Career Tracks in Academic Family Medicine: Issues and Approaches

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There are a number of possible career tracks available to individuals interested in full-time teaching in either community-based family practice residency programs or medical school departments of family medicine. These include various kinds of experience in residency and fellowship training and clinical practice. Full-time faculty may be involved in any of four major areas: patient care, teaching, research, and administration. The balance of an individual's responsibilities in each of these areas varies considerably based upon the teaching setting and the individual's strengths, interests, and career stage. Continued personal growth and career development of faculty are the joint responsibility of individual faculty members and directors or chairmen of residency programs and departments.

Diversity is required among family practice faculty in order for the multiple needs of academic family medicine to be effectively addressed in patient care, teaching, and research. The first generation of family practice faculty have been principally clinicians, teachers, and administrators. There is now a particular need for faculty who can integrate clinical, teaching, and research skills.

With family practice as a specialty now just 13 years old in the United States, there has not yet been time to develop a recognized teaching tradition in the field. During the 1970s most of the first generation of family practice faculty entered full-time teaching without previous academic or teaching experience. Many left successful practices and faced the immediate transition to the various demands of academic family medicine, including program development, teaching, research, and administration. It was not until the late 1970s that organized faculty development opportunities became available in the form of workshops and various kinds of fellowship programs.

It is now both possible and useful to take a more deliberate and reflective approach to the many issues involved in the further evolution of academic

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family medicine vis-a-vis the growth and development of faculty to meet the varied needs of the discipline in terms of patient care, teaching, research, and community service. There are two major settings of full-time teaching in family practice: the university or medical school based department or division and the community hospital based residency program (with or without affiliation with a medical school). The purpose of this paper is to outline some of the major issues and approaches involving potential career tracks in academic family medicine. The discussion will necessarily be limited to full-time faculty, since the issues involved in part-time teaching are different in both kind and degree.

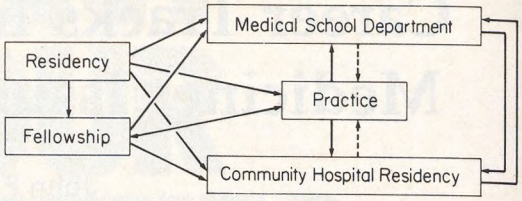

Figure 1. Career tracks in family medicine

Career Tracks in Academic Family Medicine

Although a majority of today's family practice faculty entered full-time teaching from practice, an increasing number are now considering academic family medicine as an option following completion of their residency training. Family practice residents with an interest in full-time teaching therefore face a decision as to whether to take fellowship training, enter community practice, or enter full-time teaching directly after residency training. Whether in residency or in community practice, a prospective full-time faculty member needs to weigh the advantages and disadvantages of joining a community hospital program or university-based department. Further, as long-term goals and interests in academic family medicine are considered, possible future shifts in setting and roles may become part of individual career planning. Figure 1 illustrates the major pathways within academic family medicine.

Some General Issues and Approaches

Individual Versus Program or Department Needs

It is self-evident but important to recognize that the needs and objectives of the individual faculty member and the program or department may or may not be congruent. In recruiting a new faculty member, a program or department usually has a specific job, or combination of tasks, which will be expected of the faculty member. Even if this job fits the initial needs and interests of the prospective faculty member, it is inevitable that either the job requirements (ie, program or department needs) will change over time or the individual's needs will change after a period of time in the initial job.

An individual contemplating a career in academic family medicine first needs to assess his/her own strengths, priorities, and interests in such major areas as patient care, teaching, research, program development, and administration. Many individuals require a majority of their time to be spent in patient care and teaching. Some are strongly drawn to asking and answering questions related to their field and will preferentially seek sizable amounts of time for research. Others are attracted by the problems of program development and administration; among these, some are developers, who enjoy building programs and lose interest when the task becomes maintenance of an established program. If one has had some experience in any of these areas, feedback from others may help to assess one's strengths.

Faculty recruitment by a residency program or department of family practice clearly involves a joint process of assessment of congruence of interests and goals on the part of both the program or department and the prospective faculty member. From the applicant's point of view, it is useful

to get some idea of the degree of rigidity or flexibility of roles within the program or department in terms of opportunities for future personal growth beyond the set of responsibilities for which one is being recruited. The track record of faculty roles and turnover within the program or department often provides valuable clues to this question. In some instances, an individual faculty member may opt for an initial teaching position that offers experience in a particular area even though the long-term potential for personal growth appears to be somewhat limited, with the idea that a move to another setting after a period of years will provide for continued growth.

