

**TENURE FOR CLINICAL FACULTY AT QUEEN'S.
REPORT OF A WORKING PARTY & RECOMMENDATIONS
FROM THE FACULTY OF MEDICINE***

BACKGROUND

Funding of GFT Clinical Faculty

Most M.D. clinical faculty at Queen's hold geographic full-time (GFT) appointments. This involves full-time devotion to University-related activities, including academic patient care. A minority of clinical faculty have other types of appointment (adjunct, non-renewable, etc.) which are not considered further herein.

GFT appointments can be either tenured/tenure track or special appointments. By definition, the latter are funded primarily from sources other than University operating grants or tuition fees (together called "hard" or "operating" funds hereafter). Importantly, special appointees are not eligible for tenure at Queen's, since the university won't commit longterm support to individuals whose funding is not derived primarily from the operating budget.

Funding for GFT faculty has always been complex, as their mandate involves patient care in addition to scholarly activities. Individuals have traditionally received a base salary based on academic salary-for-rank, supplemented by additional clinical income derived from patient care, mainly via OHIP billings. Beginning in the early 1960's this clinical income was limited by a University-established "ceiling", designed to discourage undue clinical work at the expense of scholarly activity. Any clinical earnings beyond the ceiling were returned to the University as "overage", which was used as a trust fund for academic purposes. A relatively minor modification of this system was introduced in 1990, in which individual clinical departments could elect to limit earnings by a sliding-scale levy instead of a fixed ceiling, but the principle of University control over clinical income remained intact.

Funding for clinical faculty was revamped in mid-1994, when a groundbreaking alternative funding plan (AFP) was negotiated between the Ministry of Health and the University in partnership with its major teaching hospitals and the clinical teachers themselves, collectively called the Southeastern Ontario Academic Medical Organization (SEAMO). The AFP contract grants a single envelope of funding for the combined activities of the clinical departments. GFT individuals receive a base salary (known as "T4 income") plus additional professional income in lieu of OHIP billings ("T4A income").

Regardless of the funding specifics, a fundamental principle has been maintained over the years, namely that GFT faculty are university scholars whose clinical activities take place in an academic milieu. Academic promotion and tenure have always been based on traditional scholarly criteria. Because of the complex and varied roles that GFT faculty undertake, several years ago the University created the designations of investigator-scholar, educator-scholar, and clinician-scholar to describe the primary mandate of individual clinical faculty members.

* Subsequently the Faculty of Medicine evolved into the Faculty of Health Sciences, which includes the School of Medicine (1998). The present report relates only to the School of Medicine but has been ratified by the Faculty of Health Sciences. The original document was supported by Senate in May 1999.

The Problem: Tenure-Track/Special Appointee Dichotomy

The above system functioned well in the 1960's and 1970's, as operating funds were sufficient to support a cadre of tenure-eligible GFT appointees. Gradually, however, operating funds failed to keep pace with the need for GFT appointments. The Faculty of Medicine responded by beginning to use clinical overage to fund new GFT faculty. In many instances the appointee's clinical billings generated enough overage to fully fund his/her base salary. Thus this mechanism, though not ideal, initially flourished because it permitted faculty expansion with little outlay by the University. Importantly, however, these GFT scholars had to be hired as special appointees rather than tenure-track, as their base salary came from "soft" monies.

In face of further and progressive constraints on operating funds throughout the 1980's and 1990's, the University administration increasingly limited the number of tenure-track appointments in the clinical departments. Specifically, during the 1980's only 30% of new GFT clinical faculty were tenure-track (20 of 66), and in the 1990's a mere 8% (6 of 71 to mid-1996). Consequently, the large majority of new GFT faculty in the past 20 years have been special appointees, funded primarily by overage derived from patient care. These individuals increasingly form the backbone of scholarly activity within the clinical departments, yet are not eligible for tenure. This contrasts with the traditional and historic situation at Queen's, in which deserving GFT scholars were granted tenure at an appropriate stage of their careers.

Over time, therefore, an unfair two-class system has evolved in which an aging tenured faculty coexists side by side with a growing number of productive special appointees who share similar job descriptions but lack academic security: only about 38% of the GFT clinical faculty is currently tenured or tenure-track, the remaining 62% being special appointees. The alternative funding plan has not altered this situation, since AFP funding is guaranteed only life of the SEAMO contract and no new tenure-track slots are available.

