

Choosing Another Path: Medical Faculty Leaving the Tenure-Track

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If a tenure-track position is the aspiration of most academics, why would those who have attained such a position choose to relinquish it?

Through our research on the topic of faculty attrition, we became aware of a small but noteworthy population of individuals at the University of Michigan Medical School (UMMS) who have left their previously held tenure-track, or instructional, positions for other, primarily clinical-track, positions within the Medical School system.

Examining faculty attrition is difficult because the individuals in question usually also leave the institutions where they gave up or failed to earn tenure. Thus, they can be difficult to locate, and their attitudes about their former employers may alter after separation. But in this case, we have access to a still-resident population, making them ideal for learning more about the experiences and perceptions of medical professionals who have chosen to leave tenured or tenure-track positions.

This inquiry is part of a study funded by the National Science Foundation's ADVANCE Project to explore issues of retention and satisfaction among academic professionals. We hope it will help the UMMS, the University of Michigan and other higher education institutions to be more successful preparing medical school students for the realities of academic employment, and in hiring, retaining, and providing satisfying careers for faculty members.

FINDINGS AT A GLANCE

Barriers to success—Participants identified three circumstances that limited their success on the tenure track:

1. Inadequate education and training to be a researcher
2. Lack of research support from administrators and colleagues
3. Difficulty finding time for research

Motivations to move—Participants gave various reasons for electing clinical track positions:

1. Some were intrinsic reasons, such as interests that had evolved and changed over time, thus making the move desirable.
2. Other were more extrinsic, such as senior colleagues, supervisors and administrators encouraging the move.

Changing Work/Roles—Most participants indicated that their work lives had changed little: They were still seeing patients and engaging in research, though in different proportions and with different research topics. Some also reported the opportunity to broaden the scope of their duties to include more administrative and service work.

THE STUDY

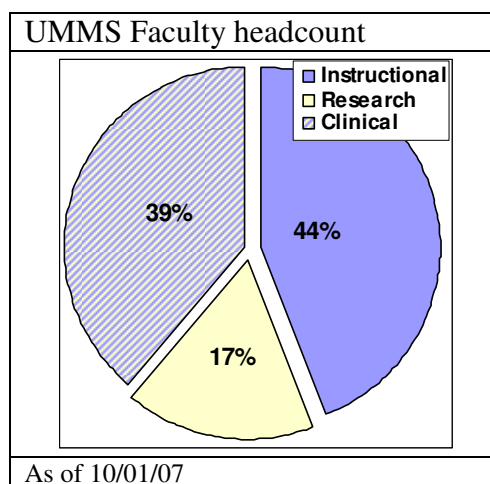
Through information available in the university's personnel database, we were able to identify 60 likely participants in UMMS who had switched from the tenure-track instructional track to the clinical track. We conducted a short web-based survey to collect some baseline and demographic data and to screen for participants who met the study criteria. We then invited the survey respondents to take part in unstructured in-person interviews. We spoke with nine men and women who began their medical careers at the University of Michigan in tenure-eligible positions but later switched to the clinical track. Seven of these people (two of whom have PhDs rather than medical degrees) have been at Michigan for over ten years, the range being between five and twenty-two years.

Faculty positions in UMMS differ from those in the most other areas of the university due primarily to the essentially different nature of the work. Fundamentally, these faculty members are physicians, for whom some portion of their duties involves interacting with patients in a clinical or hospital setting. They also have viable and directly transferable employment opportunities outside academe—private medical practices. This alternative of prestigious and remunerative outside employment is not generally available to academics in many other disciplines, especially the arts and humanities. Related to, or perhaps as a result of, these occupational characteristics, the three employment tracks in UMMS are unique to the rest of the university:

THE INSTRUCTIONAL TRACK—this is the original, and for many years the sole employment track, and the only one that awards tenure.

Position titles follow the traditional tenure track model of Assistant, Associate, and Full Professor.

THE RESEARCH TRACK—This track originated in 1974 and, as the title indicates, has a primary focus on research. Many individuals on this track hold PhDs as well as or instead of medical degrees. They may engage in teaching and mentoring activities as well as research. This track has four ranks: Research Investigator, Research Assistant Professor, Research Associate Professor, and Research Professor.



THE CLINICAL TRACK—This most recent of the tracks began in 1986. There are four ranks in this track: Instructor, Assistant, Associate, and Full Professor. While formal titles use the descriptor, Clinical Track (i.e., Assistant Professor, Clinical Track), it usually not included in common usage.