Balance of Patient Care, Teaching, Research, and Administration

Regardless of setting, the teaching program requires that a practice be developed and maintained serving a sizable patient population. Large commitments of faculty time and effort are continuously needed to provide direct patient care, clinical supervision and teaching, and administrative support for the teaching practice. Additional time commitments are involved in liaison activities with other departments and administrative personnel within the institution. It is frequently difficult for faculty with heavy commitments in patient care and teaching to find time for research. At the same time, those with substantial administrative responsibilities often find themselves short on time for patient care and/or teaching.

It is clearly impossible for faculty members to be heavily involved in all four areas—patient care, teaching, research, and administration—at any given time. Most, however, will be actively involved in at least two areas, with some responsibilities in a third area. The actual "mix" of a faculty member's activities will vary with the individual's interests and strengths and may change considerably from one career stage to another as well as from one setting to another. If an individual's primary interests are in patient care and clinical teaching, a community based residency program might be preferred, although research opportunities are increasing in many such programs. If long-term goals include a major interest in research, greater resources, flexibility, and incentives to pursue this area are usually found in a university-based department or division.

Extent of Practice Experience

It is still an open question whether a period of years in community-based family practice should be a prerequisite for prospective full-time faculty in family medicine. The advantages of this background are proclaimed persuasively by many of the first generation of faculty (this is how they did it). Many feel that this experience is essential to understanding the actual spectrum of clinical problems seen in everyday family practice as well as to understand the environment and constraints influencing the process of patient care in "the real world." If one subscribes to this school of thought, the only real question is the number of years necessary to meet the needs of the prospective faculty member before entering academic family medicine.

There are some points, however, on the other side of the issue for some prospective faculty members. Many recent residency graduates interested in teaching feel somewhat untested clinically on completion of residency training and enter practice to validate their clinical skills before returning to full-time teaching. What they usually find is that clinically they are at least as sharp as many physicians in active practice. Graduates of fellowship programs may find that some of their newly acquired research skills atrophy during a subsequent period of immersion in full-time practice. In addition, if graduates remain in practice for a prolonged period (eg, beyond five to ten years), there may be a tendency for some to become set in their ways and less able to adapt to the varied demands and ambiguities of academic family medicine. For many, such a move would represent a sizable reduction of income. For those entering full-time teaching directly after completion of residency or fellowship training, there are other ways to gain further clinical experience and the necessary insights into community practice, such as through a series of regular periods of locum tenens and increased clinical responsibilities during the earlier years in full-time teaching.

Acquisition of Teaching and Research Skills

It is apparent that teaching and research in primary care and family practice require an additional set of knowledge and skills not usually acquired in undergraduate or graduate training. Although many specialties have assumed that teaching skills are innately held through the process of self-selection for those who opt for academic medicine, family practice has stressed the importance of faculty development programs for teaching skills. In both areas, teaching and research, there are various alternatives available whereby faculty members can prepare themselves.

Fellowship programs are available that range in length from several months to two years. These provide effective ways for recent residency graduates or family physicians with practice experience to gain background and skills in teaching, curriculum development, and evaluation of teaching programs. Some fellowship programs, especially those of one- or two-years' duration, offer excellent training in such areas as epidemiology, biostatistics, and research design together with practical experience in conducting a research project.

For one reason or another, many prospective family practice faculty are unable to take such a program. A variety of other avenues are available to increase skills in both teaching and research. Many teaching programs provide periodic faculty development workshops on teaching skills together with constructive ongoing feedback from peers, residents, and students. Departments of family practice in medical schools can organize faculty development programs for research, drawing on other disciplines and resources in the medical school as needed. Thus didactic seminars in research skill areas can be held as well as "work in progress" seminars for critique and consultation of research projects in early stages of design or development. An individual faculty member, even if heavily involved in patient care and teaching, will often find it useful to participate as a member of a research group on a larger project, thereby acquiring added research experience without major time commitments. A growing number of university-based departments of family practice are organizing networks for collaborative research involving faculty in community-based teaching programs and university-based faculty.

Appointment and Promotion Requirements

A perennial issue among university based faculty concerns the criteria used in medical schools for appointment and promotion. The classic criteria used include clinical competence, teaching performance, research/scholarship, and administration/university service. The most common issue in family practice, as in some other clinical specialties, relates to how these criteria are weighted. Specifically, for those faculty heavily involved in patient care and teaching, how much (and what type) of research productivity is required for promotion and tenure? For those heavily involved in administration, how are the other criteria weighted?

