Tenure and the Faculty Physician

Stephen A. Geraci, MD and S. Calvin Thigpen, MD

ABSTRACT

Academic tenure, introduced by the American Association of University Professors in 1915, is a status that protects employed faculty members from summary dismissal and, thereby, intends to preserve their academic freedom. Initially tied to financial security through salary guarantees, academic tenure has evolved into a concept associated less with monetary support and strict scholarly productivity than at its inception, primarily owing to the growing number of clinician educators with highly competitive salaries at university-affiliated academic health centers. Achievement of tenure continues to require significant additional time and effort, but modifications in the requisite probationary period and the allowance at some institutions of tenure for part-time faculty have offset some costs, while still maintaining leadership opportunities for the individual and academic benefits for both the individual and the institution. How institutions balance their own financial risk and the demands on faculty members is likely to determine the future of tenure.

Key Indexing Terms: Tenure; Faculty physician; Academic administration; History. **[Am J Med Sci 2017;353(2):145–150.]**

INTRODUCTION

Academic tenure is a status that protects an employed faculty member (a doctor of medicine or doctor of philosophy for this discussion) from summary (i.e., without cause) dismissal, and is granted after a trial period during which the doctor has performed at a level commensurate with the standards established by his or her university.[1] At its inception, issues related specifically to physician faculty members were uncommon and less significant, as many medical colleges were originally unaffiliated with universities. Only much later were university-affiliated academic health centers (AHCs) faced with the dilemma of needing to hire and pay competitive salaries for faculty members with heavy clinical commitments while still protecting themselves from significant financial risk. This article will examine academic tenure from its inception to its current state, analyze associated costs and benefits (for both faculty members and institutions) associated with its pursuit and anticipate what its future might be, as related to the academic physician.

ORIGIN AND EARLY HISTORY

First established as a product of the 1915 Declaration of Principles on Academic Freedom and Academic Tenure composed by the American Association of University Professors (AAUP), academic tenure has undergone significant evolution over the subsequent century.[2] Initially, the intent behind the creation of tenure was protection of the academic freedom of university faculty members across the full range of disciplines, among which the medical sciences were only a portion.[2]

The AAUP's 1915 Declaration outlined 3 functions of the university, namely (1) to promote inquiry and advance the sum of human knowledge; (2) to provide general instruction to the students; and (3) to develop experts for various branches of the public service. Additionally, the Declaration highlighted the following 3 elements of academic freedom for professors requisite to the university being able to accomplish its functions: (1) freedom of inquiry and research; (2) freedom of teaching within the university or college; and (3) freedom of extramural utterance and action.[2] To establish the university as a protector of these freedoms, the AAUP established the concept of tenure as permanent employment.[2] The AAUP set forth 10 years of service as the benchmark at which all positions above the grade of instructor should become permanent, subject only to clearly defined grounds for dismissal (enforceable only through fair trial before a permanent judicial committee of the university).[2]

Twenty-five years later, the AAUP and the Association of American Medical Colleges (AAMC) collaborated on the 1940 Statement of Principles on Academic Freedom and Tenure, where they refined the probationary time until granting of tenure as 7 years, and included the rank of full-time instructor as acceptable to qualify for tenure.[3] If the institution did not plan to grant tenure at the end of the probationary time, it had to deliver notification to the teacher at least 1 year before the termination date. At the end of that subsequent year, the teacher lost employment at the institution.[3] Importantly, the concept of academic freedom that tenure was protecting had expanded to state that teachers, while being free from institutional censorship, 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." Also included in the 1940 Statement was specific

verbiage stating that economic security of the teacher with tenure was indispensable, along with the teacher's academic freedom, to a university's success in fulfilling its aforementioned functions.[3]

