether "the extra 10, 15, 20 hours a week worth of work" required to get tenure might be better spent with his family. "If I succeed and get tenure at Duke--great," he says. "And if I don't, then there certainly are other opportunities out there."

Changing money

Moody notes that even with tenure, "you're guaranteed a job, but you're not necessarily guaranteed a great salary." The way his contract works, he'll get only about 25% of his salary if he fails to secure any grant funding. And he might even be considered lucky: In **the 2007 Academic Medicine article**

Courtesy, Jayanta Debnath

Jayanta Debnath

(http://journals.lww.com/academicmedicine/Fulltext/2007/03000/The_Continued_Evolution_of_Faculty_Appointment_and.12.aspx) , Bunton and Mallon reported that 38% of medical schools offered no financial guarantee for tenured clinical faculty and 35% offered no financial guarantee for tenured basic-science faculty.

Jayanta Debnath (http://labmed.ucsf.edu/about/faculty/pathology-jdebnath.html) , a physician-scientist, found a similar ation during his job search a few years ago; he interviewed for one tenure-track position that guaranteed 100% of his salary, but ther offered no salary guarantee at all. That played only a small part in his decision, he says; a supportive working environment was more important. "I knew I was going to either have to get a NIH-funded grant between year 3 and year 5 or I was going to

have to look for some other type of employment." Debnath is now an assistant professor in the **Department of Pathology (http://labmed.ucsf.edu/index.html)** at the University of California, San Francisco, where 50% of his salary is guaranteed.

For many, Debnath's tenure-track position came with protected research time, meaning that the university covered his expenses and he could get National Institutes of Health (NIH) funding, which he recently secured. (NIH's research grant eligibility requirements have long been "tenure-track or equivalent," the term BWF and HHMI recently adopted.) "I'm one of the lucky few," he says, noting that most nontenure-track physician-scientists have neither salary guarantees nor protected time. They are expected to bring in enough money right away to both pay their own salaries and support their labs--either by seeing patients or by getting grants.

With patients abundant and grants elusive, Debnath has seen many physician-scientist colleagues forced to let their research lapse in favor of more lucrative--and often more urgent--clinical duties. "For these soft-money positions, you fund your own salary to the expense of your own lab," he says. He notes that physicians with more intensive specialties, such as neurosurgery or emergency medicine, were more likely to be overwhelmed by those duties than others. "I don't know of a single person who has succeeded" in getting a high-level research grant without a tenure-track or similarly protected position, he says.

New definitions

Tenure-system changes are happening for two reasons, says Bunton, who is a senior research analyst at AAMC. First, medical schools operate on a "tenuous" funding model that does not mesh well with the permanent commitment they make to their tenured faculty. Second, schools are recognizing that the increasing research and funding pressures of a traditional tenure-track pathway are sometimes unrealistic in the face of patient care, teaching, or--for some--family responsibilities outside of work.

Nonetheless, Bunton's research suggests that the tenure system is not in danger of disappearance. Since at least 1994, when AAMC began its surveys, no medical school has totally abandoned tenure. Only a few limit it to basic-science faculty. "I think it's really difficult to conclude that tenure is in jeopardy," she says. It's just that tenure, and its role at institutions, is changing.

It is possible, Duke University's Brown says, that these changes may prove more consistent with the values of the incoming generation of researchers, who tend to be less loyal to institutions and more interested in wide-ranging careers and work-life balance. "We have to be thinking about how we train individuals to be flexible," says **Joan Lakoski (http://www.oacd.health.pitt.edu/bios/lakoski.html)** , the associate vice chancellor for academic career development at the University of Pittsburgh Schools of the Health Sciences. Even if young researchers are not thrilled with the shrinking proportion of tenure-track positions, she says, the changing tenure picture provides opportunities for them to take advantage of their unique strengths and form new, unconventional collaborations.

Lakoski presents Wendell, who used to work in her office, as the case in point, and he agrees. "Nobody would get up ever in a workshop and propose the model that worked for me," Wendell says. "Don't be constrained by this traditional pathway."

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Science Careers From the journal Science

p://sciencecareers.sciencemag.org

Career Advice

The Incredible Shrinking Tenure Track

The fastest growing category of post-postdoc academic scientists is not the tenure-track assistant professorship to which countless postdocs aspire. It is the array of non-tenure-track jobs that carry such assorted titles as staff scientist, research associate, lecturer, and research assistant professor. Holders of these positions have "graduated" from working as trainees under a mentor's supervision but usually still have not attained a status that allows them to do independent research.

"Key to the problematic status of most non-tenure-track scientists is universities' widespread refusal to allow them to apply for their own research funding, the sine qua non of scientific credibility."

Need to clarify roles and career possibilities

The growth in this category is particularly marked in the life sciences, but is apparent in other fields as well. While the ranks of science Ph.D.s holding faculty-level jobs outside the established career ladder have multiplied in recent years, the number of traditional assistant professorships offering a shot at tenure has stagnated or even declined. Also rising is concern about this expanding cadre's duties, prerogatives, and long-term career prospects. Clarifying the roles and possibilities open to non-tenure-track university scientists and finding ways to make the best use of their talents and training presents a challenge to the leadership of the nation's research enterprise.

mmittee of the National Academies' Board on Life Sciences began to tackle this issue, along with others related to the increasingly difficult career passage facing young scientists, at a day-long workshop held on 16 June at the academies' Keck Center in Washington, D.C. Entitled "Bridges to Independence: Fostering Independence of New Investigators in the Life Sciences," the gathering drew approximately 100 representatives of universities, private funding organizations, NIH institutes, and other government agencies. Plenary sessions and breakout discussions explored many aspects of the situation of young scientists in both tenure-track and non-tenure-track university jobs.

A few of these non-tenure-track positions are the "moral equivalent" of the traditional assistant professorship in that they permit or even encourage independent research--albeit on soft money, stated Keith Yamamoto, a professor of cellular and molecular pharmacology at the University of California, San Francisco. But many nontenured staff scientists "have been treated as second-class citizens in many ways," and their situation "has to be dealt with," said David Hirsch, Columbia University's executive vice president for research.

Key to the problematic status of most non-tenure-track scientists is universities' widespread refusal to allow them to apply for their own research funding, the *sine qua non* of scientific credibility. NIH permits grant applications from scientists without tenure-track positions, but it also requires that their proposals have institutional backing. Universities are generally loath to commit themselves to providing to individuals outside the tenure track the lab space and other resources needed for research. As the life sciences increasingly move toward interdisciplinary team projects and away from the traditional single-PI model, noted NIH Director Elias Zerhouni, the nation's funding agencies will need to "redefine career paths," possibly in ways that "empower ... very senior staff scientists."

Between 1993 and 2001, the number of life scientists under the age of 35 holding Ph.D.s from U.S. universities increased from 11,000 to about 16,000, but the number of tenure-track assistant professorships at major research universities remained steady at about 1200, said Paula Stephan, a professor of economics at Georgia State University in Atlanta. In 1993, 26% of the faculty-level positions at those institutions were outside the tenure track, as opposed to 33% in 2003, she added.

In recent years, universities increasingly have replaced tenure-track positions that fall vacant with non-tenure-track slots. At research universities, faculty-level jobs lacking the possibility of tenure have risen from 55% of new hires in 1989 to 70% today. The probability that a Ph.D. recipient under 35 will obtain a tenure-track job has fallen from 10% in 1993 to 7% in 2003.

These trends have made job competition among young scientists "very Darwinian," stated Norka Ruiz Bravo, deputy director for intramural research at NIH. Tenure-track openings routinely attract scores or even hundreds of applications, several speakers

noted. Amidst mountains of resumes, hiring committees of competing research universities vie for the same small group of elite candidates. These few stars each garner multiple interviews and job offers while many of their fellow applicants count themselves lucky to receive a form rejection letter. Sometimes, in fact, departments that fail to land their top choice leave tenure-track positions unfilled rather than hire from a slightly lower echelon.