There is a common tendency among some family practice faculty to consider that existing criteria for appointments and promotions, as applied in many medical schools, impose unreasonable expectations for academic family medicine. Some argue for a "clinical track" appointment system, with criteria based more upon patient care and teaching than upon research. This is a pitfall to avoid. Family practice is not different from other clinical specialties in having heavy clinical and teaching responsibilities. Together with other specialties, family practice also requires research and scholarship to develop and sustain the specialty and define the content of teaching. Family practice can, and should, meet traditional academic criteria for appointment and promotion without special dispensations. As McWhinney has pointed out, family practice should fear not being too academic but being not academic enough.[1] Family practice needs to argue, however, for a broad definition of research fitting the types and settings of research in the field, as well as for other forms of scholarship in clinical and teaching areas, in meeting existing performance criteria for research and scholarship.

Time Management

Effective methods for time management represent a universal need for all faculty in academic medicine. The multiple demands of patient care, teaching, and research, often with some adminis-

trative responsibilities as well, pose a daily challenge. There are many individual responses to this problem, but several general approaches stand out. Perhaps most important, at least one quarter of the faculty member's time must be set aside for "academic time" or administrative tasks. Each faculty member should take responsibility for his time and be able to decline some of the many commitments which present themselves. Wherever possible, multiple products should be realized for a given outlay of time and effort (eg, work on a training grant may lead to development of a new course, added expertise in a selected clinical area, and a subsequent scholarly publication). In dealing with the daily load of assorted mail, memoranda, and related paperwork, it is helpful to make a disposition decision as often as possible on first reading rather than develop growing stacks of unfinished work which then require additional time later. Research is an activity for which many faculty, especially those involved in residency teaching, encounter difficulty in finding time. One useful approach is to organize the residency based faculty group in such a way that each member is freed from regular clinical and teaching responsibilities at periodic intervals (eg, a "research month" two to three times a year, if possible). Finally, despite all efforts at time management, night and weekend time is inevitably needed for some tasks such as writing papers and grants. There is no such thing as a 40-hour week in academic family medicine.

Maintenance of Clinical Skills

Maintenance of clinical skills presents a particular problem in family practice as a primary care specialty. The extent of this problem is unique in academic medicine, since family practice involves a broader range of clinical competencies than any other clinical specialty. The family physician has to see a large volume of patients on a continuous basis to maintain competence across the full breadth of family practice. This problem is in direct contrast to the subspecialties in academic medicine. It is quite possible, for example, to maintain "state-of-the-art" clinical competence in rheumatology by seeing a relatively small number of highly selected referral patients in one or two short specialty clinics each week. One obvious approach in academic family medicine, of course, would be to select certain clinical areas for reinforcement on a scheduled basis (eg, some office procedures), but this raises the issue of the extent to which continuity of care should be compromised within the teaching practice.

It is unavoidable that clinical skills across the breadth of family practice will atrophy somewhat over the years if clinical experience is only two, three, or four half-days each week in the Family Practice Center and occasional night and weekend call. Several approaches may be useful here. Perhaps most valuable would be periodic immersion in a full-time community practice as a locum tenens experience, which has been accepted by some teaching programs as an effective approach to the problem. Targeted postgraduate experiences may also be useful, including continuing medical education courses and selected rotations similar to those available to residents. It may also be helpful, within any given teaching group, for individual faculty members to take major ongoing responsibilities for certain clinical areas which will maintain their clinical skills in selected areas (eg, office surgery, obstetrics).

Facilitation of Growth

Growth of knowledge, skills, and expertise is a necessity for both the individual faculty member and the program or department as a collective group. There may be a tendency for some faculty members to want to continue in certain activities with which they have become comfortable and avoid other activities for which they feel less prepared. Other faculty members, having mastered one area, may want to refocus their activities in new areas. Certain jobs within a residency program or department (eg, residency director, course coordinator) may become burdensome after a period of years, and the program or activity may benefit from "new blood." The problem of "burnout" is unfortunately not uncommon among some of the first generation of family practice faculty, so that the challenge to the residency director and departmental chairman is to provide avenues

for continued challenge and growth of individual faculty members consistent with the needs of the program or department.