Over the following 3 decades, tenure underwent further refinement. In 1970, interpretive comments put forth by the Council of the AAUP clarified those modifications.[3] The comments specified that "teacher" should be understood also to include investigators who are a part of the university but who do not necessarily have teaching duties. They additionally outlined more of the due process afforded to those teachers under consideration for dismissal (for reasons other than behavior) that would arouse condemnation from the academic community. The details on due process included stipulation that suspension was justified only if clear harm would come to others if the faculty member continued working.[3]

EVOLUTION AND RECENT HISTORY

Through its protection of academic freedom, salary and due process, tenure allowed faculty members to pursue their scholarship without reliance on external financial support for nearly all of the 20th century.[4] Investigators who initiated projects that might take years to bear fruit, and who had no significant clinical practice, benefited greatly in both their autonomy and economic security. However, in the 1970s it became apparent in academic medicine, with the growth in technologies and diagnostic and therapeutic procedures, that excellence in the clinical arena would involve an ever-increasing commitment of time and effort.[5] No longer would an individual have the capacity to deliver patient care, educate medical students and residents and perform research all with great success as a "triple threat."[5,6] As a result, 2 distinct types of physician emerged—physician scientists (PS) and clinician educators (CE)—with different balances of their work efforts.[6] Clinician educators became recognized as physicians whose primary responsibilities were patient care and education, and whose research constituted either a minor or no portion of their academic contributions.[7] Although PSs also devoted time and effort to teaching, they would spend most of their time in research rather than patient care.[5]

Over the ensuing 2 decades, CEs became more commonplace as full-time medical school physician faculty members at AHCs, with the number of institutions designating individuals as CEs increasing from 61 (1986) to 91 (1997).[7] By the early 2000s, both the financial burden of tenure and the scientific criteria requisite to achieving tenure had become more difficult to justify.[8,9] The criteria for achieving tenure at nearly every institution had historically been heavily weighted toward scholarly productivity, particularly securing extramural research funding and publishing peer-reviewed scientific journal articles. If this remained true, the criteria would effectively prevent any CE from gaining tenure, resulting in frequent turnover, loss of referral lines, lack of return on the initial institutional investment in the CE, and even higher cost to the AHC in recruitment and start-up expenses for replacement of the faculty members. Institutions could not accept the financial risk of a highly salaried physician who became unproductive after being awarded tenure. AHCs faced a choice regarding the nature of tenure: they needed to change either the economic security (salary) offered and protected by tenure, the criteria for achieving tenure, or the number of pathways available for physicians to remain on the faculty.[4] To date, all 3 have taken place to some degree.

As the CE generally required a much greater initial investment, and a much higher salary, for the AHC to be competitive with the private sector, the first approach taken by many institutions as early as the 1970s was to reduce the guaranteed salary conferred by tenure.[5,9-11] Over the course of the following 30 years, this trend grew to the point that many AHCs divorced compensation entirely from tenure.[8] In the 2005 Faculty Personnel Policies Survey conducted by the AAMC of the 125 U.S. allopathic medical schools accredited by the Liaison Committee of Medical Education, only 56 of the 113 schools that offered tenure included a financial guarantee, with only 3 guaranteeing the full institutional salary.[8] Additionally, AHCs altered the criteria for achieving tenure in multiple ways. These changes included lengthening the probationary period required before tenure eligibility, instituting "clock-stopping" policies within the tenure track for those with anticipated prolong periods of no or limited academic productivity, and allowing part-time employment while on a tenure-eligible track.[12] Many AHCs also created tenure tracks for their CEs that required less rigorous publication targets and removed any requirements for extramural research funding, but were more dependent on clinical and educational scholarship (i.e., integration, application and teaching), teaching awards, national professional society involvement, leadership (both intramurally and extramurally) and contribution recognition (e.g., professional society awards and governmental commendations).[6,13]