Immense cost and risk for universities

This apparently paradoxical situation arises from the merciless economics of competition for NIH R01 grants, which several participants termed the "holy grail" of scientific survival. "Big salary differences" separate tenure-track and non-tenure-track positions, Stephan noted. That differential pales, however, beside the truly immense cost--and therefore the immense risk--that universities must shoulder to outfit new assistant professors for the big-time funding fray. Start-up costs for new tenure-track faculty members--which must be footed by the university several years before many novice assistant professors can realistically be expected to bring in significant grant money--average $300,000 at public universities and $400,000 at private ones, Stephan said. But they can go much higher--to $1 million or more, according to Robert Goldman, chair of cell and molecular biology at the Feinberg Medical School at Northwestern University, who recounted spending $3 million to hire two faculty members.

These arrangements, Goldman added, assume that NIH will begin picking up some of the costs within 3 years, an eventuality far from guaranteed for young investigators without demonstrated success winning R01 grants. Indeed, Goldman noted, hiring a proven senior researcher away from another university is often a better economic bet than launching even an apparently stellar novice. The initial investment for the established investigator is higher, but "not that much higher," and an "immediate transfer" of his or her funding soon follows, Goldman explained.

Creating opportunities for increased scientific independence among non-tenure-track scientists will therefore require a variety of new arrangements, concluded a breakout discussion led by Susan Gerbi, George Eggleston Professor of Biochemistry at Brown University. Complicating the picture, she noted, is the wide range of job situations found in that catch-all category, including, among others, former postdocs who have stayed on as staff researchers in a mentor's lab, scientists running facilities that service a number of investigators, and trailing spouses of tenure-track faculty who are working on their own projects. No data currently details this varied group's characteristics.

Clearly, though, the need for space and facilities, which NIH demands and institutions would have to finance, is a major obstacle to any effort to provide these scientists a degree of independence. In some cases, Gerbi suggested, PIs can solve the problem by providing staff scientists space and time to work on their own projects within the PI's lab. She, for example, has made just such an arrangement with a longstanding staffer of her own lab. But such a setup, she continued, keeps the staff scientist at the mercy of the PI's career moves, including retirement, relocation to another university, or loss of the PI's grant funding.

University-run "incubator" facilities providing space and various centralized services could also equip non-tenure-track scientists for independent research in the absence of large grants, suggested Christopher Espenshade, assistant professor of cell biology at Johns Hopkins University. But, warned Philip Clifford, associate dean for postdoctoral education at the Medical College of Wisconsin, the departmental divisions within universities could make such facilities difficult to establish and run. And to compete successfully for grants, Gerbi noted, nontenured scientists would need ways of convincingly demonstrating that their proposed work will be truly their own and not a "backdoor" means for PIs' labs to receive additional grants. Study sections would also have to take non-tenure-track scientists' beginner status into account in rating their proposals, the group agreed.

The entire committee will have to struggle with the issue of non-tenure-track scientists as it prepares its report, agreed Thomas Cech, president of the Howard Hughes Medical Institute and chair of both the committee and the workshop. Increasing interdisciplinary work, the growth of team science, and economic pressures following the end of NIH's "doubling" are among the forces bringing important changes to university science, he noted. Finding ways to meet the needs of non-tenure-track scientists and make the best use of their talents and skills will doubtlessly challenge not only Cech's committee but many others for some time to come.

Promotion and Tenure Manual

School of Dentistry

University of North Carolina at Chapel Hill

DRAFT

Key to interpretation of changes to document:

- Sections in red type are sections where changes were made
    - Items underlined are the specific changes made.
- Items that were deleted from the document are lined-out, e.g. ~~deleted item~~
- Sections highlighted in yellow are sections of the UNC-CH Faculty Code that have been modified recently and now are mandatory for all promotion and tenure decisions taking place in the University.

May, 1991

Revised: July, 1995

Revised: June 2004

Introduction

Promotion and Tenure is at the heart of the academic reward process for university faculty. The School of Dentistry is committed to having its faculty well-informed about the expectations for promotion and tenure and the process used to evaluate faculty. Hence, the School makes this manual available to all current and new faculty members.

It should be noted that Section I of this document is the promotion and tenure policy statement, while Sections II-IV contain supporting information.

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1. PROMOTION AND TENURE GUIDELINES

The guidelines set forth by the Board of Trustees of the University and the School of Dentistry Guidelines are the basis for all promotion and tenure decisions in the School of Dentistry. The Promotion and Tenure Advisory Committee (PTAC) uses these guidelines as the basis for their evaluation of candidates. School Guidelines were developed to conform to University Guidelines. If inconsistencies occur between the two documents, the University Guidelines take precedence.

1.1 UNC PROMOTION AND TENURE GUIDELINES

The University of North Carolina at Chapel Hill promotion and tenure guidelines are specified in the Trustee Policies and Regulations Governing Academic Tenure in the University of North Carolina at Chapel Hill, July 1, 1994, which is included with the School of Dentistry Promotion and Tenure Manual as a separate document. In addition, the University asks that the following statement be a part of the School of Dentistry promotion and tenure information:

University Criteria for Evaluation of Candidates for Reappointment and Tenure

The Trustee Policies Governing Academic Tenure in The University of North Carolina at Chapel Hill indicate that tenure is held with reference to the institution and with reference to institution-wide standards. Section 2.a. of the Trustee Policies, for example, provides as follows:

"While academic tenure may be withheld on any grounds other than those specifically stated to be impermissible under Section 4 hereof, its conferral requires an assessment of institutional needs and resources and evidence of service to the academic community, potential for future contribution, commitment to the welfare of the University, and

demonstrated professional competence, including consideration of commitment to effective teaching, research, or public service." Section 4 of the Trustee Policies provides that the decision regarding tenure "is committed, without further recourse, to the judgment of the officers of administration authorized to make it, acting in accordance with prescribed procedures. In exercise of their judgment, whether in the first instance or in review of a recommendation to reappoint, such officers may take into account and use as a basis of decision, in whole or in part, any factors deemed relevant to total institutional interests..."

The tenure system is based upon the understanding that tenure is a privilege bestowed by the institution in keeping with its needs for outstanding achievement. It represents a fundamental institutional judgment of an individual's actual and potential contributions to the professional life of teaching, scholarship, engagement and service. Thus not everyone will obtain tenure; no set of detailed criteria can exist, the mere fulfillment of which will ensure tenure; and there will occasionally be differences of opinion about evaluations of an individual's contributions. Also relevant in the tenure decision are institutional interests that necessarily extend beyond the domain of any individual department or school. To insure that its intellectual quality is maintained and enhanced, the University insists on a standard of overall excellence.

As a reflection of the relevance of institutional interests, candidates for reappointment and tenure are evaluated independently according to the criteria referenced above at several levels of university administration, including the level of the Department Chair, Dean, Vice Chancellor for Academic Affairs or Health Affairs as appropriate, Chancellor, Board of Trustees, and Board of Governors. Each level of administration may apply different or even higher standards of excellence from those applied at previous levels of review, consistent with school, division, and University-wide interests that are represented by these different levels.