All three tracks conduct research and have teaching and service responsibilities. The nature and focus of the research varies, with the Instructional and Research Tracks having greater emphasis on discovery, basic and bench research, and Clinical having greater emphasis on applied and clinical research. Only the Instructional and Clinical Tracks have patient care responsibilities.

| Features of the UMMS Tracks | | | |
|--|---------------|----------|----------|
| | Instructional | Research | Clinical |
| Eligible for tenure | Yes | No | No |
| Participation in governance: | | | |
| UMMS Executive Committee | Yes | Yes | Yes |
| University Senate | Yes | Yes | No |
| Eligible for sabbatical leave | Yes | No* | No* |
| Eligible for emerita/us status | Yes | Yes | Yes |
| Responsibilities: | | | |
| Research | Yes | Yes | Yes |
| Teaching/mentoring students | Yes | Yes | Yes |
| Patient care | Yes | No | Yes |
| * leaves may be granted for educational or training purposes | | | |

THE CHANGING CLINICAL TRACK

Today, the clinical track is much more common in the Medical School than it was a decade or more ago. Physicians are being hired directly onto the clinical track, and clinical faculty are recognized as valuable partners in the medical school. Switching from one track to another, however, is not a common occurrence. According to one respondent, “There’s this period where switching [from instructional to clinical track may be] reasonable to be entertained. And then there’s this period where it’s not. It’s not a stopgap thing [to save someone who’s nearing a negative tenure decision].”

At the same time, all is not equal between the two tracks. Among these clinical faculty, who overall are happy with their current roles, all but one of them also harbor some degree of bitterness or frustration about being regarded, in some circles, as “second-class citizens.” This feeling ranges from fairly mild (“my close colleagues respect me highly, but I know that not everyone does”) to quite pronounced (“I resent that I was forced to move from the tenure track” or “some of my mentors

believe I have really let them down”). Two respondents expressed concern about the impact of the “clinical” title should they choose to apply for other jobs in academic medicine.

“I’m not as valued [now],” one person said. “Not one-to-one with faculty that know me, no. But for faculty who don’t know me well, I feel it. [For example,] in meetings, whether they’ll listen to you. Whether you’re given time and attention when speaking.” As another respondent explained, “Research is one of your key measures of success, also the kind of research you’re doing. And clinical research is not as highly regarded.”

On the other hand, not everyone shares that perception. One physician explained that he has “never felt like a second class citizen.” Second-class status “was much more obvious five years ago than it is now. I think that people don’t pay as much attention to it now, or maybe we just don’t feel it as much....I think with time people have come to recognize that they need the clinical faculty here: one, to generate fodder for the research track, and two, to support

the research people. Because we generate the income that essentially pays for their salaries. So I don't think it's so much two-tiered anymore."

Another respondent agreed, saying there's not a prestige differential in his department. "I think perhaps in the past there may have been. I think nationally there may have been. But I think that's easing up." Said a third person, "I think what really helped is when they took the word 'clinical' off the signage. So you don't have to say that you're the 'clinical blank, blank.' You just say you're the 'professor.'"

Those who switched off the tenure track longer ago, in the mid-1980's to the early 1990's, did so when the clinical track was much less well established and recognized than it has since come to be. As one of them explained, "I don't think it was even an option to be hired on the clinical track when I started. If it was, it was never mentioned. [The assumption was] you were at an academic institution, so you're a tenure-track [person]." These "early" people were more likely to have faced uncertainty and stigma over the switch. For example, another physician said, "When I switched, my [senior colleague] considered it a real let-down and disappointment to think that a person would do anything but the instructional track....You might as well be in private practice if you're just going to be a clinician."

FINDINGS AND DISCUSSION

BARRIERS TO SUCCESS

Despite the perception of such potential negative effects, the individuals with whom we spoke did switch tracks. They gave several reasons for doing so, most of them linked to the nature and extent of the

responsibilities inherent in an instructional track position. That is, in addition to seeing patients and teaching medical students, instructional track faculty are expected to carry on "bench research" or similar high powered projects with outside funding, which they are also expected to obtain. Most of the doctors described three obstacles that made it very difficult for them to establish and maintain their research agendas and thus precipitated their moves to the clinical track:

1) Preparation to be a researcher

Participants reported that they did not have the kind of training in their pre-med, medical school, residency, and fellowship training that would have prepared them to be researchers. Without this familiarity, they really didn't know what they were getting into on the instructional track. Most believed they got little explanation from the people who hired them about what it meant to be in a tenure-track appointment. Thus they had hard times learning how to set up labs, acquire funds, and carry out the research they were expected to do. As one person said, "Looking at it now, I don't think it was good advice to say, 'Come and be on the research track,' because I wasn't prepared for that in terms of my training. I was really clinically trained....And I wasn't interested in bench research."