Approach to a Solution

To help address this problem, in 1994 then-Vice-Dean Bob Maudsley proposed phasing out tenure for clinical faculty and replacing it with a new type of special appointment called Continuing Appointment with Periodic Review (CAPR). In brief, CAPR appointees would have an initial probationary appointment for two 3-year terms, then would be granted renewable 5-year appointments subject to satisfactory review. Mixed feedback on the CAPR concept led then-Dean Duncan Sinclair to establish a Working Party charged with examining the issue of tenure for clinical faculty. Members of the Working Party comprised a mixture of junior and senior clinical faculty and included tenured, tenure-track, and special appointee members.

In the fall of 1995 the Working Party submitted a preliminary report which was distributed to all members of the Faculty of Medicine for feedback, criticisms, and suggestions. We also sought comments from CEO's of the teaching hospitals, the Queen's University Faculty Association (QUFA), and others. We received extensive and thoughtful feedback from a large number of individuals representing the full spectrum of interested parties. In general, there was broad support for the preliminary report, though a minority of respondents held strong contrary views to one or more of the major recommendations.

The Working Party subsequently held a series of additional meetings to weigh the comments and further develop a consensus position. We also co-opted Prof. Dan Soberman, former Dean of the Faculty of Law and an acknowledged expert on tenure, who was largely responsible for developing the current tenure regulations at Queen's. Professor Soberman's expertise was very valuable to the Working Party and helped crystallize our thoughts.

In the spring of 1996 the Working Party put forward a revised report containing 9 recommendations to serve as the focus for further debate. Again there was extensive and broadly-based discussion within the Faculty of Medicine over a lengthy period. The report was ultimately approved by Faculty Board and subsequently forwarded to Senate in the Spring of 1998. The document was then carefully reviewed by the Senate Committee on Appointments, Promotion, Tenure and Leave, which support the principles in the report but recommended several relatively minor changes in wording to ensure full compliance with the existing Senate policy on tenure. The present document incorporates all of these changes and has been endorsed by Senate (May 1999).

The 9 recommendations and their rationale follows. Although M.D. clinical faculty are barred by the Ontario Labour Relations Act from inclusion in a bargaining unit, the recommendations below are consonant with the recent collective agreement between QUFA and the University.

DISCUSSION AND RECOMMENDATIONS

1. There is broad agreement that the current two-class system of GFT scholars is unfair and divisive, and must be changed. Further, any replacement system should not be linked to the AFP – i.e., it should stand on its own whether or not the AFP is renewed.

GFT clinical faculty are normally hired with the expectation of scholarly career development, whether primarily as investigator-scholar, educator-scholar, or clinician-scholar. Under usual circumstances, therefore, these individuals should be granted the same academic rights and protections as other members of the University community. The University's obligations in this regard should not be abrogated simply because funding mechanisms for clinical departments are more complex than elsewhere in the University.

Recommendation 1: GFT clinical faculty should have the same scholarly rights and protections as other faculty members at Queen's.

Recommendation 2: The School of Medicine should abandon its policy of hiring virtually all GFT clinical faculty as special appointees, regardless of job description or anticipated scholarly development.

2. The principle of tenure deserves brief discussion, since there is much misunderstanding about the concept. Tenure originated with the judiciary in early 18th century England, not in academe: to assure citizens that complaints against the state would be adjudicated impartially, judges were given parliamentary protection against arbitrary dismissal or

salary reduction by the monarch. Since academic freedom was also deemed in the public interest, the concept later entered academe to thwart retribution against individuals who promoted ideas contrary to the established wisdom. Hence the essence of tenure is protection to pursue academic interests without fear of arbitrary retribution. Contrary to widespread belief, tenure has never been intended to guarantee career-long employment or fixed salary regardless of circumstances. Tenured individuals can (and should) be dismissed for just cause, e.g. incompetence, as long as there are safeguards to ensure that the grounds are appropriate. Similarly, tenure systems permit salary reductions, layoffs, forced early retirement, closure of whole departments, etc., in situations of financial exigency – provided that the decision-making process is demonstrably fair and is not arbitrarily directed against specific individuals. In this context, the principle of tenured academic protection is at least as valid today as in the past.