1.2 SCHOOL OF DENTISTRY PROMOTION AND TENURE GUIDELINES.

1.2.1 INTRODUCTION

The purpose of this document is to facilitate the evaluation of faculty in the promotion process by describing criteria to be applied in making promotion and tenure decisions. An additional purpose is to provide a set of guidelines that may be useful in guiding individual professional development. These criteria allow consideration of a wide range of the activities of all faculty members. For example, an emerging area of scholarship involves community engagement or service. Community entails a group of people who share a common location, interests, values, work or identity, and who have an association due to common traditions, or political, civic, social, cultural or economic interactions. "Community engagement is the application of institutional resources to address and solve challenges facing communities, through collaboration with these communities (CCPH, 2005)." "Community-engaged scholarship involves the faculty member in a mutually beneficial partnership with the community." It can be interdisciplinary or draw on the principles of community-based participatory research. According to the 2005 Report of the Commission on Community-Engaged Scholarship in the Health Professions, "it is important to point out that not all community-engaged activities undertaken by faculty are scholarship. For example, if a faculty member devotes time to developing a community-based health program, it may be important work and it may advance the service mission of the institution, but unless it includes the other components that define or represent standards for scholarship (e.g., clear goals, adequate preparation, appropriate methods, reflective critique, rigor and/or peer review) it would not be considered scholarship (Glassick et al, 1997).

Because of the diversity of faculty interests and responsibilities, it is not possible to establish a precise series of steps that, when taken, will automatically lead to favorable decisions concerning promotion and tenure. Moreover, since a decision to promote includes a judgment of superior quality of performance, an organized set of illustrations carries with it the risk of being misleading. Nonetheless, the examples of activities cited herein, though not all inclusive, are typical of those considered in the promotion decision.

Faculty may be evaluated in terms of their teaching, scholarship, professional and community engagement/service. For the period being evaluated by the current promotion, the weights

applied to these three areas in reaching a promotion and tenure decision generally will reflect the proportion of time allocated to each area in the candidate's Terms and Conditions of Appointment Statement as may be modified by the Chair during their employment. Service implies a donor-recipient relationship in which one party, generally the community, receives benefit from interaction with the faculty member. "Community engagement is the application of institutional resources to address and solve challenges facing communities through collaboration with these communities (CCPH, 2005)." The defining aspect of engagement is the collaboration and mutuality of benefits.

All decisions on promotion and the awarding of academic tenure shall be based upon considerations of the demonstrated professional competence, the potential for future contribution of the faculty member, and of the needs and resources of the institution.

Sections I.2.2 through I.2.4 specify criteria for different types of faculty. The School of Dentistry defines those faculty members as follows:

Tenured and Tenure-track – those faculty members who have earned permanent tenure or who are appointed to probationary positions with eligibility for tenure.

Fixed-term -- those full-time faculty members who are appointed for a specified period of time for a specific purpose, such as teaching, research, academic administration, or public service from an academic base. The academic rank will have a prefix-qualifier, such as Clinical or Research, depending on the nature of the appointment.

Adjunct -- those faculty members who are part-time and appointed for a specified period of time for a specific purpose.

1.2.2 TENURED AND TENURE-TRACK FACULTY

It is the duty of faculty in the tenure track to contribute in each of the three areas-*teaching, scholarship and* community-engagement/*service*. Such a spectrum of contribution is essential to the vitality and excellence of the institution, as well as to the professional growth of the individual faculty member.

As an integral part of each promotion evaluation, the primary commitments of the faculty member are considered and an assessment made of their opportunity to contribute to each area of activity. Contributions in the areas where the greatest responsibilities and opportunities lie are weighed more heavily in the evaluation.

The School of Dentistry follows the regulations set forth in Section 2 of the Trustee Policies and Regulations Governing Academic Tenure as to the timing of reviews for re-appointments and promotion. The School also is in accord with the Chancellor's March, 1992 Memorandum detailing a Faculty Major Disability and Maternity Leave Policy. The current policy allows for temporary relief from employment obligations or less than full-time employment, each with commensurate compensation reductions, with appropriate administrative approvals. This temporary relief can be provided for compassionate reasons of health, requirements of childbirth or child care, or similar compelling reasons. Such relief may include extensions of the period of probationary appointment to coincide with the extent and duration of the relief from full-time employment.

1.2.3 FIXED TERM FACULTY

Faculty appointed for a fixed *term make* important and continuing contributions to the vitality and excellence of the University. There are two distinct types of fixed-term faculty, clinical and research. These faculty members may enjoy satisfying academic experiences and professional growth through the pursuit of activities primarily in two of the three areas. Although the criteria for evaluation of faculty in the tenure track and faculty being considered for fixed-term appointment at a higher rank are the same for each area, the different concentrations of activities between fixed-term and tenure-track faculty result in circumstances that merit additional specification.

1.2.3.1 Clinical Instructor, Assistant, Associate, and Full Professor.

It is expected that faculty in the clinical track will be evaluated primarily on the effectiveness of their teaching, supplemented by consideration of their community-engagement/service or research activities. Even though the expectations for the amount of teaching are greater for faculty in this track, the criteria for evaluation of effectiveness are the same as for faculty in the other tracks. In addition, if a clinical faculty member is evaluated for teaching and community-engagement/service, there is still the expectation that they will participate in scholarly activity defined in its broadest sense (see section on

research). This requirement is imposed in the spirit of maintaining the academic viability of the teacher rather than requiring data-based research activity from all faculty members.

1.2.3.2 Research Instructor, Assistant, Associate, and Full Professor

It is expected that faculty in the research track will be evaluated primarily on the quality of their research, supplemented by consideration of their teaching or community-service/engagement activities. It is recognized that research track faculty operate under particular restrictions imposed by the need for their salaries to be funded primarily from research activities. Research productivity should be commensurate with the time devoted to research and achieving the status of an independent investigator is expected to occur sooner than in other tracks. It also is recognized that for research track faculty, teaching roles involving activities as a research mentor, thesis advisor and committee work, and graduate level teaching may be more compatible with their prime source of salary support than clinical, preclinical and didactic teaching of pre-doctoral students.

1.2.3.3 Administration:

It is recognized that there are a few faculty whose appointments are based on a need for administrative leadership. These faculty members are heavily committed to administrative roles that are both essential to and valued by the School. Fixed-term faculty members in these roles are eligible for consideration for promotion based on either evaluation of teaching or research and community-service/engagement. ~~In these instances, service can be the primary area of evaluation for promotion with teaching or research.~~ *However,* an evaluation of the functioning of the unit that they supervise must be a major component of the evaluation. This can be by a process similar to that used in the evaluation of a program director or chair prior to re-appointment.

In instances where Department Chairs and Unit Directors are being reviewed, it is generally considered that they spend 30% of their time in Departmental Administration. This time can be considered as service to the School and University.

1.2.4 ADJUNCT FACULTY

Adjunct faculty members are part-time faculty members that serve in a variety of very valuable roles in the School of Dentistry. The adjunct faculty group includes individuals who provide teaching,

research, or community-engagement/*service* with time commitments that range from one or two days per semester to one to three days per week. Dental personnel who provide supervision to students on extramural rotations also have adjunct faculty appointments. Some adjunct faculty members are paid and others receive no remuneration. All such faculty members have demonstrated their commitment to promote the academic and professional interests of the School of Dentistry. Their contributions to these efforts are recognized through appointment at higher rank when appropriate.

Due to their part-time work schedule, appointment at higher rank for adjunct faculty ordinarily will be at longer intervals than full-time faculty. *Initial review of part-time faculty with a commitment of one-half day a week or more will occur at seven years, with subsequent reviews occurring at five year intervals, thereafter.* The department professors committee and the Department Chair may conclude that more or less time is needed for consideration for appointment at higher rank based on the scope, value, and quality of the part-time participation of the individual. *Such consideration is highly relevant for individuals who have less than weekly commitments to the School of Dentistry*. Adjunct faculty who do not have a continuing relationship with the School of Dentistry will not be considered for higher ranks.