"If I could do it over," said another doctor, "I'd make a better decision about what I really wanted to do—a time-intensive clinical endeavor or basic research. Because they weren't really compatible...It can be done if people make smarter decisions than I did....Some of this has to be thought out very thoroughly early on."

In some cases, this lack of understanding about the nature of the instructional track

meant that people ended up doing things that didn't really fit with their career goals. "I didn't come to UM with any strong interest in doing lab work....Oh, I had done a fair amount of undergraduate research, but I really didn't want to be working in a lab....Of course, there are lots of other levels of research that a tenure-track person can do that are not necessarily in the lab doing bench research. But the way the administration was set up then, that wasn't explained. It was just 'This is what it is,' and you were just sort of left on your own to pursue it."

2) Lack of research support from administrators and colleagues

In addition to having inadequate research backgrounds, participants frequently said that they did not get support from their new UM administrators and colleagues. "People would say 'Oh, yeah, sure, do this.' And encourage you to do research. But there was really no mechanism in place to make it doable for somebody who is relatively new." They mentioned needing mentors to help them learn about and understand the research obligations and processes; needing collaborators who could bring them into already existing research projects, as a way for them to get initial training and support; and needing financial support for their research until they were able to write proposals for funding. "At the time, I thought I could do it. But in retrospect, coming in fairly green...I think I was kind of under-qualified for what I was supposed to do [on the tenure track]. And there's really a lack of mentorship. In our department, there was no one." People whose clinics were off-site, away from the UM hospital, had an especially hard time finding opportunities to collaborate with

colleagues on worthwhile, funded research projects.

As one physician concluded, "When you bring in junior faculty on the tenure track, they really need to be teamed with a senior faculty person who has some things going that can help them; pull them into their research that's tied to what the junior person is going to do; help them get some publications; and help them along the track."

In order to improve the system for new instructional track faculty, another respondent suggested, "I would have an ombudsman at the hiring point. At that point, I did not have a mentor and didn't have a clue about start-up packages. So I got a small amount of money to help with research—in comparison with other people, whom I've learned came in with much more to help their research....So [instructional faculty would benefit from] having somebody who's not department affiliated who can help maximize the package for new faculty, in terms of start-up funds, protected time."

3) Finding time for research

Participants often said that they could not find space in their already very busy schedules to conduct research. Many of them said that the only time they had for research was weekends and evenings, after they had already spent long days in their clinics. For these people, time spent on research meant time they didn't have for their families and private lives. The job thus became overwhelming. As one male physician said, "I came to the realization that, at least for me, I could pull off two of them [seeing patients, doing research, spending time with family] but probably not all three....And my family is non-

negotiable. That's the part that stays. So the question was 'which of the other two stays?'" Since he also felt he wasn't well prepared for "doing lab life," he took the advice of senior colleagues and moved to the clinical track. In the words of another, "I think the vast majority in my field...want to do good patient care and do good research. But they also want to have a life outside of work as well."

MOTIVATIONS TO MAKE THE MOVE

Some of the physicians made the decision to switch tracks because, somewhere in the course of their tenure-track careers, they discovered that their interests had shifted, and they no longer enjoyed doing research and writing grant proposals. "I actually had changed. Even while I was on the tenure track, I realized that it wasn't what I wanted to do....My job was changing from being very laboratory based to building up a vigorous clinical program. So [my supervisor said], 'You're successful, a lot of the stuff is clinical anyway, this change actually makes sense....I think it's better to put it [the switch to clinical track] through now than after you've been denied tenure.'"

In two instances, the decision to switch tracks came as a result of the physicians' own illness or illness of close family members—situations that, in the words of one woman, meant "I didn't get things published, bottom line." She and others were very strongly urged to switch tracks by senior colleagues, administrators or tenure committee members who believed they were unlikely to have strong enough research records to win tenure. "I was allowed a year of suspending my tenure clock, due to family issues. And that was helpful. However, the reality of my situation was

more than a year long. And so to have the University be more realistic for what the faculty bring, in terms of their personal lives, would be really helpful. And I don't think it would lessen the academic excellence that the University is aspiring to at all." Said another respondent, "I felt like this [the switch to clinical track] was my last shot to have any kind of academic life."