Subsequent to, and in some cases concurrent with, these criteria adjustments and financial and timeline accommodations, AHCs began offering non-tenure tracks for CEs. Rather than having a probationary time that ended either in dismissal or in some measure of economic security and protection, CEs signed time-limited contracts that stipulated some or most of their compensation through their department's or hospital's clinical practice plan, usually paralleling some measure of productivity. Although the number of total physician faculty members climbed precipitously from the 1970s through the 2000s, the percentage of physicians in non-tenure tracks also increased steadily and at a much faster pace.[8] By 2010, nearly 60% of all full-time faculty

TABLE. Adapted with permission from the AAUP resources on contingent appointments at https://www.aaup.org/issues/contingent-faculty-positions/resources-contingent-appointments. Accessed September 26, 2016.[26]

Trends in faculty employment status, 1975-2011 All institutions, National totals	Rate of growth by time period						
	1975-1989	1989-1995	1995-2001	2001-2007	2007-2011	1975-2011	2001-2011
Full-time tenured faculty	19.9	4.5	−2.1	4.2	6.1	35.6	10.6
Full-time tenure-track faculty	−10.9	−2.0	14.1	7.2	1.1	7.9	8.4
Full-time non-tenure-track faculty (%)	72.1	11.8	37.0	17.9	13.1	251.5	33.3
Part-time faculty (%)	59.5	27.0	30.0	38.2	11.3	305.3	53.8
Total faculty (%)	32.4	13.0	19.5	22.3	9.5	139.5	33.9
Contingent faculty (%)	63.3	22.2	32.1	32.1	11.8	289.1	47.7
Tenured/tenure-track faculty (%)	8.9	2.6	2.4	5.1	4.5	25.7	9.9
Proportion of total growth attributable to contingent positions	84.3	90.8	94.8	91.6	85.1	89.5	89.4

See full trend data table for explanatory notes and source information.
Compiled by AAUP Research Office, Washington, DC; John W. Curtis, Director of Research and Public Policy (3/20/13). *Note*: 2007-2011 growth rates on this page only corrected 7/18/13.

physicians were in non-tenure tracks, and approximately 70% of all newly hired full-time faculty members were also in non-tenure tracks.[14] These trends mirror tenure and non-tenure-track developments within the academic labor force as a whole through 2011 and 2014, respectively (Table and Figure).

Despite the non-tenure option removing concerns regarding probationary time and mandatory termination for some, CEs in this pathway discovered other ways in which their roles were limited. Despite comprising a significant portion of the faculty members at most AHCs, CEs were often not able to sit on particular AHC committees, be a part of the faculty voting body, or in most ways have their influence match their significant (clinical) financial contribution to the institution.[4]