Adjunct faculty will be reviewed only in those areas designated for their specific responsibilities. Thus the review may be limited to a single area. Criteria for evaluation *can include but will not be limited to teaching evaluations, chair's evaluations, CV, supporting letters, and any available faculty evaluations.* Documentation for adjunct faculty who supervise students at extramural sites would rely primarily on student reports and evaluation by the director of the extramural rotation program.

1.2.5 AREAS TO BE EVALUATED

The areas of activity evaluated in these decisions are: (1) teaching; (2) scholarly activity, the essential component being research; and (3) community-engagement and professional or public service. These areas are interrelated and mutually supportive; participation in one enhances performance in the others.

1.2.5.1 TEACHING

Teaching is a primary function of the University. It is related to and supported by research and other scholarly activities. It extends beyond the institutional setting and serves the profession and the community at large. All faculty in the tenure track and appropriate fixed term faculty must make a significant time commitment to teaching.

Faculty members are expected to be knowledgeable of the literature and other information in their field of expertise. The complete faculty member should demonstrate the ability to assimilate and integrate this knowledge and the ability to effectively teach such knowledge.

Evaluation of teaching effectiveness does not lend itself solely to quantitative measurement and, in the final analysis, may be largely subjective. However, input into the evaluation from peers, department chair, students and other sources can help maximize the validity of the value judgments that must be made. *For full-time faculty, a teaching portfolio is the accepted method to document teaching ability and effectiveness. Suggested contents for such a portfolio are described in section 3.3.3.1.a & b.*

The criteria for teaching effectiveness that shall be considered in evaluation are quality, innovation, impact upon students, and degree of responsibilities. Evaluation will be made in all areas of the faculty member's assignments including: classroom teaching, laboratory and clinical teaching, course coordination, seminar leadership, supervision of individual student projects, and development of instructional materials.

Quality

The foundation of quality teaching is mastery of the subject, including the spectrum of the current literature in one's discipline. Essential components of the teaching effort are appropriate methods of instruction, effective planning and organization, appropriate methods of evaluation, and adequate feedback to students.

Teaching of superior quality may be characterized by:

- Utilization of highly effective oral, visual, and written communication techniques
- Stimulation of critical thinking and problem solving
- Encouragement of conceptual comprehension as well as factual recall
- Encouragement of students to raise questions and express ideas
- Performance of duties with enthusiasm and energy

- Continually up-dates teaching based on current knowledge, techniques, and concepts

Innovation

Teaching excellence includes some degree of innovative effort on the part of a faculty member. Innovations in teaching must accomplish more than mere change. Rather, new methods should show measurable advantages over those previously used. Some examples of innovations in teaching are:

- taking advantage of new technology to improve teaching effectiveness
- development of new courses and programs or unique learning experiences
- use of educational research - development of methods to evaluate individual teaching, courses, or curriculum

Impact upon students

A positive impact of teaching on the student should be the goal of each faculty member. The qualities of teaching that have positive influences on the student are numerous and may be difficult to measure. *A complete appraisal regarding the quality of teaching may be obtained through formal evaluation of teaching; however, informal evaluations may be used to supplement the formal teaching evaluation. Some examples of informal evaluation are:*

- *students pursue independent study as a result of interaction with the faculty member*
- *students provide unsolicited evaluation of faculty*
- *awards earned by students under faculty mentorship*

Desirable qualities of teachers may include but are not limited to those described by the following:

- presents a balanced point of view
- treats students with respect
- provides constructive criticism without belittling
- is reasonably available for consultation
- is fair and reasonable in evaluation of students

- compliments students for appropriate contributions or performance
- continually evaluates his/her own teaching
- meets teaching obligations by being prompt and available throughout the teaching/clinic session
- presents material at the appropriate level for the type of students being taught
- takes opportunities presented to teach individual students in the clinical setting
- follows course guidelines as to appropriate laboratory objectives and methods
- is effective in small groups or seminars in leading discussions
- devotes appropriate time in mentoring students and displays organizational skills that result in student achievement

Student input in faculty evaluation is essential, but is only a portion of the information considered. . Such input must be used in conjunction with the other factors that affect the quality of teaching *as shown in section 3.3.3.1.b that describes the contents of the teaching portfolio.*

Degree of responsibility

The degree of responsibility assigned to the faculty member is a consideration. The extent to which the faculty member's responsibilities contribute to the teaching programs of the school is of importance (e.g. directing a course or having primary responsibilities for a teaching program).

1.2.5.1.1 SCOPE OF TEACHING ACTIVITIES

Teaching is defined in the broadest possible context and may encompass lecture, small group, seminar, clinical and laboratory instruction, *and one-on-one instruction.* Recipients may be undergraduate students, allied dental education students, predoctoral dental students, advanced education students, residents, graduate students, and postdoctoral fellows. Dissertation and thesis supervision and mentoring of students and fellows also are included under this definition of teaching.

1.2.5.1.2 CRITERIA PERTINENT TO ALL PROMOTION DECISIONS

The criteria for teaching effectiveness that shall be considered in promotion decisions to assistant, associate, and full professor include quality of teaching, innovation in teaching, innovation in methods for evaluating students, impact upon students, and nature and extent *of responsibilities*. It is recognized that authoring a textbook is scholarly activity and that the book itself can be viewed as evidence of teaching. The School of Dentistry may consider authorship of textbooks either as teaching or a scholarly activity usually at the discretion of the candidate (See Section 1.2.6.)

1.2.5.1.3 CRITERIA PERTINENT TO FULL PROFESSOR DECISIONS

Promotion based on excellence in teaching is viewed similarly to promotion based on research and service accomplishments. Promotion is not based on time-in-rank. _The expectations for promotion to full Professor in the area of teaching involve wider recognition of the individual as a teacher and evidence of a more scholarly approach to teaching. Examples of these characteristics may include but are not limited to the following:

- Service as a course director, graduate program director, or residency director provides an opportunity to demonstrate organizational, testing, feedback, mentoring, and student remediation skills beyond those demonstrated by simply participating as a course member. Being a successful course director is an indication of the teaching maturity expected of a full Professor.
- Broader contributions to the teaching profession, such as authorship of textbooks, curriculum offerings or teaching materials adopted by other institutions, publication of reports involving innovative new educational or evaluation techniques, development of new programs, and/or publication of conceptual articles regarding dental education
- Contributions to the teaching mission outside the University such as participation in regional, national, and international educational activities, participation as a visiting professor or outside speaker (non-research), and activity in national organizations devoted to teaching

- Publication of peer-reviewed articles on new educational methodologies, clinical techniques, or clinical case studies appropriate to the teaching mission.

1.2.5.1.4. METHODS OF EVALUATION

Evaluation of teaching effectiveness cannot be solely a quantitative measurement and, in the final analysis, has a subjective element. However, input into the evaluation from peers, department chairs, students and other sources can help maximize the validity of the value judgments that must be made.

Assessment of all the faculty members teaching assignments will be part of the evaluation including classroom teaching, laboratory and clinical teaching, course coordination, seminar leadership, supervision of individual student projects, and mentoring.

The methods currently used to evaluate teaching by the School of Dentistry are detailed in Section 3.3.3.1.

1.2.5.2 SCHOLARLY ACTIVITY

Scholarly activity is a central mission of a research university. Its components are: the compilation, synthesis, and transmission of current knowledge; and the generation of new knowledge through original research and publication of the findings. All faculty in the tenure track and appropriate fixed term faculty must engage in scholarly activity, a major portion of which must be original research.

In the evaluation of this aspect of promotion, attention shall be directed to the time a person has had for scholarly activity, the guidance and support provided to expand that time, and the resources available to enhance productivity. In all instances, the quality of the scholarly activity, as judged by authorities in the field, will be the critical measure.

Compilation, synthesis, and transmission of current knowledge

All scholarly activity supports teaching and community-engagement/professional service. The compilation, synthesis, and transmission of current knowledge is one aspect of this activity that contributes to and advances scholarship. Such scholarly work may take many forms.