In every case—even those where the respondents harbor resentments over circumstances of the switch from the instructional to clinical tracks—the physicians overall enjoyed the work they were doing and didn't want to jeopardize their University of Michigan careers by going up for tenure, being denied, and thus being forced to leave their exciting jobs with strong career and medical benefits.

The often heard assumption is that women in the Medical School are more likely than their male colleagues to opt out of the tenure track for family-related reasons.

As this report suggests, however, both men and women physicians opt out or are forced out of the tenure track for a number of reasons, most of which have more to do with the culture and structure of the Medical School than with family-related issues.

| Reasons for Leaving the Tenure Track—as reported by the survey respondents | | |
|---|------------------------------|--|
| Issues are with leadership and administrative support, not with colleagues. | 50% 25% 4% 4% | Inadequate mentoring/support for junior faculty Unhelpful/incompetent chair/unit head To seek more supportive or congenial colleagues Join a unit where I and/or my work are more appreciated |
| Real or perceived, difficulty attaining tenure is a big motivator. | 38% 13% 13% | In anticipation of a negative tenure decision A negative interim/pre-tenure review A negative tenure decision |
| Some switchers seek to avoid the tenure trap, but obviously not to better their situation in other classic ways. | 33% 0% 0% 0% 0% | For greater job security To earn a higher salary Better benefits/benefit package To work in a more prestigious unit The desire to try something new |
| Switchers' desire better balance—but NOT necessarily for the "family" reasons that are often thought to be the primary reason that women opt out of tenure track positions. | 21% 21% 8% 4% 0% | To achieve better balance betw work & personal life To work in a less pressured environment To have a more desirable work schedule To start a family/ provide care for family member(s) Inadequate support/flexibility for family issues |
| Good news/ bad news—no reports of sexual harassment, but one in eight indicate stereotyping is an issue. | 13% 0% 0% | Gender/ethnic stereotyping Sexual harassment/tension Personal values/ideology not in line with dept's |

CHANGING WORK/ROLES

Many of the men and women with whom we spoke say that their jobs have changed very little since their switch. “Things really haven’t changed a whole lot really, besides the title. If you look back at me three years ago versus what I do now, there’s not a big difference.” Without the added stress of a strong, lab-based research program to maintain, they continue to spend most of their time seeing patients in their clinics and

some time working with medical students. One woman concluded that her day-to-day life didn’t change after she switched paths. “I was working just as hard doing the clinical work that I was doing before. The percentage of time didn’t change because it would have been during my free time that I would have had to do the tenure-track stuff.”

All respondents say that they still do research, as is required of them, but it usually represents a smaller percentage of

their time. In addition, the nature of the research is broader: drug trials, education-focused studies, more applied than theoretical. “The expectation is still there [on clinical track] to be producing in terms of publications and to be held to a high standard in terms of education of the residents and so forth,” explained one physician. “It’s just that the number of publications and the standards for producing a ‘coherent story’ with the research [are different].” Clinical research “is a little looser. Publications can be educational and can be student oriented.”

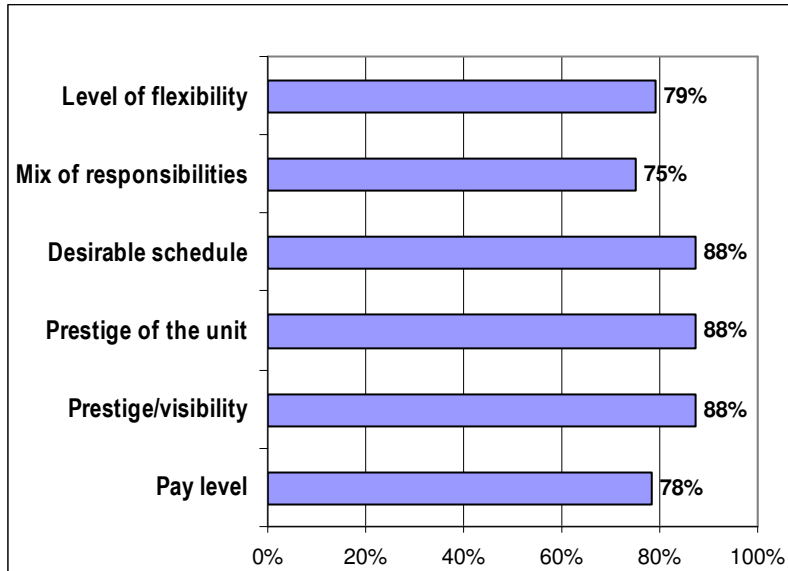
Many of these physicians also reported a broadening of their roles, having taken on administrative duties and appointments, running clinics and programs, serving on the boards of national medical organizations, for example. “I think most of the administrative duties tend to be given to people on the clinical track,” explained one physician, “to allow the researchers to concentrate on other stuff.” And, in some cases, where those administrative responsibilities are extensive,