3. Despite the above, some individuals (including academics) believe that tenure is an outdated concept and/or that it should not apply to clinical faculty. Proponents of the latter belief argue that clinicians either do not require or do not deserve tenure protection, since a substantial or predominant part of their work and income relates to the provision of clinical care. Tenure is therefore deemed not only irrelevant or of little practical value, but actually detrimental because it inhibits staffing adjustments needed to meet the Faculty's collective clinical obligations.

The Working Party disagrees with this mind-set, which ignores the fact that this clinical care is delivered in an academic setting and is integral to the scholarly mandate of the GFT faculty. Moreover, clinical faculty share similar scholarly obligations and commitments with other University faculty, and are judged by equally rigorous criteria for academic advancement. Loss of academic protection would therefore render clinical faculty vulnerable to arbitrary dismissal for administrative reasons. Abandonment of tenure may ease the task of senior administrators in the School or affiliated teaching hospitals but would be anathema to the academic protection and well-being of individual faculty members.

Hence the Working Party disagrees with any proposals such as CAPR which weaken the academic security of GFT clinical faculty and arbitrarily set them apart from other members of the scholarly community at Queen's.

Recommendation 3: We strongly recommend the retention of traditional tenure for qualified GFT clinical faculty at Queen's.

For interest, a recent survey of U.S. and Canadian medical schools revealed that 96% retain tenure systems. Of the 9 schools with no tenure for clinical faculty, however, 4 are Canadian: Laval, Ottawa, Toronto, and Western (Jones RF and Sanderson SC, *Academic Med* 69:772-778, 1994).

4. Given recommendation 3, the crucial hurdle is how to meld tenure with fiscal reality: available "hard" funding is grossly inadequate to fully support the number of clinical faculty worthy of tenure. After extensive review, the Working Party believes that this

dilemma should be solved by de-linking tenure from guaranteed full salary-for-rank. In this model, tenure would be granted on academic grounds alone and would not depend upon availability of full operating funding for rank. Instead, operating funds available collectively for the clinical departments would be distributed proportionately to individuals (see point 5 below). The exception would be currently tenured faculty, who would continue to receive salary-for-rank until retirement unless they voluntarily relinquished this privilege (there are major legal and ethical impediments to forced elimination of this exception).

This proposal is based on the principle that academic protection for all deserving GFT faculty is more important than full salary-for-rank for a few.

Recommendation 4: Tenure for GFT faculty should be granted solely on the basis of academic merit and de-linked from availability of full salary-for-rank operating funds.

5. This proposal requires an appropriate distribution of the relatively limited operating funds collectively available to the clinical departments. For fairness, individuals should receive more or less than the average “share value” based upon job description and other agreed-upon criteria such as seniority, merit, etc. For example, a GFT clinician whose job description mainly involves research should normally receive a greater proportion of operating funds than one whose contribution involves a larger proportion of patient care which is compensated separately. Exact policies for the appropriate distribution of these funds would need to be established by a collegial mechanism. However, each individual should receive a specified reasonable minimum share of the operating funds.

Over time, the hard funds available for distribution will progressively increase as currently tenured faculty retire or resign; about 20% of the tenured GFT faculty will be retiring within the next 5 years, and fully 50% within the next decade (42 of 83). Nevertheless, only a portion of the overall operating funds will thereby be freed up for redistribution – still far too little to permit full salary compensation for the average GFT faculty member.

Recommendation 5: Collectively available operating funds for GFT clinical faculty should be distributed proportionately, with some individual variation based upon job description and other agreed-upon criteria.

6. University fringe benefits (pension, insurance, etc.) have always been based on salary-for-rank, which in turn is adjusted annually for seniority/progress through the ranks, negotiated inflationary increments, etc. All current GFT faculty have such a “nominal salary” for determination of benefits, regardless of whether this salary is derived from “hard” or “soft” monies. Special appointees have traditionally been able to use their clinical income to fund benefits on the “soft” portion of their nominal salary. For fairness, this tradition should continue within the new system we propose.

