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# Mission Critical: Reimagining Promotion for Clinician-Educators

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Academic clinician-educators who teach health professions trainees and lead educational programs have been penalized by the mismatch between their daily contributions to the academic mission and traditional promotion criteria focused on peer-reviewed publications and external reputation. Despite two decades of incremental approaches, inconsistency and inequity persist in the promotion process for clinician-educators. The authors propose five steps to mark a new approach to academic advancement for clinician-educators: (1) elevate the scholarly approach to teaching over peer-reviewed publications; (2) allow clinician-educators to identify an area of focus; (3) broaden the evidence for educational excellence; (4) prioritize internal referees; and (5) increase clinician-educator representation on promotion committees. Achieving meaningful change requires transforming entrenched traditions and policies at multiple levels. Changes that advance equity are necessary to retain academic faculty members who train the next generation of health professionals.

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Promotion pathways in academic medicine have had intractable issues of inconsistency and inequity for decades.[1–4] Despite pledges to value the clinical, research, and education missions, differential rates of advancement through professorial ranks (assistant, associate, and full) across faculty tracks persist.[2,3] Clinician-educators, who teach health professions trainees and lead educational programs, are penalized by the mismatch between their daily contributions to the academic mission and traditional promotion criteria focused on publication records and external recognition.[5–8]

Higher-education institutions developed the promotion and tenure process for arts and sciences faculty centuries ago.[6] Following its adoption by medicine in recent decades, academic promotion is now a requisite pathway for most health sciences faculty. Increasing academic rank has implications for salary, benefits, funding, and leadership opportunities, and, more existentially, confers power and validation by one's institution.

In this perspective, we propose abandoning the failed decades-long tinkering of research-focused promotion criteria and reimagining advancement for clinician-educators as a process that promotes excellence in training the next generation of health professionals.

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## INCREMENTAL APPROACHES

In 1999, Levinson and Rubenstein highlighted how promotions criteria were inconsistent with the job descriptions of most clinician-educators, whose working hours are allocated to teaching and doctoring.[9] Academic leaders created clinician-educator promotion tracks as an initial response to address this inequity.[10,11] Today, only 43% of U.S. medical schools have educator advancement pathways.[12]

A second strategy was the inclusion of the educator portfolio (EP) that encapsulates contributions to teaching, assessment, curriculum, mentorship, leadership, and scholarship in promotion packets.[13,14] The EP can offer a comprehensive view of educational contributions but is a lengthy qualitative document that is manually compiled by the candidate.[14] Consequently, many faculty elect not to submit an EP, and promotions committees often consider them to have limited utility.[1]

A third programmatic approach focused on helping faculty thrive in clinician-educator roles. Many institutions have implemented mentoring programs, leadership and negotiation courses, family-friendly policies that support caregivers, anti-bias training, and options to defer advancement ("stop the clock") based on personal and pandemic circumstances. Despite these efforts, women and faculty from historically excluded groups, including clinician-educators, still advance at a slower rate and leave academics more frequently.[1,2,15–21]

## RE-ENVISIONING ACADEMIC ADVANCEMENT FOR CLINICIAN-EDUCATORS

We propose five steps to mark a new approach to advancement for clinician-educators (Table 1).

**Table 1 Steps to Advance Equity for Academic Clinician-Educators in Promotion**

| Problem | Solution | Action |
|---|---|---|
| 1. Clinician-educator impact is measured primarily by published papers | Emphasize a scholarly approach to teaching rather than peer-reviewed publications | Expand the definition of education scholarship |
| 2. Clinician-educators hold roles that are not assessed during the advancement process | Allow each clinician-educator to identify a role-specific area of focus | Promotion committees develop the capacity to evaluate specific clinician-educator role expertise |
| 3. Clinician-educator expertise is primarily assessed with teaching scores | Broaden the evidence for demonstration of educational excellence | Create new systems to capture and catalogue relevant evidence (e.g., learner performance) |
| 4. Clinician-educators' local contributions are not visible to external referees | Prioritize internal stakeholders (e.g., learners and colleagues) | Elevate input from local colleagues who directly observe the educator's daily work |
| 5. Insufficient number of clinician-educators on promotion committees | Increase the number of clinician-educator faculty on promotion committees | Appoint more committee members with expertise in education science |

1. *Elevate the scholarly approach to teaching over peer-reviewed publications*

A conceptual shift that places a higher value on a scholarly approach to teaching than the production of original scholarship is the first step to re-envision the promotion process for clinician-educators. In 1990, Boyer extended the definition of scholarship beyond discovery to include the scholarship of teaching (to stimulate transformative lifelong learning), application (of knowledge to real-life work), and integration (across educational disciplines).[22–24] This reframing of scholarship recognizes that all fields—including education—advance because of the collective activity of many skilled practitioners (i.e., teachers) in partnership with innovators and knowledge generators. Promotion committees can enact this conceptual shift by emphasizing an educator's scholarly approach to teaching in addition to their production of original (discovery) scholarship.