their work lives have altered. “What I’m doing has changed a lot,” said one physician. “At the time [I was on the tenure track] I was doing work in the hospital and running the medical student program, responsible for lectures. And doing some clinical research, but not much.” Now she has primarily administrative duties. “I had to give up working with medical students. It was a different path and set of skills.”

NUMEROUS ADVANTAGES CITED

Without exception, the people in this study very much enjoy their current roles. They like the increased flexibility; the opportunity to develop their talents and national reputations in previously unexpected directions; the choice to devote themselves to their patients and other responsibilities; and the relatively greater time for family and personal lives—without a reduction, and in some cases even an increase, in compensation.

For the most part, respondents (from both the survey and interviews) felt they were at least as well off, if not better, as a result of their decision to leave the Instructional Track.



Asked to compare their current position to their previous tenure-track job, the majority indicated that, on a number of measures, their current position was “about the same” or “better”

Most of them say “I really like my job” in one way or another. For many of them, losing the “security” of tenure is not a drawback. “From my point of view, I saw no downside [to the clinical track], because tenure doesn’t mean a lot. What does tenure mean when your department doesn’t want you? It means you’re ratcheted back to a salary which is baseline. You’re often given things you don’t want: an office you don’t want, assignments you don’t want. So they make your life miserable. The only thing tenure is good for is staying here. It’s not good for salary; it’s not good for almost anything. So I didn’t see anything negative about making the switch.”

According to one respondent, “Being on the clinical track gives me an automatic license to stay here. No one has ever said to me, ‘You only have this many years and then you’re out.’” Said another, “It’s interesting that [as a clinical] I’ve never signed a contract with the University....I guess when you first hire on they have the opportunity to review in a year or two. In a tenure track it is seven years in which to attain tenure. In the non-tenure track it’s a little looser it seems....It’s probably easier to get rid of you on the clinical track, but you really have to be pretty incompetent.”

RESENTMENT, RECRIMINATION & REPROACH

At the same time, many respondents expressed resentment over certain aspects of their situations.

1) Treatment during the switch process

This is especially true for those who made the switch in the mid 1980’s and 90’s, before the clinical track became as common as it is today. “I was counseled to switch to the clinical track.” But, at the same time,

“they [Provost’s Office] wanted to make it clear to the Medical School that switching tracks is something they frowned on. If somebody hasn’t made it on the tenure track, then that’s too bad, and that switching tracks should not be allowed, especially late in the game. And I spent a year terribly affected by that personally. And it affects the satisfaction of faculty like me.”

2) Apparent capriciousness of tenure standards and criteria

Respondents believe that some of their colleagues got tenure with records no better than the ones they amassed and for which they were warned they would not get tenure. “Was I was a little bit bitter back then? Sure. And mainly at the reality that I’d worked [very hard], I’d had a fair number of publications, and someone else was going to get advanced with fewer publications, with neither one of us meeting [some] arbitrary number....But that [bitterness] is gone. And I’m happy where I am.”

Said another, “I do have a little bit of bitterness, and it’s not so much that I didn’t make it [on tenure track]. But I look at the standards and what I was told coming in, and I look back at what people did before. And I look at our senior faculty and see what they did to be promoted to associate professor on the tenure track. I look at my CV, and I don’t see dramatic differences....The average number of publications for going from assistant to associate [used to be] twenty publications....But the average has now bumped up to thirty. And there’s just no way, as a clinician, without some mechanism. And it’s just frustrating...that the standards just keep getting pulled farther and farther away.”