Recommendation 6: University fringe benefits for GFT faculty should continue to be based upon a “nominal salary” which is related to traditional full salary-for-rank as adjusted annually.

7. A corollary tenet of this proposal is firm linkage of the GFT University appointment with a clinical appointment that provides additional income derived from patient care. This would normally be a hospital appointment via the affiliation agreements which already exist between the University and the teaching hospitals. This linkage has traditionally provided and should continue to provide a major source of income for most clinical faculty members through their patient care activities – either via T4A income within the AFP or by OHIP billing in the absence of an AFP. In special circumstances the clinical activities might be non-hospital based in whole or in part. There may also be unusual individual GFT clinical appointments in which there is minimal or no funding derived from patient-related activities.

Recommendation 7: A GFT tenure-track appointment should normally be firmly linked with a clinical appointment that will provide an additional source of income, and is contingent upon the continuation of hospital privileges. Loss or significant change in hospital privileges may result, after careful review, in modification or termination of the University appointment.

8. In this proposal, therefore, academic freedom and security of appointment are provided by tenure, whereas income security is provided primarily through the linked clinical appointment. The individual could not be removed from either appointment except for just cause, with all the appropriate safeguards for appeal, etc. As a corollary, it must be understood that the University appointment is contingent upon the continuation of hospital privileges; loss or significant change in hospital privileges may result, after careful review, in modification or termination of the university appointment. Normally, it should be an express term of employment that a tenured faculty member who resigns or is dismissed for cause no longer has an enforceable claim to retain a clinical appointment. In the unusual event that a tenured individual loses an affiliated clinical appointment for reasons unrelated to University performance, any salary adjustments derived from operating funds should require University approval.
9. An important question is whether it is “legal” to dissociate tenure from a specified guaranteed salary. For faculty members in Arts and Science, for example, tenure without reasonable salary-for-rank could be construed as meaningless and the equivalent of constructive dismissal. Nevertheless, none of the University’s documents specifies that a tenured appointment must be accompanied by a particular salary. Moreover, in the School of Medicine there has long been an historical separation of income from rank for clinical faculty. A University solicitor and Professor Soberman both informed the Working Party that there is no legal barrier to implementing the above proposal. QUFA also examined this issue and acknowledged that, due to the unique funding situation for clinical faculty, tenure-stream GFT faculty could receive salaries that are less than full salary-for-rank. This limitation on salary should be expressly stated in the employment contract.

For interest, in the recent survey cited at the end of point 3 above, the large majority of U.S. and Canadian medical schools provide either limited or no financial guarantees for tenured clinical faculty. Hence there is ample precedent for the concept of dissociating tenure from salary-for-rank for a medical school's clinical faculty.

10. The Working Party also examined a totally different approach that would preserve linkage of tenure with salary-for-rank. This approach assumes that clinical income from either OHIP billings or an AFP envelope is equally as "hard" as traditional University funding from the Ministry of Education and Training and other sources. Tenured salary-for-rank could therefore be guaranteed from either combined operating plus T4A funds (if an AFP continues) or combined operating funds plus OHIP billings (if an AFP is not renewed). In the latter instance, the School of Medicine/University would exercise control over individual OHIP income via levers already available, namely levy or ceiling payments. Because clinical faculty members' total income is substantially higher than base University salaries, the Faculty would remain fiscally solvent despite guaranteeing full base salary-for-rank. This alternative proposal would require commitment by the University to career-long salary guarantees derived from clinical sources of income – a radical change. Further, the concept raises a number of major issues and serious potential problems including the University's responsibility/liability for clinical care, whether the University's operating budget includes clinical monies, jeopardized tax status of professional income, etc.

Despite these barriers, the Working Party raised this proposal in the original preliminary report because of its advantage in permitting tenure with full salary-for-rank. However, the feedback from a wide spectrum of the Faculty was overwhelmingly negative. As a result, the Working Party concluded that this option was not worth further exploration.

