Recruiting and Retaining Clinician-Educators

Lessons Learned from Three Programs

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Market-driven reform of the health care system in the United States has led to a demand for changes in medical education. The Sixth Report of the Council on Graduate Medical Education (COGME) states: "The growth of managed care will magnify the deficiencies of the current educational system, yet will also provide new and essential educational opportunities to improve the preparation of physicians for their future roles."[1] The report defines competencies for primary care and managed care practice, then recommends curricular reforms, including changes in the sites used for training. The COGME report further recommends: "The size, composition and competencies of the full-time faculty at medical schools and residency programs must be reviewed in order to assure that they are appropriate to train physicians for their future roles."[1]

As Dr. Evan Charney points out, medical education uses an apprenticeship model.[2] Specialists and subspecialists have been well served by a system that uses trained, experienced physicians who practice their specialties in appropriate settings, usually within teaching hospitals. These same elements are essential for training generalist physicians, creating the need for community-practice settings as training sites and practicing physicians as clinician-educators.

As medical schools and residency training programs attempt to adapt to the nation's demand for changing the physician workforce, it is evident that nowhere is the balance between specialists and generalists more skewed than in academic health centers.[3] Changes in medical practice as well as medical education now mandate that more community physicians and full-time academic generalist clinician-educators be successfully incorporated into the faculty. This article outlines lessons learned in the recruitment and retention of clinician-educators using different strategies at three medical centers: the University of Utah, Emory University, and the University of Cincinnati.

PEDIATRIC CLINICIAN-EDUCATORS: UNIVERSITY OF UTAH

Organization of the Program

Like several pediatric residency programs in the United States, Utah's uses private practices and community sites to provide longitudinal experiences.[4–7] Approximately one third of pediatric residents are placed in private community practices, one third in publicly funded community clinics, and the remainder in the outpatient clinic at the University Hospital.[8] In the community practice sites, the residents are paired one-to-one with preceptors. Meeting the different expectations and levels of commitment required in a longitudinal community-based program poses logistical, quality control, and organizational challenges. Office space for resident education must be adequate, and the office staff and the preceptor's partners must be supportive. We require offices to be located within a 30-minute drive of the hospital. Program evaluation is essential to meet the concern that educational quality will suffer from moving residency education to community settings.[9] Our evaluation showed that residents placed in community practices saw more patients with a wider variety of medical problems than residents in the other settings.[8] The training site was unrelated to scores on the pediatric in-training examination, but residents placed in private offices scored higher on the behavioral pediatrics examination and on a practicum examination.[8]

Community teaching practices must be fitted into an organizational component of the medical school. We expanded our division of general pediatrics to include a section of community pediatrics. An outstanding community physician chairs this section. The chair's role includes selecting and recruiting private practice preceptors, coordinating the teaching and faculty-development programs, and serving as the liaison between community teaching physicians and full-time faculty.

Recruitment of Community Faculty

The pool of preceptors for the residency and medical student programs consists of practicing pediatricians within a 30-minute drive of the medical school. The Children's Medical Center and the Pediatrics Department of the University Hospital have open medical staffs. Physicians who admit patients to the pediatric services are required to teach. Previously, full-time faculty members and community physicians coattended on ward rotations. When the community-based continuity clinic program was instituted, physicians who in the past taught in inpatient settings often preferred the option of teaching in their offices.

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The enthusiasm of these physicians for embracing community teaching may have reflected their desire to teach in more familiar settings, as opposed to the hospital setting. Because the program now has a 10-year history, graduates who had their continuity experiences as residents or students in one of the local private offices have now become available as faculty and prove to be especially interested and qualified.

Initially, the full-time faculty recruited community preceptors by informally approaching them. As the program developed, local private physicians requested participation. Community faculty are now recruited and selected jointly by the continuity-experience director and the pediatric residency program director. Two methods are used for assessing the competency of potential recruits. First, full-time faculty members rate the community preceptors as teachers based on their coattending experiences in the hospital. Second, one full-time generalist faculty member makes a site visit to the office of the potential preceptors, during which the faculty member observes the organization of the practice and the pediatrician's relationships with patients, staff, and partners.