One respondent compared the Medical School with other parts of the University: “I

look at the CV's of my colleagues who have gotten tenure through LS&A, and it's remarkably less than what is required at the Med School. And so having some parity, and being more realistic at the Med School for what people can do, and do well, would be really helpful...to get a year off to prepare before you go up for your promotion [like LS&A offers], is unheard of at the Medical School....And so that says to me that LS&A values their faculty and wants them to succeed. And I was really left, many times, not feeling that. I was pretty alone."

3) Comparative quality of their clinical research

Since going onto the clinical track, many of these physicians have been able to do very successful research. In some cases, they believe ironically that their current accomplishments are enough to warrant their being tenured, and they regret they were not given the time to establish their research programs before being urged to switch tracks. So now they have good research reputations but not the credentials that recognize and reward their accomplishments. "So now I'm doing what maybe I could have been doing then [on the tenure track]. But who would have told me?"

"The bottom line is that, even though I'm on the clinical track, I feel that what I'm doing is the same or more.... So it's a little bit of a bad feeling I have, that it's not quite fair; I feel that I am doing as much research [as when I was on the instructional track.]"

4) Implications of gender discrimination

Among the medical school women with whom we spoke, there were a few implications of gender discrimination, some more blatant than others: Related to women's greater but unacknowledged and

unaccommodated need for family-related career flexibility; related to differential standards for tenure and salary; related to outright hostility and lack of support from male colleagues. "I think," said one woman, "that some of the [female doctors] who might tell you their stories have left. I know of three or four women in my area who were pushed out."

Another woman physician had this perception: "A [male] candidate came up for promotion along the tenure track at the same time [as I did] and was clearly going to get it. And did get it, with fewer credentials—not meeting the same standards that I was told I would need to get to be advanced. And that just really irritated me." Gender could have been a factor, she supposed. "I'm in a field that's almost all male. And I haven't really run into obstacles along the way because I'm female. So I hesitate to [suggest it here], you know. I don't know....It certainly occurred to me."

5) Miscellaneous disadvantages

The respondents also cited other, usually minor drawbacks to the clinical track, like not having sabbaticals or not being able to serve on faculty senate committees. "The only thing I can't do [on the clinical track] at the University of Michigan is vote or be on the Faculty Senate, and who cares? It would be nice if the Faculty Senate recognized the people in the clinical track. But I understand one of their issues is tenure and the devaluation of the university system because of clinical people coming in. I don't know what to say [about that]."

RECOMMENDATIONS

While all the people with whom we spoke seem content in their current clinical positions, it is also true that most of them harbor some degree of bitterness and resentment over the situations and processes involved in their switch from the instructional track.

The Medical School is clearly in a better position than it was in the past, when the clinical track was a relatively less well defined and well accepted option. However, in terms of improving overall career satisfaction for its medical staff, the Medical School could consider—

- 1) More clearly defining and explaining the two tracks during the hiring process, thus helping would-be employees to determine whether—by accepting positions in either the tenure-track or the clinical ranks—they are situating themselves in careers that best suit their training and interests.
- 2) After hiring physicians into instructional track positions, creating conditions to support the new employees' success: Liberal start-up funds, research mentors, opportunities to collaborate with already established researchers, and so forth.
- 3) Perhaps allowing more time in their schedules for instructional track faculty to pursue their research, in order to lessen their stress and pressure.
- 4) Adopting more flexible time-to-tenure, modified duties and other policies (similar to those in other areas of the University), to acknowledge and accommodate physicians' whole life needs.
- 5) Creating departmental climates that recognize and value the contributions of both

instructional and clinical faculty, so that the “second class” stigma associated with the clinical track disappears.

The Center for the Education of Women (CEW)

CEW is a unit of the University of Michigan with a three-part mission of service, research and advocacy. It is a nationally recognized catalyst for change as well as a welcoming place for individuals. Faculty and staff are welcome to use all of CEW's services.

CEW's ongoing research agenda includes work on issues related to both tenure-track and non-tenure eligible faculty, and to worklife and career flexibility.

The National Clearinghouse on Academic Worklife (NCAW), developed and maintained by CEW, provides faculty, researchers and administrators with a single resource to find articles, reports and sample policies about academic work from multiple disciplines.

CEW also supports several networking and leadership development programs aimed at UM faculty and staff. Through the President's Advisory Commission on Women's Issues (PACWI) and by other means, CEW works as an advocate on behalf of faculty, staff and students at the University of Michigan.

In addition, CEW provides free counseling to women and men regarding academic, career and life issues.

Additional information about these and other CEW activities is available at www.cew.umich.edu.