Boyer's five dimensions of scholarship are: teaching, discovery, integration and application and engagement (Boyer, 1990). "The scholarship of teaching includes transmitting, transforming and extending knowledge. The scholarship of discovery refers to the pursuit of inquiry and investigation in search of new knowledge. The scholarship of integration consists of making connections across disciplines

and, through this synthesis, advancing what we know. The scholarship of application asks how knowledge can be practically applied in a dynamic process whereby new understandings emerge from the act of applying knowledge through an ongoing cycle of theory to practice to theory. The scholarship of engagement connects any of the above dimensions of scholarship to the understanding and solving of pressing social, civic and ethical problems."

Activities that support teaching and/or community-engagement/service may include: the publication of textbooks, book chapters, review articles, case reports, technical and clinical procedures, and instructional materials; the development of new continuing education courses; and the editorship of professional journals.

Research, scholarship and publication

Research is the generation of new knowledge through use of the scientific method. Such research may be basic, behavioral, clinical or in health services. It is most frequently expressed as manuscript publication in refereed scientific journals.

A reasonable level of research productivity is required; however, it is the quality of the investigative activity that is of primary importance in evaluation. The quality of research can be most readily measured through two peer review mechanisms: publication in refereed journals and the acquisition of grant funds from sources that evaluate proposals using a quality peer review system. It is recognized that quality research can be conducted without the support of peer reviewed grant awards.

Additional demonstrations of the research record may include: invitations to present one's research at other universities or major scientific meetings, appointment as a section or symposium chair, receipt of awards or other special recognition for outstanding research, appointment to NIH study sections, supervision of thesis or dissertation research, service on thesis or dissertation committees, and publication of research abstracts.

To be considered for promotion to Assistant Professor, the Instructor must be regarded by the department chair and peers as one who has or can develop the background, talent and commitment to do good research even though a tangible measure of research productivity may not yet be evident. To be considered for promotion to Associate Professor, the candidate should have worked as a productive independent investigator or collaborator, achieved first author status on publications, and participated as a

co-author on others. Specific numbers of publications in each case are not as important as the quality and significance of the work.

The Associate Professor who expects to be promoted to Professor must show continuing research development. Sustained activity as an independent investigator or collaborator and reasonable first author activity should be evident. The faculty member should be a recognized authority in his/her discipline and as such, should be committed to guiding the development of young faculty in their scientific endeavors.

1.2.5.3 PROFESSIONAL AND COMMUNITY OR PUBLIC SERVICE AND ENGAGEMENT

Professional and community or public service and engagement are related to those activities that pertain to one's role as a professional and as a University faculty member. Faculty effort in this area of evaluation may include administrative activities, patient care, continuing education, and other types of professional service to the profession, community, state, University, national and international level

Service and engagement activities are important ways in which a faculty member connects the resources of the University to social and health issues faced in society. However, service and engagement activities will not be considered as the scholarship or service unless they are formal and meet the criteria identified in the previous section on "Scholarly Activity."

It is expected that the level of professional service will be commensurate with the proposed rank. Faculty at associate and full professor ranks are expected to perform service activities that reflect their more senior status, such as chairing important school committees, and service at the professional, community, state, University, national, and international level.

Administrative Responsibilities

A variety of administrative activities may exist that serve the School of Dentistry, the University or Profession that should be considered when evaluating contributions to professional service.

It is recognized that there are a few faculty whose appointments are based on a need by the School for administrative leadership. These faculty are heavily committed to administrative roles that are

both essential to and valued by the School. Fixed-term faculty in these roles are eligible for consideration for promotion based on either evaluation of teaching or research and community-service/engagement, while tenure track faculty will still be evaluated in all three areas. In instances where department chairs and unit directors are being reviewed, School of Dentistry guidelines provide that 30% of their time is spent in departmental/unit administration. This time can be considered as service to the School or University.

Examples of administrative responsibilities may include:

- *Assistant or Associate Dean*
- *Department Chair or Program Director, including Graduate Program Directors, Center Directors.*
- *Special activity director or coordinator*
- *Leadership role in faculty governance or professional organizations*
- *Serving in the capacity of a journal editor*
- *Serving as a Chair of a Committee for the School or University*

Patient Care

Patient care will be evaluated only when it is an assigned responsibility of the faculty member. Faculty members are expected to provide exemplary patient care, using current methods that are respected by patients and peers both within the University and in the professional community. Examples of additional activities relating to patient care are:

- certification by specialty board
- fellowship status in national clinical dental organization
- membership on a specialty examining board
- service as a consultant on patient care (e.g. third-party payment groups, courts, health organizations, *dental healthcare companies*)
- development of new clinical programs
- development of new clinical techniques
- acquisition of patents on clinical materials or instruments

Continuing Education

Continuing Education is a special responsibility of the School of Dentistry and its faculty members. The State, the profession, and the general public depend on the School for help in maintaining state-of-the-art practice in this area of health care delivery. Continuing education is both an instructional and public service activity that the School of Dentistry is uniquely qualified to provide. Only a faculty whose collective responsibilities include research and other scholarly activities can provide these important services from an informed base of current and developing new knowledge in the field.

Continuing education, as a special responsibility, is not applicable to all faculty members. For those faculty members who participate in continuing education, their effort will be evaluated as part of their service commitment to the School of Dentistry. Because continuing education also is an instructional activity, the learner (attendee) evaluations from this activity can be used as documentation of general excellence in teaching.

Examples of CE activities to be considered for promotion include:

- *Presentation of continuing educational lectures*
- *Development and/or presentation of a new CE course*
- *Major revision of existing CE courses*
- *Table clinic*
- *Development of interactive or web-based CE offerings*

Other Service to the University, the Profession or the Community

All faculty members must share in the work necessary to maintain the operation of the institution. Furthermore, faculty members are expected to contribute to the growth of the institution through efforts that are aimed at improving programs and facilities. Especially, the faculty should contribute to the maintenance and growth of their profession. Finally, faculty members are encouraged to serve the community at large in a professional or leadership capacity that enhances the stature of the University or the health of the public.

Examples of other service/engagement activities related to the University, the profession or the community are:

- service on boards and committees or other assignments within the School of Dentistry, University, or profession
- leadership in curriculum development and implementation of clinical activity, curricular research programs, etc.
- contribution to faculty government
- contribution to professional organizations
- service to professional journals as a manuscript referee, reviewer, etc.
- service as a consultant to accrediting and other educational review boards
- service on boards and committees in the community-at-large in a professional capacity
- building partnerships with communtiites to develop and diversifty the health workforce.
- delivering community-based quality health care
- translating research into practice and policy and disseminating research findings to communities
- *inservice training activities within the School or University, e.g. infection control and emergency updates.*

1.2.6 RESPONSIBILITY OF THE CANDIDATE FOR PREPARATION OF DOCUMENTATION

To assist in the evaluation process, candidates are required to prepare appropriate supporting documentation. At minimum, this will include a curriculum vita (CV), for which the School of Dentistry has a prescribed format (see Section IV).

Candidates who are full-time faculty are also required to identify persons who can provide meaningful letters of evaluation (see Section IV). All letters received will be used in the evaluation process, and will be forwarded to the Health Sciences Advisory Committee if the process reaches that level of review (see Section III for procedures). Full-time candidates must also prepare a portfolio appropriately documenting their teaching contributions as detailed in Sections 2and IV, and a brief (1 to 3 pages),

An Assessment of Promotion and Tenure Requirements at Dental Schools

Elizabeth S. Pilcher, D.M.D.; Anne Osborne Kilpatrick, D.P.A.; John Segars, B.S.