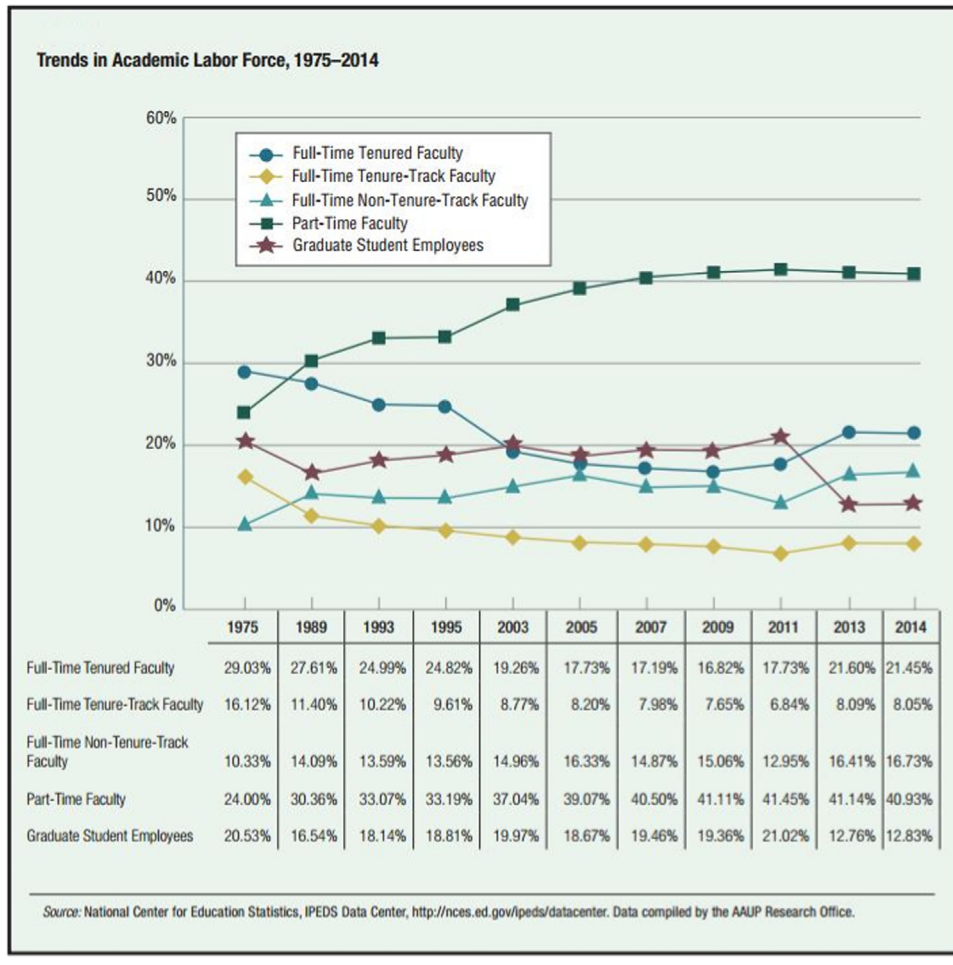
For the PS, the non-tenure track also became a preferable option for institutions, but not necessarily for faculty members, as the 21st century began. With competitive grants becoming increasingly difficult to obtain and providing shorter funding terms, AHCs found the salary guarantees of the tenure track untenable for PSs also. AHCs created non-tenure-track positions without long-term economic security, but financed through soft grant funding or through the PS increasing his or her clinical activities.[15,16] Physician scientists have faced issues with the non-tenure track similar to those for the CEs. However, instead of there being an imbalance between influence and financial contribution, the imbalance was often between the institutional support they received and the contribution they made to the AHC beyond their research productivity. Tenure track positions were advertised, but with salary reductions that had to be offset by the faculty member securing funding from an external source.[8] All of these developments occurred in the context of a changing economy that brought fewer public funds into AHCs. This financial climate, ultimately, has all but forced the separation of tenure and guaranteed salary at institutions throughout the country.[8]

DILEMMAS OF TENURE

With the earlier evolution in mind, some of the current dilemmas associated with tenure for CEs are obvious. However, it is essential to examine the other quandaries that exist, with the caveat that these vary widely among AHCs and that understanding individual institutional guidelines on promotion and tenure are vital for the individual contemplating such awards. To achieve tenure at any institution, however, work beyond patient care and bedside teaching are always necessary. This effort may include demonstrating extraordinarily high performance in activities that the faculty member is already undertaking as part of his or her job description (such as higher volume clinical productivity), development of influential quality improvement initiatives, creation of educational curricula, or production of scholarly work relevant to their major institutional activities. Recognition for superior performance, contribution, or productivity with tangible awards in the teaching or direct patient care arenas may also be required.[12]

However, there may also be an effort that is well outside the usual flow of work for the individual. Institutional service on department and university committees is commonly required, and extramural participation as a leader or significant contributor to one or more regional or national specialty societies is expected. Many institutions set specific benchmarks for scholarship that are much higher than those for non-tenure-track faculty members, including conditions that the scholarship be of a particular type, quantity or quality (e.g., impact factors and other metrics of journals publishing their articles).[12]

The dedication needed to achieve each of these components is further compounded by the fact that