Recruitment is enhanced by our full-time academic generalists, who practice within the confines of the medical center. They provide the community physicians with colleagues and supportive "go-betweens" who often can smooth relationships with specialist faculty. The program must be planned so that the concerns of individual preceptors can be addressed. These usually include time, space, finances, program content, resident selection and assignment, malpractice coverage, disruption to the practice, recruitment of patients for the resident's practice, and fears regarding the legitimacy of their roles as resident teachers. An effective recruiting method involves asking currently active preceptors to discuss with interested community physicians the rewards of the program, to address their concerns frankly, and to explain how the program deals with problems.

Retention of Community Faculty

Community teaching requires a considerable commitment from the preceptor to the program.[10–15] Practitioners at Utah teach two half-days per week for a 3-year period. More time is required for program administration, such as scheduling resident clinics and completing resident evaluations, and for participation in faculty-development activities. The residents require office space, nursing and staff support, and examining rooms.

The initial funding from the Health Resources and Services Administration that supported Utah's program has declined. Preceptors are currently uncompensated, but a study of the economic impact of incorporating residents into private practices indicates that the presence of a resident does not adversely affect the numbers of patients seen and the dollars billed by the preceptor.[10] If resident visits are attributed to the preceptor, the total number of patients seen per half-day increased by 30% to 50% after the resident's first 6 months in the office. The point must be emphasized, however, that these favorable economics apply to an apprenticeship model, which paired residents one-to-one with preceptors and used teaching techniques that minimize disruption to patient flow. The financial impacts of block rotations and of teaching medical students are less favorable.[11]

Faculty development is integral to the program's success and to faculty retention.[12] Seminars conducted for all the generalist preceptors at Utah include 1-day workshops, as well as four 1-hour sessions held at the beginning of each academic year. In addition to teaching techniques, these seminars include updates on clinical problems and seminars on medical topics that are selected by the preceptors.

Of the more than 30 practicing pediatricians recruited by Utah in the past decade, only two have discontinued participation. In the residency program, however, few are continuously active as most take a year or two off between precepting residents. In the student program, preceptors take students nearly every year, probably because there are fewer demands when teaching medical students. Success in retaining community preceptors perhaps reflects not only the preceptors' philosophical commitment to outpatient teaching, the personal rewards they get from outpatient teaching, the perceived lack of financial penalty, and the faculty development, but also our efforts to incorporate them into our program and give them recognition.

Bonding the preceptors to our program is enhanced by site visits from the full-time faculty who are responsible for administering the program. Preceptors are visited monthly during their first year of participation, bimonthly during the second year, and quarterly thereafter. The site visitor provides support for the preceptor by determining concerns about the program and problems with the resident. The visitor observes a complete resident-patient visit and the subsequent preceptor-resident interaction, and provides feedback to both the resident and the preceptor. A written evaluation is given to all parties, including the full-time faculty member who is to make the next site visit. Although this process is intimidating, the majority of preceptors have commented that they highly value this aspect of the program.

Before the community continuity program, appointment and promotion of volunteer faculty were perfunctory at best. Presently, all are given clinical faculty appointments in the Department of Pediatrics. A separate committee evaluates community faculty. Criteria for promotion are yet to be fully defined. Our next step will be writing promotion criteria with the same attention to detail used for our full-time faculty. Extreme care will be given, however, to make the promotion process a reward for those participating, and not a traumatic experience, as has often been the case for full-time faculty.

PRIMARY CARE CLINICIAN-EDUCATORS: EMORY UNIVERSITY

Emory University School of Medicine is developing a primary care network to align its strategic and economic goals into a vertically integrated system. The network currently includes 104 physicians—about one third of its projected total—encompassing four disciplines, general internal medicine, family medicine, obstetrics and gynecology, and pediatrics. It is based at two teaching hospitals with affiliated practices, six large health centers strategically placed in growing areas that roughly surround the hospitals within a radius of 10 to 20 miles, and smaller practices. The large health centers contain subspecialists as well as primary care physicians. The smaller practices most often consist of three to five physicians in a single primary care discipline. The network is now sufficiently developed to allow access by patients with managed care contracts, wherever they may live within the metropolitan area.