Abstract: Tenure and promotion are integral parts of the academic environment; however, in this era of growing shortages of faculty, as the baby boomers retire and the majority of dentists choose private practice, recruitment and retention may be affected by the way institutions handle promotion and tenure. A national survey of U.S. dental schools conducted in 2007 assessed the existence of multiple employment tracks for faculty and examined the requirements for promotion and tenure. All responding schools reported the existence of multiple tracks for academic faculty appointments. Many dental schools reported that they provided opportunity for faculty members to switch from one track to another, thus circumventing the traditional "up-or-out" policy. The number of schools offering non-tenure appointment tracks has also increased. This finding indicates an apparent increase over time in flexibility regarding tracks and tenure. The majority of schools did not report requirements for the number of publications necessary for promotion. Those that did report requirements showed an increase in expected scholarly activity relative to past studies, indicating that it may be more difficult than ever to achieve promotion.

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In this era of growing shortages of dental faculty as baby boomers retire and the majority of dental graduates opt for private practice, recruitment and retention may be affected by the way institutions handle promotion and tenure, integral components of an academic environment. Until the rise of the modern research institutions in the early twentieth century, university and college faculty members were hired on an annual basis, and they were not required to meet exact academic standards or have appropriate academic credentials.[1] However, in 1915, led in part by the American Association of University Professors (AAUP), academics defined themselves as a profession and instituted rank, criteria for promotion, and tenure—all designed to standardize qualifications and develop procedures for releasing faculty members who were unproductive. According to the AAUP, tenure and promotion are generally assessed at the same time in a faculty member's career: six to seven years after an initial appointment at either instructor or assistant professor level. Faculty members undergo a vigorous review of their research and teaching achievements. If they are deemed worthy by their peers, they are promoted and granted tenure. If they fail to meet the criteria, they suffer the consequences of an "up-or-out" policy and must leave the institution. This policy seems standard for most undergraduate institutions, but may not be the norm for health professions universities today. It is recognized that the definition of tenure may be interpreted differently by different academic institutions. For the purpose of this study, tenure will be defined as the assurance of continuous appointment to a particular faculty rank, with continuation of salary commensurate with the rank.

Academic dental institutions vary in their requirements for promotion and tenure, and they vary in their expectations of the achievement of tenure and the time frame for accomplishing both. Research in this area has focused primarily on issues relating to tenure, but there has been little research on promotion requirements in dental education. The relationship of tenure to promotion in academic rank (and the reverse) is close, in many instances occurring at the same time in some institutions but as separate decisions in others. This article reviews the literature on tenure in U.S. dental schools for the period 1980 to 2008, summarizes research on the development and influence of "academic appointment tracks" (or categories) on promotion and tenure, and then reports the findings of an online survey submitted to all dental schools in the United States during 2007 to assess promotion and tenure practices and standards. The answers to questions about promotion and tenure from the respondents are analyzed, and information obtained from current promotion and

tenure documents of many academic dental institutions is described.

Tenure and Alternative Appointment Tracks at U.S. Dental Schools: Literature Review

In 1982, all U.S. dental schools offered tenure. At the time, over 90 percent of dental faculty members were in tenure-track positions, and over 54 percent of faculty members had been awarded tenure. Deans stated that tenure was "an asset in the recruitment and retention of high-quality faculty."[2]

A 1990 study of U.S. schools of dental medicine by Kennedy[3] compared the status of faculty in 1980 to faculty status in 1990 and found a decline in the total number of faculty by 12 percent, but an increase in the proportion of tenured faculty. In 1995, Mayhew and Van Stewart[4] surveyed deans of schools of dental medicine; of the thirty-four schools responding, 59 percent of the faculty members were tenured. They also found that institutions requiring sixteen or more publications for tenure review increased in the period from 1993 to 1995. Their findings agree with Kennedy's 1990 observation that dental schools, "at least as reflected in the tenure review process, would appear to be imposing more stringent expectations for scholarship, especially for clinical faculty." In 1998, Kennedy and Hunt[5] reported a shift to more non-tenure-track positions in response to more stringent demands on faculty members seeking tenure and the increasing demand for faculty for schools of dental medicine.

The 1995 Institute of Medicine report *Dental Education at the Crossroads* recommended "that dental schools and their universities supplement tenure-track positions with other full-time non-tenured clinical or research positions that provide greater flexibility in achieving teaching, research, and patient care objectives."[6] Mayhew and Van Stewart's[4] survey of deans of schools of dental medicine included questions about tenure/non-tenure options for faculty employment to determine how many schools were offering these options. Of the thirty-four dental schools represented in that survey, twenty-two offered alternative tracks—most having a clinical option (clinical, clinical scholar/research, clinical teacher/educator, research, or other). Even though 81 percent of schools had a "strict" up-or-out policy, half offered faculty members the opportunity to reapply, while 70 percent of the schools offered faculty members the opportunity to be rehired in non-tenure-track positions.

In 2002, Hunt and Gray[7] categorized responses from fifty-four dental institutions according to seven appointment tracks in which faculty might participate: tenure-track research emphasis, tenure-track clinician scholar, tenure-track clinical emphasis, clinical track, research track, faculty administrator, and full-time administrator. Their findings suggest that the non-tenure-track positions might help fill needed positions in clinically oriented schools. Such positions might be attractive to those pursuing an academic career after a career in the military or to those dentists who want to supplement their salaries in faculty practice activities rather than concentrate on original research rewarded by tenure.

A 2004 study of pediatric dentistry faculty members by Wood et al.[8] was conducted in part to assess the impact of diminishing pediatric dental faculty members. These researchers noted that dental schools were increasingly using general dentists to teach pediatric dentistry and that there was a growing blurring of the discipline of pediatric dentistry, accompanied by a reduction in the number of pediatric dentists in academic positions. Seventy-five percent of pediatric dental faculty members who responded to the survey reported that the existence of clinical tracks would aid in the recruitment and retention of faculty. Two-thirds of the pediatric dentistry faculty reported that they maintained a part-time practice in addition to their academic positions. Thirty-one percent reported that they were required by their institutions to supplement their base salary with private practice activity. This study concluded with a suggestion that developing alternate career paths to emphasize clinical teaching in addition to traditional academic paths would improve the crisis in this workforce.

In 2004–05, Chmar et al.[9] analyzed results of a survey of over 10,000 full- and part-time faculty members, both paid and volunteer positions, and found that 19 percent were tenured and 6 percent were on tenure track but had not yet been awarded a tenured position. This study group consisted of all faculty members, those in traditional academic positions as well as those designated "clinical." Seventy-four percent of these faculty members were on a clinical track or another non-tenure track. The typical faculty member entering academics from private

practice was, on average, fifty-four years old and had been hired as a part-time, non-tenure-track, clinical science faculty member at a lower rank. And the typical faculty member leaving for private practice was forty-three years old with a part-time, non-tenure-track, clinical science faculty appointment.[9]

Trotman et al.[10] reported on findings from three studies in 2000, 2004, and 2007 regarding attitudes of tenure-track and non-tenure-track faculty about the work environment in academic dental medicine. The 2000 and 2004 studies reflected an appreciation for teaching, yet a level of frustration with the promotion and tenure process due to lack of clarity. The 2007 study surveyed all full- and part-time faculty in clinical, basic science, and behavioral departments in fifty-six U.S. dental schools, with a 17 percent response rate. Over 80 percent of the respondents said the overall process for obtaining tenure was not clear at all or could be improved. Overall, the findings of these three studies indicated that the clarity of the tenure and promotion process, performance standards, and expectations and career-planning advice were perceived by faculty members to be minimally adequate in U.S. dental schools. A majority of non-tenure-track faculty in the 2007 study said their rights and obligations and the evaluation processes were not clear. There is a growing discussion about the future of academic tenure, which is generally tied to promotion. Peterson,[11] in a 2007 article on academic tenure and higher education, observed that there is a crisis in faculty recruitment and retention that will continue to be a significant problem for dental schools during the next decade. She recommended that policies regarding tenure be reviewed for clarity at the institutional level; that up-or-out policies be modified or possibly even eliminated; that multiple faculty tracks be considered so that faculty members can have designated functions, focus, and expectations versus a "one size fits all" philosophy; and that "academic freedom and due process be protected for all faculty members regardless of status."