	1975	1989	1993	1995	2003	2005	2007	2009	2011	2013	2014
Full-Time Tenured Faculty	29.03%	27.61%	24.99%	24.82%	19.26%	17.73%	17.19%	16.82%	17.73%	21.60%	21.45%
Full-Time Tenure-Track Faculty	16.12%	11.40%	10.22%	9.61%	8.77%	8.20%	7.98%	7.65%	6.84%	8.09%	8.05%
Full-Time Non-Tenure-Track Faculty	10.33%	14.09%	13.59%	13.56%	14.96%	16.33%	14.87%	15.06%	12.95%	16.41%	16.73%
Part-Time Faculty	24.00%	30.36%	33.07%	33.19%	37.04%	39.07%	40.50%	41.11%	41.45%	41.14%	40.93%
Graduate Student Employees	20.53%	16.54%	18.14%	18.81%	19.97%	18.67%	19.46%	19.36%	21.02%	12.76%	12.83%

FIGURE. Used with permission from the AAUP Annual Report on the Economic Status of the Profession, 2015-2016: Higher Education at a Crossroads: the economic value of tenure and the security of the profession. https://www.aaup.org/sites/default/files/2015-16EconomicStatusReport.pdf Accessed October 2, 2016.[27]

timelines are still often placed on tenure eligibility. Although the timeline was formerly prescribed nationally, it is now set at the discretion of the AHC. New hires may be offered initial years that do not count as part of the probationary period, and the institution may also choose to suspend the timeline ("tenure clock") during periods when an individual will clearly be unproductive, such as extended family or medical leave.[13] In a 2008 AAMC survey, AHCs using probationary periods longer than 8 years for PSs had climbed from 26 to 45% over the preceding 25 years, and from 26 to 50% for CEs over that same time period.[8] In this survey, 83% of AHCs offered the option to "stop the clock" for child care, 77% for care for an ill family member and 80% for personal medical disability.[13] Although these accommodations often help a faculty member successfully navigate the tenure track, many institutions still employ an "up or out" policy. In an unpublished 2012 AAMC survey, 40% of the 88 responding AHCs reported that clinical faculty not achieving tenure are terminated or given a terminal contract, whereas 8 AHCs (9%) reported that faculty members could continue, but only on a renewable basis that may include a reduced salary.[17] As a result, and as noted by others, although tenure flexibility is available at many AHCs, the application of such options remains infrequent.[13,18,19]

ADVANTAGES OF TENURE

Although there are several dilemmas of tenure at present, there are advantages that tenure brings to both the faculty member and the institution. First and foremost among these is the prestige associated with tenure. Peers both within and outside a given AHC generally view tenured faculty members with greater esteem, often associating them with high-level expertise in their particular fields.[20] This expertise, too, is of great enough significance to the organization to warrant a career-long commitment, which presently usually includes some financial component, from the institution. Colleagues' recognition of high-level competence increases networking opportunities exponentially,

creating faster routes to long-term career goals. Institutions may also benefit from higher retention rates of tenured versus non-tenured faculty members.

Additionally, tenure opens doors to additional leadership positions or privileges, such as voting membership on executive or faculty senate committees or eligibility for chairmanships, that are typically not available to non-tenure-track members.[4,17] This allows those tenured to exert greater influence over the conditions of their work environments and, sometimes, the personnel with whom they work.

Tenure also affords greater protection from being terminated without significant cause.[3,4] Although disagreements with leadership might lead to the firing of even the productive non-tenured clinician, the tenured faculty member is more likely to be engaged more thoughtfully by their superiors for solutions, or even asked to join the leadership group.[21] The reasons for the different approach to the tenured faculty member amidst disagreement may include not only protected salary or benefits that might be part of the tenure position but also the greater mobility of faculty members with tenure.[17] Outside institutions typically view tenure as a sign of productivity, accomplishment and commitment to furthering academic medicine. Because of this perception, they are often willing to offer what had not been previously available at the tenured faculty member's home institution, be that more protected time, a higher guaranteed salary percentage or a collaborative opportunity or financial investment in the faculty member's area of expertise. Many will also offer “tenure on appointment” to those already tenured at their home institution as part of a recruitment package. From the perspective of the individual making an initial decision to enter either a tenure track or a non-tenure track, the possibilities of relocation, a long-term career in academic medicine, leadership positions or elite level accomplishment in the future are major considerations supporting the pursuit of tenure.