Recruitment of Clinician-Educators

Currently, recruitment is driven by the need to have viable practices. Though buying practices with a full complement of patients is preferred from an economic standpoint, a significant minority of the 104 physicians hired to date have been recruited from Emory's own residency programs, or recruited directly from other sources. The busy community practitioners, who have joined the network with their patients, are given financial incentives to maintain productivity. Likewise, residency graduates placed in network practices are expected to build a full complement of patients after 3 years. For the most part, these individuals will spend 90% to 95% of their time in practice, and 5% to 10% of their time teaching or in other academic activities. Some individuals may concentrate entirely on clinical practice.

Teaching Within the Network

The Management Committee of the network includes members designated by the chairs of the clinical departments, a director who is the vice-president for primary care services, and leaders from the business and executive staffs. Chair-designees are strong supporters of the teaching mission. To date, several sites have evolved into outpatient residency training sites, including two family practice centers, the two largest general internal medicine group practices, and the largest practice of obstetrics and gynecology.[16–19] The internal medicine and family medicine practices are joint faculty and resident practices, in which the residents function in an apprenticeship model and have their own panel of patients whom they follow longitudinally.[20,21] Medical student outpatient experiences also are being developed in the network.[22–25] Medical student teaching tends to be one-to-one preceptoring.

In the residency training sites are clinician-teachers with more than 5% to 10% teaching responsibilities. About one tenth of our physicians are currently in this category. Their duties include precepting one-to-one or with a group of primary care residents, attending on inpatient teaching services, teaching medical students, developing or evaluating residency curricula, and advising or mentoring students. These academic duties may require up to 80%, or as little as 15%, of the time of clinician-teachers with these roles. All also see their own patients. Teaching time is funded through primary care network funds earmarked for teaching, departmental funds, and grants or gifts to support teaching. While the faculty are teaching, they also bill for participation in the evaluation and management of patients seen with the residents. A first-year trainee in family medicine is assigned 25 to 30 families. This grows to 100 to 125 families by the third year of training. A comparable number of individuals are assigned to the trainee in internal medicine.

The role of medical students in the practices is determined individually on the basis of the student's needs and abilities.[26] The first week may be spent with the student "shadowing" a faculty member until the student's abilities are determined.[27] Students then generally see patients by themselves and see the same patient again with the preceptor, who reviews the case. For medical student teaching, some clinicians in the network could be part-time preceptors for 1 or 2 months as their sole teaching responsibility. These clinicians might spend 95% of their time in practice and 5% in teaching.[28]

Faculty Recruitment

Early on, we relied on professional recruiters and advertised to attract physician candidates. In a short time, our physician capacity exceeded the number of patients available, so the recruitment process was slowed. Subsequently, the chair-designees on the management committee assumed responsibility for recruitment. Candidates have been identified in a variety of ways. Established community practitioners who want to sell their practices to our network frequently come to us through the recommendations of friends who are already practitioners in the network. Highly qualified clinician-educators, chosen for leadership roles in the residency programs, come through the department's academic contacts. Each department recruits outstanding graduates of its residency program, beginning in October or November of each year and culminating in the "signing up" of the future graduates in the spring. Also, we are frequently approached by physicians who want to move to the Atlanta community. Many of these people are graduates of residency programs in other cities who write to the department seeking employment. The number of physician candidates identified through these informal networks has exceeded the needs of our system, and this approach appears to identify superior

candidates compared with the previous approach of advertising in national journals.