Methods

In 2006, the Medical University of South Carolina College of Dental Medicine conducted a review of its promotion and tenure criteria. Consensus among the planning faculty members was that the college's promotion policies should acknowledge and reward different contributions of faculty members to the academic mission. This revision of promotion and tenure guidelines followed changes that had been undertaken in other colleges within the university. As a result of this review, the College of Dental Medicine developed and approved a two-track system to replace the single-track system for promotion. The new tracks created in 2006 were academic clinician and academic researcher. The requirements for promotion in these tracks emphasize different aspects of academic life; thus, a faculty member on the academic researcher track is expected to conduct and publish more research than a faculty member on a clinical track. Requirements for the academic clinician track place greater emphasis on teaching and patient care. The university does not have an up-or-out policy for promotion or tenure, but tenure guidelines were also clarified in this process.

As a result of this revision of promotion and tenure guidelines, we designed a study to determine the status and content of promotion and tenure (P&T) guidelines in U.S. dental schools. The goal of the study was to assess current academic appointment and P&T practices to inform and guide other dental schools that may also be considering revisions to the tenure track.

In 2007, an online survey was conducted to assess the existence of tracks, requirements for tenure, and the flexibility of promotion processes among U.S. colleges of dental medicine. We constructed the survey based upon a review of the literature and anticipated direction of changes in promotion and tenure (P&T) standards. The survey was pilot-tested by a group of American Dental Education Association (ADEA) Council of Faculty members for content and clarity, and the survey was revised based upon their comments. The survey contained nineteen questions, including four questions related to demographics and contact information. Five questions related to tenure policies including the existence of an up-or-out policy and time requirements for reaching such. Seven questions related to promotion requirements, including the existence of multiple tracks and the number of publications expected for advancement to different academic levels. An open-ended question allowed participants to explain each track at their school. Finally, two questions related to the current status of P&T guidelines at that school and the willingness to share those guidelines with other schools. In addition to responses to the survey, schools were asked to submit a paper or electronic copy of their current P&T guidelines. University Institutional Review Board approval was obtained, and the survey was placed in a web-based format.

All U.S. dental schools were contacted through their ADEA Council of Faculties representatives. Each representative was contacted by email three times over a three-month period and instructed to ask either the head of the Promotions and Tenure Committee or the academic dean to respond to this survey. At the end of the three-month period, the schools that had not yet responded were contacted by emailing the survey to the dean's office with the same instructions for filling out the survey. A copy of the survey is available upon request from the primary author.

Results

The total number of completed surveys was thirty-six, for a response rate of 64 percent. The data reported in this article and conclusions made are based upon the thirty-six responding schools. Of the respondents, twenty-two were categorized as public, eleven as private, and three as private, state-related. This distribution ratio parallels the national totals of thirty-seven public, fifteen private, and four private, state-related.[12] The size of the dental schools was determined by a count of their undergraduate D.M.D. or D.D.S. students, with student bodies ranging in size from 120 to 1,400. The median student enrollment for schools that participated in this survey was 320, close to the national median of 313 students. In addition to the survey responses, electronic or paper promotion and tenure documents were obtained from thirty-four dental schools. The blending of requirements for promotion and achievement of tenure varies from one institution to another, but these data are reported separately wherever feasible.

Tenure

Schools were asked if they had an up-or-out policy for their faculties. Twenty-three schools (63 percent) of the thirty-six reported an up-or-out policy; however, the time frame varied. The average time for twenty-two schools reporting a specific probationary period prior to obtaining tenure was seven years from initial appointment, with the range extending from six to ten years (see Figure 1). One school reported a tenure system but did not specify a time frame. Some schools expressed their individual policy with a range; for example, faculty members are expected to apply for tenure after they have been employed for five years but are not required to achieve it until

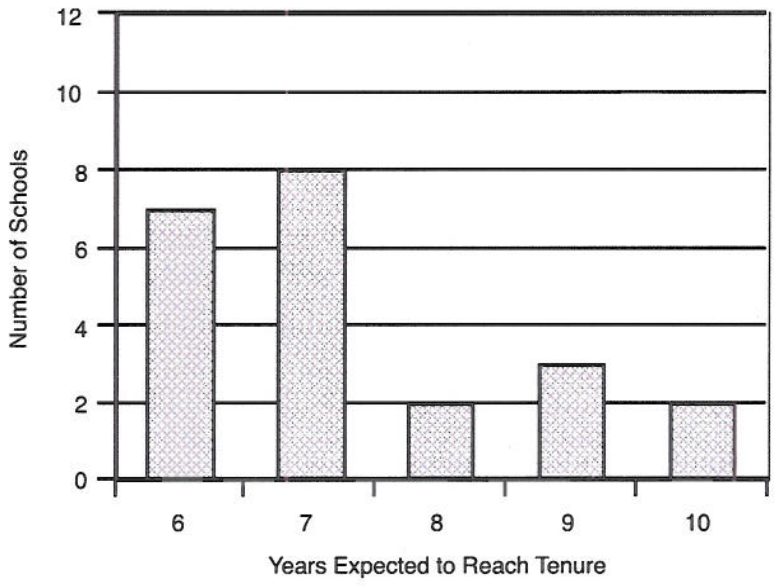

Figure 1. Time expected to reach tenure in surveyed schools with up-or-out policy

seven years. In these instances, the midpoint of six years was used in reporting the results. The remaining thirteen schools either do not have tenure available or do not require tenure as a condition of continued employment.

Respondents were also asked, "If a faculty member does not achieve tenure within a given time frame, is there a mechanism by which that person could remain on the faculty?" Of the twenty-three reporting "yes" to an up-or-out policy, seven schools requiring tenure within a given time frame do not have any alternative for the faculty member to remain if he or she does not achieve tenure in the required time frame. Sixteen schools (69 percent) stated they have a mechanism for the faculty member to remain at the school. One school reported that faculty member must switch from a tenure to a non-tenure position prior to the up-or-out time frame if the candidate is informed that the tenure petition is likely to be denied because of a mid-probationary period review or other assessment of qualifications. Thus, the switch to a non-tenure-track position prior to the end of the tenure clock would be more likely to be interpreted as a switch for reasons other than expected denial of tenure. Other schools have stipulations that limit the number of times a faculty member can switch tracks, usually once or twice. Because switching from a tenure track to a non-tenure track is an option for some clinical-based dental faculty members, the question was asked whether faculty in a clinical track could become tenured. Twenty-seven (75 percent) schools replied "yes." The majority of responding schools allow tenure for faculty members whose primary appointment is clinical and whose primary responsibilities are teaching and patient care. Schools were asked if teaching was a requirement for achieving tenure. Thirty schools (83 percent) responded that teaching is required for tenure. No schools specified that this teaching requirement was only for certain academic tracks.

Promotion

In response to a question about offering faculty members more than one track, all thirty-six schools responded that multiple tracks are available and that multiple tracks allow faculty to be assessed for promotion based upon different criteria. Thirty-two (89 percent) have both tenure and non-tenure tracks available. Two schools have only tenure tracks, and two schools have only non-tenure tracks. Thirteen schools (36 percent) list a separate track for dental faculty members who are primarily appointed to research positions. The majority of schools (59 percent) also offer non-tenure tracks for faculty members whose responsibilities are primarily clinical teaching and patient care, and not academic. Due to the many varieties of tracks described by the schools, it was extremely difficult to categorize tracks except as presented.