For the institution, the benefits of tenure include, first and foremost, the tenured faculty member having a greater sense of freedom to contribute to the AAUP's aforementioned listed functions of the university: (1) to promote inquiry and advance the sum of human knowledge; (2) to provide general instruction to the students and (3) to develop experts for various branches of public service.[2] Additionally, the concepts of guaranteed due process, academic freedom and at least partial long-term salary support that tenure now incorporates are far more likely to attract the most capable faculty members than are short-term renewable contracts.[3] This attractiveness is true not only for the hiring of potentially highly competent junior faculty members directly out of training, but also of capable senior faculty members from other institutions or practice environments. Retention rates are commonly considered higher among tenured faculty members.

THE FUTURE OF TENURE

With the constantly changing face of medicine, particularly in its economic infrastructure, it is very difficult to predict exactly what will become of tenure. Beyond the financial considerations that may lead to salaries being divorced entirely from the awarding of tenure, there are many other factors at play. The time and effort required to provide high-quality clinical care, the increased expectations surrounding trainee supervision and medical student education, the rising competition in obtaining grant funding, and the near constant direct accessibility of physicians to their patients make meeting the demands of a tenure track ever more difficult for the CE.[22,23] Taking only the patient care changes of the last 10 years into account, patients' expectations of rapid communication and continuous availability of their health care providers have grown remarkably. Patients' working knowledge of disease processes, influenced by both accurate and inaccurate information easily available to nearly everyone, makes their care increasingly nuanced. Despite the finer distinctions in the care of each patient, third-party payers and AHCs have intensified their demands to meet standardized metrics for quality, cost containment and client satisfaction, all of which add considerable additional workload to those providing clinical care.

Additionally, there are non-work-related factors, such as a growing number of extracurricular opportunities for physicians' children and the higher frequency of spouse employment, to consider as challenges to committing the personal time needed to meet institutional tenure requirements.[22,24,25] In light of these myriad dynamics, physician “burnout” rates, particularly with the widespread institution of electronic medical records, are soaring.[23] How burnout will affect tenure, or tenure affect burnout, is a central issue affecting the future of tenure. Will more physicians opt for a tenure track because of the prospect of guaranteed employment after a certain period of time? Or will a greater proportion choose non-tenure tracks to avoid the additional scholarship and AHC service requirements? Physician burnout ultimately could be a driver toward changing the fundamental expectations of and for tenure, and for altering the composition of the tenured faculty at any given AHC to include more part-time faculty members or even members who have demonstrated balance of their work and meaningful extracurricular commitments over time.

CONCLUSION

Ultimately, in the face of pressures which often constitute a different form of “tyranny” from that being described in the AAUP's 1915 Declaration, it is a strong possibility that tenure will at some point no longer be connected to either of the 2 concepts on which it originally stood—academic freedom and financial security. However, there remains the prospect that tenure will

retain some of what made it originally attractive to those of high ability and strong personality, by offering motivated academic physicians the prestige that comes from recognition of their accomplishments and commitment to the medical field. The decisions dictating the future of tenure will continue to increase in complexity for both the employing institutions and the individual faculty members.

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From the Departments of Medicine and Medical Education (SAG), Quillen College of Medicine, East Tennessee State University, Johnson City, Tennessee; Division of General Internal Medicine, Department of Medicine (SCT), University of Mississippi Medical Center, Jackson, Mississippi.

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Correspondence to: Stephen A. Geraci, MD, Department of Medicine/ETSU, PO Box 70622, Johnson City, TN 37614 (E-mail: geraci@etsu.edu).