Recruits identified by the academic departments generally are more interested in teaching than either those identified by advertising or the established practitioners who join the network. In internal medicine, the strategy includes identifying one or two experienced physicians to lead the teaching and practice program at each major site. These experienced physicians are augmented by outstanding graduates of the residency program. In family medicine, there are a number of candidates seeking clinical roles who responded to our previous advertising campaign, whereas the department has identified a smaller number of faculty largely for academic/teaching roles. Most candidates for the Department of Obstetrics and Gynecology were identified through personal contacts of faculty members. Many were former residents or were trained by members of the department at other locations. By matching the interests and qualifications of candidates with available job descriptions, we hope to maintain physician satisfaction with their careers in our network. The majority are mainly practitioners. Some are designated for substantial teaching assignments. However, there is flexibility and opportunity for changing roles.

The recruitment process requires that each recruit be interviewed and approved by the chair-designee, and also by the local medical director in the practice to which the recruit will be assigned. Recruits are discussed and approved by the vice president and the Management Committee as a whole, and their appointments must be approved both by the department and the medical school's Executive Committee. Most recruits join with the rank of instructor, with the expectation of promotion to assistant professor on the clinical track in 1 or 2 years given satisfactory performance. Those with leadership roles may expect further promotion, based on excellence in teaching or administration or both, but will also need adequate scholarship to qualify for promotion.

Retention

We predict that retention of clinician-educators will be determined by three factors in the future: their compensation, their voice in the decision-making process, and their loyalty to the system.

Compensation

Entry-level salaries for residency graduates must be at least competitive, defined as within 10% to 15% of private sector offers.[29] Salaries for established practitioners joining the network may be somewhat below the compensation received while in private practice. This discrepancy is acceptable given that membership in the network provides security and relief from some administrative functions, but the salaries also must be competitive. The system is in rapid flux. Salaries of entry-level generalists currently exceed those being offered as recently as 3 or 4 years ago by almost 50%. It is not impossible that this trend will soon level off given pressure for downward fees exerted by managed care. Our current approach provides salary incentives based on individual and group productivity, plus other factors, including quality of care, patient satisfaction, and teamwork. Physicians with more than 5% to 10% time spent in teaching will receive a separate component of salary for that endeavor. The principle for this component is that it not change overall compensation and that it reflect excellence in teaching.

Physicians' Voice

There will be tension between individual practice style and the needs of a large organization. We hope for a creative tension, such that individual physicians will have the incentive to improve their practices and group productivity. This goal can best be achieved if physicians in the network perceive having a voice in an open, defined decision-making process, which is fair and representative.

Loyalty to the System

The hard-working individuals we seek must relate positively to management leadership, and to the overall goals of the network. What will make these individuals loyal to the system? In addition to fairness and representation, physician leadership of the network should have sufficient contact with each individual practitioner to establish a personal bond. Faculty-development programs, continuing medical education programs, and teaching in the network will be unifying factors. These components are synergistic, and promote a greater good for the system as a whole that will complement individual excellence in practice. We define faculty development, beyond continuing medical education, as helping physicians become better teachers and better able to function in an academic environment. We will conduct individual needs assessments for faculty that can be met by individual mentoring and extensive reading files, as well as seminars and workshops.

Summary

Teaching, in this vision, provides a framework for unity and loyalty within the network. We envisage several teaching components. A mentoring system for first- and second-year students will ask individual faculty to discuss their practice with a student and allow "shadowing" for several sessions. Any physician in the network can participate in this program. Clinical experiences for third- or fourth-year students will encompass 1 month of working within a practice, also accessible to clinicians who have 5% to 10% of time set aside for teaching.[30,31] Each of these programs may have its own faculty leadership and opportunities for faculty development. The residency programs will be based in central sites where clinician-educators have substantial time for teaching. However, individual residents may elect to work in community sites. Here again, faculty with a smaller time commitment to

teaching may participate as preceptors and attend faculty-development programs. Our timetable to achieve these educational goals is 2 to 3 years. All of the efforts are currently ongoing, although our short-term horizon emphasizes developing the clinical practices.