Scholarly teaching resembles the intellectual arc of scientific experiments and should be credited as such in the promotions process.[25] A scholarly approach includes review of the relevant education literature, articulation of objectives, experimentation with teaching methods, and reflection on educational results to inform continuous improvement.[26] For instance, a procedural skills teacher who revises her instructional methods from videos to hands-on practice with observation and feedback would document the literature she reviewed and the educational principles she employed (e.g., mastery learning), and track the procedure performance of her students in a simulation lab. This is the evidence that promotion committees should appraise in evaluating her scholarship. Dissemination and peer validation in the form of workshops, invited talks, or publications would strengthen the case for this teacher's expertise—but would not define it.

Educators who create digital media, like podcasts or blog posts, can outline this same scholarly process and intellectual journey and have the opportunity to document the extent of their impact through downloads, impressions, view counts, and other measures of engagement, which often eclipse by orders of magnitude the citation counts that promotions committees are accustomed to seeing.

2. *Allow differentiation based on the clinician-educator's area of focus*

Clinician-educators should begin the promotion process by declaring a domain of expertise. Many educators' primary focus is on program leadership, curriculum design, learner assessment, education research, or advising and mentorship.[1,27] For example, a fellowship program director may devote substantial efforts on accreditation requirements, learner wellness, and holistic review initiatives. This educator could identify education leadership as their primary educator role at the start of the promotion process and present the most recent program self-study or site visit report from the Accreditation Council for Graduate Medical Education, learner burnout inventory scores, and progressively increasing diversity of each incoming class. Just as scientists and scholars with multiple talents are advanced based on their specific area of study, educators should be evaluated on their specific area of expertise within health professions education.

3. *Broaden the evidence for educational excellence*

Promotion committees must expand the sources of data used to judge educational excellence.[26,28,29] Teaching evaluation scores, like manuscript counts, have intuitive appeal for their simplicity. However, teaching evaluations are inconsistently collected and prone to bias, correlate more with learner satisfaction than learner achievement, and may be misaligned with the educator's area of expertise.[30–34] A physical examination course director may revise facilitator guides for her small-group instructors as part of an annual curriculum improvement process. To examine the highest-level outcomes data of her curriculum revision efforts, the promotion committee should review her students' standardized patient examination scores at the end of the course. Even if her teaching scores are high, learning outcomes from the students in her course, which reflect her educational specialization and innovation, should be prioritized in her advancement appraisal.

4. *Prioritize internal referees*

Promotion committees should look internally to assess an educator's impact, just as they seek external validation of a scientist's innovation. Clinician-educators serve populations *within* the academic health system: learners, patients, and

colleagues. External referees do not directly observe teaching and patient care, which renders "external reputation" the wrong *primary* tool to assess most clinician-educators' impact.[35] In contrast, internal referees often have direct experience working with the clinician-educator, as colleagues caring for the same patient, co-facilitators in teaching sessions, or collaborators in curriculum design and delivery.[36] Direct observation of teaching or review of curricular materials could be structured using published rubrics.[36–40] When promotions committees tip the scales toward internal referees' descriptions of daily contributions, external referees can round out the holistic review by focusing on generalizable appraisals that cross institutional lines, such as the impact of disseminated scholarly products or novelty of educational innovations. External references may have a supplemental role, but promotion committees should prioritize internal evaluations that highlight a clinician-educator's skill and reputation in teaching, doctoring, and collaborating.

5. *Increase clinician-educator representation on promotion committees*

Promotion committees need balanced representation across all academic missions to ensure equity in advancement. Investigators on these committees bring expertise in evaluating research faculty, including knowledge of competitive grants, leading journals, and cutting-edge discoveries. Like the biomedical sciences, health professions education is a discipline with its own evolving practices, literature, and innovations. It is challenging for clinician-educators to assess the specialized work of a biomedical scientist—and the converse is equally true. Promotion committees need adequate numbers of clinician-educator members, proportional to their representation in the institution, to make informed appraisals of frontline educators.

Achieving meaningful change requires transforming entrenched traditions and policies at the department, school, and university levels. Stakeholders include academic senates and university units removed from the realities of health professions education. As a first step, institutions should revise promotion criteria to recognize multiple forms of scholarship and expertise of clinician-educators. Next, academic health systems should help clinician-educators collect and display data that capture their impact with the same ease as manuscripts and grants can be imported from public databases into promotion software programs. Finally, institutions must ensure proportional inclusion of clinician-educators on promotion committees.

We must stop holding all faculty to the same monolithic expectations in academic medicine. Excellence comes in many forms. If we fail to advance clinician-educators based on their designated roles and expertise, they will continue to experience an inequitable system that judges them against standards designed for others. Academic medicine is uniquely situated, among its tripartite mission, to train the next generation of health professionals. The time has come to reward and retain the faculty who deliver on that promise.

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