As a new faculty member gains experience in patient care, teaching, and other areas, naturally his or her interests may change as new directions for future growth appear. Periodic reassessment of performance, interests, and needs is important. This should be carried out at least annually with the residency director or department chairman and should include constructive feedback of performance by students, residents, and faculty colleagues. Consideration should be given at appropriate intervals to taking on new responsibilities and changing the "mix" of patient care, teaching, research, and/or administration. Such changes might be possible and desirable in the same institution, while others might call for consideration of a move to another institution. The matter of geographic mobility clearly is a personal one, with many factors to be considered, including family considerations. A case can be made, however, for the value of experience in more than one institution over a career in academic medicine. After several major moves in his own career, Osler went so far as to describe the "intellectual infantilism and precocious senility which besets any teacher whose career is spent too much in one place"![2]

Incorporation of Nonphysician Faculty

The inclusion of nonphysician faculty in various disciplines within family practice programs or departments is essential to the advancement of academic family medicine. The appointment, retention, and promotion of nonphysician faculty in departments of family medicine, however, present some problems in many medical schools. Tenured positions may be quite limited for nonphysician faculty in many institutions. Nonphysician faculty (eg, behavioral scientists, epidemiologists) are less versatile than physician faculty, especially in clinical and teaching areas, and are less capable of generating clinical income. Stable ongoing funding of nonphysician faculty positions presents a special problem, especially beyond the termination of training grants. These problems may be somewhat alleviated in residency programs with a stable base of hospital support and clinical revenue, but they have to be addressed in any family practice teaching program where the number of faculty positions is unavoidably limited.

Several approaches to these problems merit attention. First, each nonphysician faculty member, regardless of field, needs to establish an area of teaching involvement and expertise as well as active contribution to the research effort of the program or department. Some, or in some cases most, of this research may be in collaboration with other faculty members. Nonphysician faculty often take major responsibilities in curriculum development, evaluation of teaching programs, faculty development, administration of research programs, and related activities. In order for these contributions to be incorporated into programs and departments on a stable and long-term basis, these faculty members need to become indispensable and in many cases to develop their own sources of future funding through various grant programs.

Responsibility for Career Development

There is no question that the individual faculty member is in large part responsible for his career development in the various ways which have been discussed. The role of the program or department administration in the career development of faculty is equally important and often not fully appreciated.

There are a number of approaches that can be taken by the program or department administration to promote growth among faculty. These include the following:

1. Recruit a sufficient number and appropriate mix of faculty so that everyday service and teaching commitments do not preclude an adequate amount of "academic time" for all faculty members.

2. Provide both formal and informal mechanisms of faculty development in teaching, research, and administrative skills for faculty in the department as well as those in affiliated residency programs.

3. Encourage personal growth of individual faculty members through constructive feedback, building on individual strengths, periodic reallo-

cation of faculty responsibilities, and decentralized leadership within the program or department.

4. Foster a mutually supportive, intellectually stimulating environment wherein productive faculty can develop and mature without having to leave the institution in order to grow.

5. Develop and maintain a solid fiscal base for the program or department which can support a faculty size *above* the critical mass required to maintain daily service and teaching commitments.

Comment

Most of the issues that have been discussed are not unique to academic family medicine. For example, other clinical disciplines with heavy service, consultation, and teaching commitments often have severe time barriers to research activities. Some issues, however, apply particularly to family medicine (eg, the breadth of clinical skills involved, the embryonic stage of research development, and the special importance of maintaining close interactive ties with community practice).

Knopke and Anderson have recently proposed a conceptual model for individual faculty development over a career in academic family medicine.[3] The more pragmatic and everyday issues which have been addressed in this paper can be combined with their conceptual schema for career planning and counseling. From a staging point of view, it is preferable for a faculty member during the early years of his career to be largely involved with patient care and teaching but still have time to pursue special interests and initiate research and scholarly projects. Faculty members in university settings facing promotion and tenure requirements cannot delay for long their active involvement in scholarly activities. During these early years, administrative responsibilities should be kept to a minimum, since they may interrupt an individual's progress in other vital areas.

Regardless of setting, academic family medicine is a varied and stimulating life with active involvement over a career in at least three major areas of the traditional four: patient care, teaching, research, and administration. As changes are considered at any point during a career, whether a move or major change of activity in the same institution, certain trade-offs are unavoidable. For example, heavy involvement in research or administration will necessarily compromise some clinical skills, whereas major clinical and service responsibilities will make it difficult to devote much time to research.

It is fortunately still too early for any traditions to have developed as guidelines for future family practice faculty. The first generation of faculty have been principally clinicians, teachers, and administrators. The clinician-teacher-researcher, so important to the future of the field, is still evolving. Because of the dimensions of the concerns and needs of academic family medicine, however, more rather than less diversity will be required among family practice faculty in the future.

There is no single blueprint for developing a career in academic family medicine. Multiple career tracks are available, each calling for different strengths and a different "mix" of activity. Decisions made in one direction early in a career can be made in new directions in later years. Every career is unique, since it draws on the particular interests and special talents of each individual faculty member. The 1980s will see new traditions become established in academic family medicine, with new role models of faculty having much to contribute to family medicine as well as to the rest of the medical profession and the community at large.

References

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