AMBULATORY MEDICINE CLINICIAN-EDUCATORS: UNIVERSITY OF CINCINNATI

Since 1992, the University of Cincinnati's Department of Medicine has provided medical students with clinical teaching at outpatient sites. Like many programs around the country, the recruitment and retention of university and community-based faculty to work with students in the outpatient setting has been challenging. Efforts such as designing a curriculum, faculty development, and feedback and evaluations of faculty participants are now widely used to increase faculty participation in ambulatory teaching. Several strategies have enhanced these traditional efforts at recruiting and retaining faculty. We have also identified and addressed some of the barriers to our efforts, which other institutions may recognize now or in the near future.

Recruitment of University-Based Faculty

In the rapidly changing academic health care environment, faculty in the Division of General Internal Medicine are faced with the ever more difficult task of balancing clinical productivity demands with teaching and research expectations. This tension has affected our recruitment of faculty, who are concerned that ambulatory teaching of students may not be recognized as much as other academic activities for purposes of promotion, and that time spent teaching may adversely impact their clinical productivity. Our institution, therefore, made a determined effort to recognize ambulatory clinical teaching as an activity with merit equal to the department's clinical, research, and other teaching activities.

Faculty in the Division of General Medicine document their ambulatory teaching activities as part of their clinical teaching portfolios. During late spring and early summer, each faculty member meets with the division director to plan his or her academic activities for the year. The director will have assigned to each activity of the division a clinical teaching unit (CTU) value. All faculty are required to have 270 CTUs to maintain full-time status. During recent years, ambulatory teaching has been added to the list of activities that count toward this requirement. This addition has leveled the field by recognizing the efforts of those who enjoy and excel in ambulatory teaching. The director annually reviews performance in all activities with each faculty member. Performance assessments are entered into faculty portfolios, which form the basis for promotion in the clinician-educator track. The Promotions Committee rewards faculty who consistently exceed the minimum departmental requirements, especially in ambulatory teaching.

This distribution of effort has led to a faculty teaching plan for the department. Using the same relative values assigned to all clinical teaching activities, the Department of Medicine assigns a dollar amount for CTU (Table 1). For example, if a faculty member commits to 400 CTUs for the year, then the teaching component of salary would be 400 × \$98 (value assigned per CTU for 1996–97) or \$39,200.

This strategy enhances recruitment and retention of faculty by providing them with objective data and remuneration for teaching. They can make choices based on personal and professional needs. The strategy allows ambulatory teaching activities to compete effectively with other demands on faculty loyalties.

Recruitment of Community Faculty

Approximately 80% of internal medicine practitioners in Cincinnati have had graduate or undergraduate training at the University of Cincinnati and a sense of loyalty to its educational mission. To transform this loyalty into tangible commitment, we provide community practitioners with a sense of partnership with the university in ambulatory education.

To enhance partnership, we organized respected, community-based clinician-educators into the Community Coordinators Committee. The Committee communicates the goals and objectives of the outpatient teaching rotation to current preceptors and identifies community physicians who are qualified potential preceptors. The liaison role of the Committee helped address concerns of the Department of Medicine that the quality of teaching would be difficult to control when using many preceptors in a variety of outpatient settings. The Committee also provided the program with insight about the impact of the curriculum on the community preceptors. We avoided making decisions about the outpatient teaching rotation that would adversely affect the preceptors and thereby hamper recruitment and retention efforts. The Committee also helped

Table 1. University of Cincinnati Department of Medicine Clinical Teaching Activities and Their Relative Values (CTUs)*

Activity	Relative Value (CTUs)
Inpatient teaching (wards)	100
Inpatient consulting	50
Ambulatory student clinic	50
Private office precepting (students)	30
Resident continuing clinic (half-day for entire academic year)	140
Ambulatory morning report (students)	10

**All activities are 1 month unless otherwise specified; CTU indicates clinical teaching unit.*

solve specific problems faced by preceptors (e.g., time-pressured preceptors found that scheduling a student for a full day in the office was less stressful than splitting their time into two half-days).