The survey also asked questions pertaining to the number of publications required for advancement through the academic ranks. The majority of the schools (twenty-three of thirty-six, or 63 percent) responded that they do not have a quantitative requirement for publications. Of the schools that reported having a quantitative requirement, five reported a quantitative requirement for publications to be appointed at the level of instructor, ranging from one to seven. Of the eight schools reporting a required number of publications for promotion to assistant professor, the range was one to ten, with an average of 4.75. Thirteen schools reported quantitative publication requirements for promotion to associate professor. Eleven schools require between four and thirty publications, with an average of 9.46 publications. Two schools reported the requirement as a function of continuous productivity, e.g., one to two publications per year. Thirteen schools also require a specific minimum number or range of numbers of publications for promotion to the rank of professor. Over half of those responding require between fifteen and fifty publications, with an average of 16.2.

P&T Guidelines

Schools were also asked to relate the current status of P&T guidelines. The guidelines were described as currently under revision, existing and needing revision, existing and ok, or recently revised. Thirteen schools (36 percent) reported that their guidelines were either currently under revision or needed to be revised (see Figure 2). Schools were asked if they would be willing to share the information in their P&T guidelines. Four schools were not willing to share their guidelines because they report the status of their guidelines as "currently under revision" or "needing revision."

Discussion

For a number of years, studies have demonstrated that there is an ongoing shortage of dental faculty in U.S. schools. Competition from private practice opportunities and a decline in encouragement/recruit-

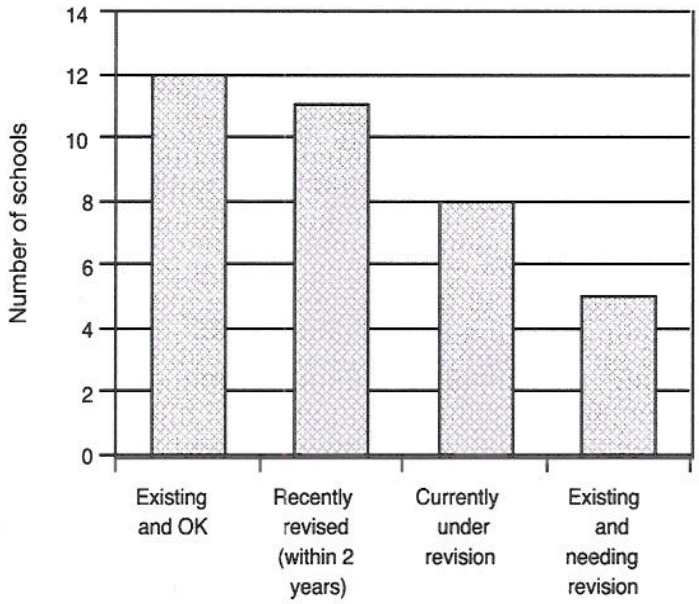

Figure 2. Status of promotion and tenure guidelines at surveyed schools

ing of graduates to pursue the educational arm of the dental profession have contributed to a small pool of individuals who are interested in academic positions, especially early in their careers. Additionally, a high percentage of the present faculty is approaching retirement age, as has been documented in the periodic dental school workforce studies conducted by ADEA. Thus, retention of those faculty members entering academic positions becomes even more critical, and tenure and promotion are key components affecting that retention.

Findings in this study reflect the trend to increase diversity, or flexibility, in academic standards and to identify additional opportunities for promotion and tenure for faculty members through multiple tracks. These tracks offer added channels for rewarding teaching, clinical care, and research in the promotion and tenure process. There has been a modest increase in the percentage of schools that have recognized the need for additional tracks. In 1990, Clark et al.[13] reported that 50 percent of dental schools had a clinical track, but based on the data reported by schools in our study, that percentage has increased to 59.

All faculty members on a clinical track should not be interpreted as being on a non-tenure track. Three-fourths of the dental schools now recognize faculty members on a clinical track as being eligible for tenure. Although the majority of schools still have an up-or-out policy, most have developed mechanisms to allow faculty members to remain without tenure. Schools allowing faculty members to switch to a non-tenure track increased from 26 percent in 1990[13] to 69 percent in our study. The number of schools with non-tenure tracks has increased from fewer than 40 percent in 1980 to 78 percent in 1989[13] to 94 percent in 2007.

At the same time, some schools appear to have raised the bar by increasing the number of publications required for promotion. Clark et al.'s[13] 1990 study reported an average of 1.5 publications required for promotion to assistant professor. However, we found the average number of publications required for promotion to assistant professor was 4.75. For promotion to associate professor, the average increased from 5.5 (reported by Clark et al.) to 9.5 in our study. And the average number of publications required for promotion to full professor increased from 11.0 (reported by Clark et al.) to 16.2 in our study. These findings reflect the requirements of the thirteen schools that reported having a specified numbers of publications required. While caution

should be used when comparing these data from two separate surveys since the respondents will have differed, we believe that the increase is large enough to show a significant difference. This increase could be problematic in recruiting and retaining faculty members under the current system.

As early as 1984, Smith[14] debated the value of "counting of publications" as a criterion for effective scholarship. According to Smith, the emphasis placed upon faculty members to demonstrate scholarship through publishing (publish or perish) was largely false, and his suggestions were to "support excellence where we find it" rather than expecting all faculty members to fit into a given model. However, data from our study confirm the existence of a numbers requirement for publications as a guideline for promotion in many schools. It is also recognized that the degree of emphasis on research of each university may affect the expectations of scholarly activity for promotion and tenure. Our study did not address this issue.

In 2001, Shepherd et al.[15] surveyed new (defined as within one to five years) dental educators throughout North America to ascertain what could affect the recruitment and retention of new faculty. Faculty members noted that salary was important, but that the work environment and reasonable criteria for promotion and tenure could outweigh salary considerations. Perhaps the increase in creation of multiple tracks will create a more positive environment by allowing faculty members to be assessed based upon their strengths rather than a standard set of criteria.

Conclusion

This study reports on findings from a survey completed in 2007 by respondents at thirty-six of the fifty-six U.S. dental schools assessing faculty tenure and promotion policies. The survey results reflect an increase in complexity and variety of these policies, which may address the challenges of recruitment and retention in this age of faculty shortages. It is also recognized that the degree of emphasis on research of each university may affect the expectations of scholarly activity for promotion and tenure.

We propose that providing more flexibility in tenure and promotion criteria that reflect the value of unique contributions of dental faculty members who serve in varied roles within dental education will increase retention of existing faculty and perhaps make the dental academy a more attractive alternative for graduates who may be considering this field. The challenges facing schools of dental medicine to ensure an adequate supply of faculty for the future will be affected by compensation that will never be competitive with private practice. Thus, the academy must concentrate on strategies to recruit and retain outstanding faculty members. Providing alternatives to promotion and tenure other than the up-or-out process and offering multiple tracks appear to be methods for addressing the growing shortage and exodus of dental school faculty. The fact that 94 percent of dental schools provided non-tenure tracks in 2007 reflects this trend.

Future research should focus on those schools without tenure or quantitative requirements for promotion to determine if they are facing recruitment and retention challenges and, if so, what actions are being implemented to answer those challenges. The variety and range of P&T guidelines and policies among dental schools reflect a diversity of strategies being applied to recruit and reward the various contributions made by researchers, clinicians, and teachers. In addition, schools should attend to the environment of the teaching institution to ensure faculty members feel they are involved and included in the decisions affecting them. Providing clear expectations to achieve tenure and promotion should increase faculty perceptions of involvement, increase job satisfaction, and hence, improve retention.

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