Career development and compensation: Strategies for physicians in academic health science centers

A perspective from a Canadian academic health science center

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Academic pediatricians play a unique role in society’s efforts to prevent disease and provide health care for infants and children. In addition to the direct provision of care, they have a responsibility to generate, evaluate, and disseminate health- and disease-related knowledge. Despite these expectations, the funding for research and educational activities of pediatricians at academic health science centers (AHSCs) is usually derived from the academic physicians’ patient care activities. This creates what is arguably the major dilemma for a leader in pediatrics—the challenge of how to promote career development, enhance academic performance, and fairly evaluate and competitively financially reward all the activities of an academic pediatrician.

Although there is some variability in Canada and the United States, the parent faculty of medicine usually only provides very minimal amounts of money to clinical department chairs for the compensation of academic physicians at affiliated AHSCs. This, along with policies limiting research salaries (ie, in Canada there are no salary lines within a research grant and there is a cap on the amount of salary that US-based investigators can receive through National Institutes of Health funding), make it difficult to fund salaries for clinician-scientists. Similarly, there is little or no funding for an academic physician’s educational activities; in most universities, teaching is usually an unpaid expectation that is exchanged for what is most frequently a non-tenured academic appointment.

If there is no alternative strategy, the physicians at an AHSC who generate the most clinical care income will receive the greatest personal financial benefit, regardless of their contributions to research, education, and administrative activities. Because this is not congruent with the goals of an academic department, leaders in pediatrics have had to develop strategies to adjust for the misalignment of the source of funding and the expectations placed on their full-time physicians. A frequently used approach is for the depart-

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mental practice plan to “tax” the clinically derived income and then re-distribute these monies for research and educational activities. It is important that there be an optimal “taxation rate.” If the “taxation rate” is relatively low, the department has three options. The department might adequately support only a small number of physicians, each physician might spend only a small amount of time doing research or education, or the department might be forced to compensate pediatric researchers and educators less than their colleagues who have a predominately clinical focus. Regardless of the option taken, the low taxation rate would limit total academic output. In addition, if only a few physicians had their research activities supported, there would likely be discord between the “have” and “have not” members of the department; if all physicians were supported for a small amount of research, it is very unlikely to produce high-quality academic outcomes; and a low compensation rate for pediatric researchers and educators would make it very difficult to recruit and retain such physicians. In contrast, if there is a high tax rate, one would not be surprised if the clinically focused physicians held some resentment toward colleagues who spend large portions of their time devoted to research and education yet receive comparable rates of personal compensation. A high tax rate scenario also makes it difficult to retain excellent clinicians and to maintain staff morale and an environment of collegiality within the AHSC; after all, a leading AHSC must provide state-of-the-art clinical care to its patients. Some chairs of pediatrics may have been able to find an optimal-moderate taxation rate for his or her department.

In most Canadian centers, academic pediatricians are compensated with one of the approaches described above. Contrary to a long-standing rumor, Canada does not have a socialized health care system. Rather, it is single-payer, fee-for-service system; its origin and evolution have been recently outlined. In the Canadian health care system, governments set aside an amount of money for physician compensation, and the physician-run provincial medical associations determine how this money is allocated by setting a fee-for-service reimbursement schedule. Thus, the Canadian system more closely resembles a large single-payer system or health maintenance organization (HMO) (also known as the provincial government’s ministry of health). Canadians pay fees (also known as government taxes) for the health care provided by this “HMO,” with the physicians deciding the parameters determining the allocation of physician income. Pediatricians’
In brief, the goal of this CDCP was to align the funding directives and the expectations of the department with its strategic goals, and link compensation to a peer review of performance in clinical care, education, and research.

In conclusion, our department is in the unique position of having an AFP combined with a CDCP. These complementary strategies enhance the career development of individual physicians, improve the ability of the department to achieve its strategic goals, and link compensation to a peer review of performance in clinical care, research, education, and administrative activities.

**REFERENCES**

4. O’Brodovich H, Pleinys R, Walker NE. Peer-reviewed Career Development and Compensation Program (CDCP) was developed between 1996 and 1997 and implemented in 1997. In brief, the goal of this CDCP was to align the clinical, research, and educational time along with the related resources to pediatricians who have the appropriate talent, training, skill set, and commitment to the relevant activity. It is the author’s contention that there are several factors required for the development, implementation, and acceptance of a CDCP when there is an AFP for the funding of physician compensation. First, it requires a change in the culture of a department for example, individual physicians should not view protected time for education or research activities as a right, but rather, a privilege.

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**Figure.** The Job Activity Profile distribution of the Department of Pediatrics in 1996 and 2001. Ad, Clinician-administrator; Ed, clinician-educator; Inv, clinician-investigator; Sc, clinician-scientist; Sp, clinician-specialist; Te, clinician-teacher; FTE, full time equivalent.

**Table.**

<table>
<thead>
<tr>
<th>Job title</th>
<th>Activity profile</th>
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<tbody>
<tr>
<td>Clinician-teacher</td>
<td>Major (50%-65%) commitment to provide, advance, and promote clinical care; usually participates in significant bedside teaching and some research activities</td>
</tr>
<tr>
<td>Clinician-educator</td>
<td>Major (≥50%) commitment to education administration and educational developmental or research in education; participates in clinical care and bedside teaching</td>
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<tr>
<td>Clinician-scientist</td>
<td>Major (75%) commitment to research; participates in clinical care and education</td>
</tr>
<tr>
<td>Clinician-investigator</td>
<td>Significant (30%-70%) research commitment; contributes to clinical care and education</td>
</tr>
<tr>
<td>Clinician-administrator</td>
<td>Major (≥50%) administrative responsibilities; contributes to clinical care, education, and research</td>
</tr>
<tr>
<td>Clinician-specialist</td>
<td>Predominate (≥70%) commitment to provide, advance, and promote excellence in clinical care with contributions to education and research</td>
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Further details regarding job activity profiles are available on request from the author.