Other successful efforts include timely feedback about preceptors' performance, responsive administrative staff to solve problems, and academic recognition of teaching efforts by community physicians. Recognition has been accomplished by a variety of methods, the most prominent of which are appointment and promotion in a volunteer faculty track, and the presentation of the Blackenhorn Award established by the Department of Medicine to recognize annually one to four outstanding community clinician-educators.

Such partnership-building strategies help the University of Cincinnati add breadth to student education while enhancing the reputation of community physicians working closely with the Department of Medicine.

Retention of Faculty

Our recruitment efforts have the goal of retaining faculty in the outpatient teaching rotation for the long term. Of the current faculty involved in the program, more than 60% are now long-term participants (defined as 3 years or more of active teaching in the rotation) (Fig. 1). This is a significant percentage of physicians who are willing to make a long-term commitment to undergraduate ambulatory education despite highly demanding schedules.

Challenges Ahead

As in a number of health care markets around the country, Cincinnati has seen a major shift of health care delivery into integrated delivery systems. The emphasis on vertical integration has been the major focus in our locale. In several ways, this shift makes recruitment for outpatient teaching more difficult.

Our faculty practice has integrated with several community internal medicine groups into the Health Alliance of Greater Cincinnati. Integration has increased clinical productivity demands for the general medicine faculty leaving less time available for outpatient teaching. The previously described faculty teaching plan was designed to address this problem. However, there remains the tension of competing clinical and academic interests. This tension has resulted in some full-time faculty limiting their involvement in the teaching programs, which requires enhanced efforts to recruit more physicians.

Market changes have also placed demands for greater clinical productivity on community physicians. We rely heavily on volunteers among community physicians to participate in the outpatient teaching program. In spite of the comradery we have developed with community faculty, we are facing the fact that we may not be able to rely on the volunteer efforts of community physicians for much longer. We will need different models for recruiting and retaining community faculty to sustain the shift in medical education to generalist training outside the walls of the university. In Cincinnati, this has meant financially compensating community physicians for the time they spend working with trainees as part of the practitioners' total compensation package as members of the health care system. Eventually the dean of the College of Medicine may need to redistribute teaching funds from the traditional inpatient teaching services to provide the funds necessary to recruit and retain qualified community and university faculty for ambulatory medical educational programs.

Finally, scheduling of activities regarding faculty-development programs also has become problematic owing to increased clinical demands on all faculty. However, our preliminary data indicate that physicians who participate in these programs have a greater likelihood of long-term commitment to the ambulatory medicine program (80% of physicians who participated in the faculty-development program versus 50% of nonparticipating physicians maintained 3- to 4-year commitments). We are exploring new avenues for offering faculty-development programs to our preceptors that increase the level of participation and thereby increase their chances of long-term commitment. Some possibilities include 1-hour, community-based hospital conferences several times a year as well as development of a home page on the World Wide Web for physicians to access the material covered in traditional faculty development programs.

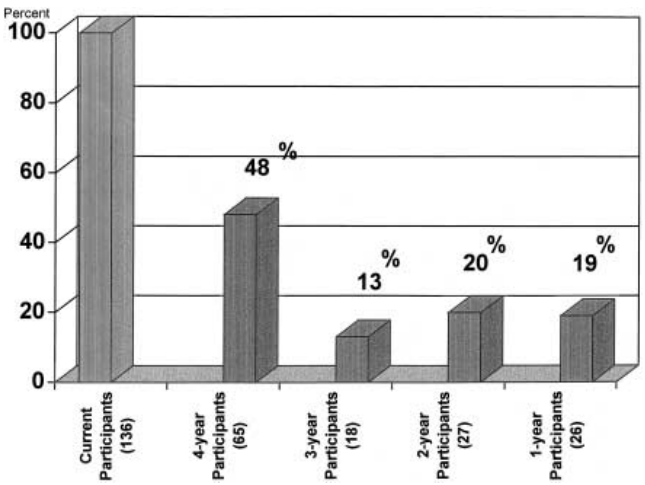

FIGURE 1. Retention of faculty preceptors in ambulatory education programs, University of Cincinnati Department of Medicine, 1996.

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