EDITORIAL

Clinical faculty and medical education — turmoil in academe

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In the current uproar over the funding of universal medical care programs and a shortage of physicians and nurses, little attention has been focused on the dismal funding of Canada's medical schools. Yet, they are in crisis because of restrictions on budgets.

Canadian medical schools have been financed traditionally by an allocation from global university budgets, part of which comes from student tuition. Additionally, in most provinces, designated funds from the ministries of health are also targeted for medical training. Medical school budgets mainly pay geographic fulltime faculty (GFTF), who are expected to fulfil the schools' missions in research and teaching, namely, the creation of knowledge and the advancement of learning. However, over the years there has been a change in emphasis from teaching activities to research productivity.[1] As a result, GFTF are expected to devote their major energies to research and administration, with comparatively little time spent in teaching. Research activities are held up as their most important activity, and teaching is regarded to some extent as an "add on."[2] Thus, promotion and salary increases are judged mainly on research activities and peer- reviewed publications. There is little reward for excellence in clinical care and teaching.

However, if one were to ask the paymasters of the schools, namely the taxpaying public, what the primary mission of the medical school was, I am confident the answer would be that of training doctors and other health professionals. We need doctors to look after sick patients and carry out other health-related activities in our society. Most would consider acquiring new knowledge to be important as well but not the primary role of the medical school. In recent years, there have been signs of awakening as the universities finally became more aware of their important role in education, and teaching is assuming a new found importance. That change was slow in coming and is still evolving, especially in medical schools.

By tradition, the burden of clinical training of future doctors is left to the volunteer activities of unpaid clinical faculty who rely on clinical earnings for their livelihood and, because of their dedication, willingly contribute long hours imparting clinical expertise to the next generation of doctors, thus ensuring the renewal of the profession. Physicians have accepted this as a professional obligation in the Oslerian tradition and have discharged it willingly, without expectation of reward.

The role of clinical faculty is critical to the function of the medical school in training doctors, and without their contributions the school would be unable to meet training expectations. Only practising clinicians can demonstrate the excellence in clinical skills required to train doctors. Students, residents and GFTF recognize that most clinical faculty are outstanding physicians, based on their knowledge and excellent care, and often turn to these physicians for their personal and family care. They are, indeed, the engines of clinical medical education and are critical to the educa-

tional mission of the medical school. Despite this, the traditional medical school budget, which takes no account of the volunteer hours put in by clinical faculty, usually does not include funds to pay them appropriately for their work. Universities likely have little idea of the size of the contribution made by clinical faculty. They have always been taken for granted by the faculties of medicine, who see them as a reliable, willing, inexpensive and endless source of teaching.

This system worked fairly well when payment schedules for clinicians were reasonably generous. allowing them to donate time to the university, with personal satisfaction and perhaps prestige being their only reward. Today's clinical faculty have inherited this tradition of medical education but are finding it intolerable because of pressures not previously present. With falling incomes, rising overheads, increasing demands on the physician's time and new labour-intensive curricula, it has become difficult for clinical faculty to contribute the necessary unpaid time to teaching. Unfortunately many clinical faculty are now beginning to view their relationship with the medical school not as a pleasure and a mission but as an irritation that interferes with their livelihood, and unpaid teaching time has become an issue.[3] A recent questionnaire to clinical faculty at one teaching hospital in Vancouver found that 80% of those who replied felt their work was undervalued by the university; and a shocking 50% were apprehensive of expressing discontent for fear of retribution. Not only is the provision of unpaid teaching time by clinical faculty becoming more onerous, but the decreased productivity and extra workload associated with the presence of trainees in the ambulatory setting is making it increasingly difficult for clinical faculty to take students into their offices. An evaluation of the Harvard Pilgrim primary care clerkship and ambulatory care residency found that clinical productivity of teachers decreased by 16% due to time spent supervising trainees. As Kuttner noted: "not surprisingly teaching took time."[4] We have arrived at a turning point in medical education. To ensure that high-quality clinical training of medical students continues, the value of volunteer activities of clinical faculty in teaching and administration will have to be measured and appropriately compensated in salary and benefits.

The need to recognize the contributions of clinical faculty comes at an inopportune time for the schools as they cope with budget constraints, making it difficult to meet their missions and goals. This is aggravated by new pressures to increase training positions due to a perceived shortage of physicians in Canada. In their search for more money, medical schools are eyeing clinically generated funds to supplement the shortfall in budgets. Subtle and not so subtle pressures are being applied, which tie use of hospital-based resources by physicians to contributions to department budgets. In recent decades in the United States, there has been a steady extension of the power of medical schools into hospitals in larger cities, creating "medical school empires."[5] Hospitals became more oriented toward research and training than patients' needs. As the schools became affiliated with groups of hospitals, usually in larger centres, and exerted their influence, hospital medical staff appointments became linked to university appointments. The schools gained the potential to insist on conditions for appointments; conditions such as mandatory unpaid teaching[3] or contribution of a portion of clinical income from practitioners to the medical school. This is reminiscent of a proposal suggested at one US medical school in the 1960s to tax affiliated private doctors to support house staff.[5] The proposal failed. A similar situation has evolved in Canada and, in my view, has been encouraged in recent years by regionalization of medical services. Hospital resources in metropolitan centres have become administratively more concentrated, with closer ties to the medical schools. In the face of this, many clinical faculty are afraid to voice their concerns for fear of retribution, which might affect their practice income. However, problems of medical school funding cannot be solved by co-opting clinical funds to education and research. Society must recognize that medical education is a social expense that is borne collectively, like other types of education. The previously hidden costs of educating doctors through the work of clinical faculty can no longer be met on a volunteer basis. Governments and universities must make budgetary adjustments to see that clinical faculty are paid for their services like other members of society are paid for theirs. In addition, medical schools must ensure that advance-

ment in rank for clinical faculty is fair and based mainly on the amount and quality of teaching and demonstrated excellence in patient care.

At the University of British Columbia clinical faculty have formed the University Clinical Faculty Association to bargain with the university for basic rights and appropriate remuneration for services, similar to that accorded to GFTF. This is long overdue.

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