11. Under usual circumstances, GFT faculty should be hired with the expectation of scholarly career development ultimately leading to tenure – i.e., a tenure-track appointment. Occasionally, however, there may be a need for clinicians who primarily undertake patient service with little expectation of scholarly achievement. A tenure-track appointment is inappropriate for these individuals. Traditionally they have been offered either a GFT special appointment or an adjunct appointment, depending on individual circumstances. The Working Party believes these options should continue. It is important, however, that new GFT scholars should normally be given a tenure-track appointment, as the University should not be able to avoid its obligation to these members by offering them a lesser appointment.

Recommendation 8: GFT faculty hired in anticipation of a scholarly career should be given a tenure-track appointment. Occasional individuals hired primarily for clinical service with little expectation of scholarly achievement should be given a GFT special appointment or an adjunct appointment, depending on circumstances.

12. In the feedback received from the Working party's preliminary report, some Faculty members objected strongly to dual tenured and special appointee streams for future GFT

faculty. They argue that fairness demands the same type of appointment for all clinical faculty, that either everyone or no one should be tenured, and that the Working Party's proposal merely replaces one unfair two-class system with another. Some also believe that special appointees are financially more vulnerable within an AFP, since their clinical monies are controlled by the central AFP governance; this is raised as a further argument against two types of GFT appointment.

The Working Party acknowledges these concerns but we think they are misplaced. First, we believe it is inappropriate to lump all clinical faculty into one category regardless of job description, scholarly mandate, or academic contribution to the University. Second, there is a fundamental difference between the present two-class system and our proposal: currently, special appointees and tenured faculty are doing similar or identical work, with the University having the same scholarly expectations of both – yet the special appointees lack academic protection solely because of bad historical luck in the timing of their appointments. Indeed, it's a particular anomaly that vigorous young special appointees are often the most productive scholars. There is universal agreement that this dichotomy is unfair. This contrasts strikingly with the Working Party's proposal, in which all GFT scholars would be tenure-track; the few new special appointees by definition would have different job descriptions and academic expectations.

Third, the University has always exerted control over the clinical earnings of GFT faculty – tenured and special appointees alike. The AFP has not altered this, nor are special appointees disadvantaged financially by virtue of the AFP. If anything, the AFP provides greater protection against unilateral fiscal control by the University, since the Clinical Teachers' Association is an equal partner in AFP governance. Hence we disagree that the AFP uniquely enhances the financial vulnerability of special appointees.

13. Finally, what happens to the large number of current special appointees? The Working Party considered several options:
- a) Giving “grandfathered” tenure to all special appointees with minimum service of, say, 6 years. We believe this is inappropriate, since some have not attained the scholarly achievements to justify tenure.
 - b) Permitting application for tenure after an appropriate minimum length of service, e.g. 6 years, to be judged by the usual academic criteria. Those who choose not to apply would remain special appointees, as would those who apply but fail to succeed. This is a reasonable option but may inundate tenure committees with inappropriate applications, since “there's nothing to lose”. The latter fear may be groundless, however, as most individuals are aware of the stringent grounds for tenure and are unlikely to submit frivolous applications.
 - c) As in b), except that those who apply but fail to achieve tenure would then lose their University appointment. We believe this option is unfair, as it would unduly inhibit tenure applications and may result in loss of some excellent people in favour of weaker individuals who choose not to apply.

- d) Grant tenure upon pro forma application to special appointees who have already achieved the rank of Associate or full Professor, since these individuals have already met the rigorous academic scrutiny required for promotion. Special appointees at the rank of Lecturer or Assistant Professor would be handled as in b). The Working Party favours this option.

Recommendation 9: Current special appointees at the rank of Associate or full Professor should be granted tenure upon pro forma application. Others should be permitted to apply after an appropriate minimum length of service, to be judged by the usual academic criteria. However special appointees should be under no obligation to apply for tenure, nor should the status of their special appointment be affected if they either do not apply or unsuccessfully apply for tenure.

SUMMARY OF RECOMMENDATIONS

Recommendation 1 GFT clinical faculty should have the same scholarly rights and protections as other faculty members at Queen's.

Recommendation 2: The School of Medicine should abandon its policy of hiring virtually all GFT clinical faculty as special appointees, regardless of job description or anticipated scholarly development.

Recommendation 3 We strongly recommend the retention of traditional tenure for qualified GFT clinical faculty at Queen's.

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Members of the Working Party

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