COMMENTARY

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# Unfinished Business: Bringing Greater Equity to Career Advancement and Promotions for Clinician Educators in Academic Medicine

## BACKGROUND

### Historical Background

Much of what we do in academic medicine today is rooted in history. Some aspects of our current practice have evolved, while others have not. An important example is the definition of scholarship for the purposes of advancement of clinician-educators.

Despite the call to move away from the historical dichotomy of "teaching versus research" more than 30 years ago, much of our mental model, methodology for evaluating scholarship, and structure for promotion in academic medicine remain stuck in the past.

In 1990, Ernest Boyer proposed that the ". . .honorable term 'scholarship' be given a broader meaning."[1] Specifically, scholarship has 4 separate yet overlapping domains: the scholarship of discovery, the scholarship of integration, the scholarship of application, and the scholarship of teaching.

The scholarship of teaching, however, remained elusive in its definition. In 2006, the Association of American Medical Colleges proposed 5 domains for documenting quality and quantity of educational activity: *teaching, curriculum, advising/mentoring, educational leadership/administration, and learner assessment.*[2]

Unfortunately, academic medicine still has not fully adopted these recommendations. In this paper, we review the current state, discuss its implications, and offer proposals for improvement. Additionally, we ask what the academic medicine community seeks to highlight through the advancement and promotions process.

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Requests for reprints should be addressed to Sherine Salib, MD, Department of Internal Medicine, Dell Medical School, The University of Texas at Austin, Health Discovery Building, Austin, TX 78712-1876.

E-mail address: Sherine.Salib@austin.utexas.edu



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## CURRENT STATE AND PROBLEM

### Where Are We Now?

Many academic medical centers have successfully expanded the meaning of scholarship to include more than research. This is important because scholarship is typically the stepping stone to career growth and promotion. However, the manner in which scholarship is recognized and rewarded remains inconsistent, with research still garnering the most weight when it comes to career advancement. Research productivity remains the primary measure for assessing faculty members' scholarly contributions, leadership hiring decisions, promotions, and tenure status. Academic rank correlates with quantitative metrics of research productivity. Scores such as the h- and m- indices, which measure publication productivity and citation impact of research, increase with successive academic rank, and are associated with tenure.[3] Despite calls in the literature to move toward a more inclusive system of recognition and growth for faculty in academic medicine, current approaches for evaluating and advancing faculty remain grounded in an assumption that research is the primary form of scholarship.

These findings belie the experience of faculty focused on clinical work and teaching. A recent study found that, despite the rapid growth of academic hospital medicine over 2 decades—ample time for many hospitalists to be promoted—only 11.7% had been promoted (associate 9.0%, full professor 2.7%). The median number of publications was zero.[4] Related research found that career success in clinically focused academic medicine jobs "*is complex and may not be captured by traditional academic metrics and milestones*."[5] Specifically, many early-career faculty do not feel promotion is meaningful or important, and research forms of scholarship seem out of sync with their time, energy, and areas of passion compared with recognition of clinical and teaching work.

## Disparities Exacerbated

This misalignment amplifies disparities in our profession, an issue which the COVID-19 pandemic shined a light on. Underrepresentation of women in research publications, and as first and last authors, is prevalent in academic medicine.[6] Moreover, women are underrepresented among senior academic ranks, a difference related, at least partly, to disparities in publications. These disparities also impact faculty who are underrepresented in medicine.[7]

Finally, disparities arise when academic medical centers attempt to closely align their promotions criteria with those of the larger university system with which they affiliate. Because the roles, activities, and forms of scholarship are fundamentally different, it is difficult for practicing clinicians in an academic medical center to demonstrate promotable contributions in the same way as faculty members in other schools, such as engineering or history—an example of structural bias within our system.

Thus, there remains inequity between the clinician-educator tracks vs the research tracks, which more significantly impacts generalists, women, and those underrepresented in medicine. This negatively impacts promotion and advancement, since lesser value is placed upon non-traditional types of scholarship—a form of hidden curriculum in academia.

# PROPOSED SOLUTIONS

## A Shift in Paradigm—Philosophically and Practically

Any viable solutions that would level the playing field must start by us responding to the "*why?*" behind what we do. What are—or should be—the drivers for recognition, career growth, and promotion in academic medicine? Essentially, promotion and advancement serve 2 main purposes: first, as recognition of excellence, and second, a way to highlight behaviors and performance that we want to encourage.

Work in academic medicine is impactful because its scope extends beyond the immediate sphere of an individual physician's practice. Impact should be measured accordingly. For instance, teaching physicians' work not only impacts their patients, but by teaching the next generation of physicians, and by coaching and mentoring others, they impact patient care more broadly.

Thus, true impact and influence in academic medicine extend far beyond written scholarship. We offer several insights about how to apply this reality to career advancement.

## Conceptual Foundations

A change in practice will require revisiting the 4 types of scholarship (*discovery*, *integration*, *application, teaching*), specifically from an academic medicine lens. There should be agreement among the academic medicine community that each of the 4 types of scholarship is equally important.

Despite stated or written policies, scholarship of application (eg, quality improvement, clinical) and the scholarship of teaching (eg, talks, curricula) receive less credit in terms of scholarly value. This needs to change—at cultural *and* policy levels. We need to talk about all forms of scholarship as having equivalent value.

## Practical Interventions

It is important to align the theoretical recommendations for promotion and growth with practice. This can be done with the following general principles:

1. Revise criteria used by promotions and tenure committees by asking committees to increase their catalogs of representative examples of scholarship, including a more balanced set of references for all 4 types of scholarship. Examples include:
   - Advancing the stature of scholarship of application—which often is most appropriate for clinicians who create tools, guidelines, protocols, and quality-improvement efforts to improve the practice of other clinicians.
   - Advancing the stature of the scholarship of teaching—which impacts the practice of future physicians.
   - Counting equity-promoting activities as a form of scholarship due to their impact on systems that inform practice.
2. Ensure equity among clinician-educators by offering sufficient support (including protected time, resources, and mentorship) for scholarship.
3. Help clinician-educators understand ways in which they are disseminating work, beyond traditional research.
4. Endorse forms of evidence for impact that traditionally have been neglected, such as number of users of clinical protocols, number of attendees to Tweetorials, or number of times a written tool or guideline is accessed (ie, forms of clear dissemination that may not come with a journal impact factor).

In summary, there is a disconnect between the theory and practice of career advancement in academic medicine. To truly recognize and reward all scholarship across the continuum—from discovery to integration to application to teaching—we need to revisit our assumptions, our biases, and our systems for evaluating academic achievement in medicine. Doing so will not only serve to advance the careers of many academic physicians, it will also decrease persistent disparities in who we promote.

Sherine Salib, MD, MRCP, FACP[a]
Mrinalini Kulkarni-Date, MD[a,b,c]
Read G. Pierce, MD[a,d]
[a]*Department of Internal Medicine, Dell Medical School, The University of Texas at Austin*
[b]*Division of Endocrinology*
[c]*Department of Medical Education*
[d]*Division of Hospital Medicine*

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