1

Deciding on an Academic Career

> *Medicine is the oldest learned profession in the world and it is rooted in the past. Each successive generation of doctors stands, as it were, upon the shoulders of its predecessors, and the fair perspectives that are now opening before you are largely the creation of those who have gone before you. It is therefore reasonable to think that anyone who has spent a long professional life in medicine must have something to hand on—however small or modest.*
>
> Sir F.M.R. Walshe, *Canadian Medical Association Journal* 1952;67:395.

Have you ever thought: "I have learned a lot in medical school and specialty training (and perhaps in practice). Wouldn't it be great to teach students and residents what I know? Maybe I could even do some research. I wonder what a teaching career is really like. Might a career in academic medicine be right for me?"

THE JOY OF TEACHING

"Doctor Taylor, I made the diagnosis! His symptoms were just what you described in class." Out of breath from running across the courtyard outside the cafeteria, this medical student, Jennifer, couldn't wait to tell me about her diagnostic triumph.

Every 6 weeks I teach a small-group seminar for third-year medical students about the diagnosis and management of headaches. In the session, we spend about 5 or 10 minutes discussing cluster headache. A few weeks earlier, Jennifer had been part of my seminar group. Subsequently, as part of the clerkship, she had been seeing patients in the office of a community family physician, when a young man came in with a history of a series of terrible headaches that had

been prompting him to visit the emergency room, where he had received various injections of pain-killers, but no definitive diagnosis.

Jennifer had interviewed the patient prior to his seeing the doctor. When he told of his recent series of once-daily headaches and a similar series about 9 months ago, Jennifer had one of these "Aha!" moments that, regrettably, clinicians experience all too rarely. She asked some more questions, everything fit, and she presented the patient to her preceptor with a tentative diagnosis of cluster headache. Of course, she was correct, and for the patient, it was the initial identification of the problem.

No wonder Jennifer was excited and couldn't wait to tell me about it.

For the academic clinician involved in teaching medical students and residents, this sort of experience is a highlight that you will recall happily for a long time. Teaching is why most of us chose academic careers.

One of our contributors, who entered academic medicine soon after residency, writes, "I grew up wanting to be a teacher, but I didn't believe that I could teach medicine until early in my residency. From that point, it was just a matter of choosing between practice-based teaching, residency-based teaching, or medical school–based teaching."

Another contributor is a radiologist who made the move to academic medicine after three decades in successful private practice. When asked why, he replies, "I wanted to do some teaching." This is a common response by our book's contributors, but there can be other reasons as well. Later he adds, "Also, I wanted to give something back to medicine."

But there is more to academic medicine than teaching. Teaching is definitely part of what you do but may be a small part of your daily activities. There will also be clinical care, probably some administration, and the opportunity for research and scholarship. While doing this, you should also learn about the organizational dynamics of the academic medical center, including the cultural expectations, the hierarchy of power, and the unspoken rules. I tell you much of this in the pages to come—but not all. When it comes

to teaching skills, research, medical writing, and getting grants, there is way too much for this single volume; many books and articles have been written on these topics, and I will provide tables listing some of my favorite resources.

At this point, I think it is important to examine the phrase I will use in the book to describe the clinician who chooses an academic career: the *academic clinician*. And that will also take me, early in the book, to an area of controversy.

THE ACADEMIC CLINICIAN

Before I began writing this book, I thought a great deal about what I will call us—patient-care-oriented physicians who work in academic medical centers where there is the opportunity to teach, administer programs, do research, and write for publication. In fact, there is more than the opportunity; excellence in one or more of the nonclinical parts of the job is the key to advancement and "academic success."

Currently, a number of terms are used. Two terms you will hear are "clinician-educators" and "clinician-teachers." The former is most commonly used. Branch and colleagues use the terms interchangeably.[1] Over the past 10 to 15 years, academic medical centers (AMCs) have established clinician-educator faculty positions, which now constitute an entry-level academic job for many young physicians.

Branch and colleagues state that, "Although no consensus exists, the essence of all definitions includes the concept of a superior clinician, who is also a dedicated teacher."[1] This is the academic rationale. However, on an economic basis, the clinician-educator positions were established because AMCs needed clinicians to generate income that would support the institution in the face of decreasing federal and state funding for education and for hospital care of the needy. Thus, clinician-educators are filling an important need but are not necessarily highly respected in the institution. When the status of the clinician-educator is contrasted with the status of research-oriented faculty, the reality of the two-tiered academic system becomes, in the jargon of Wall Street, transparent.

The most flagrant evidence of the status differential becomes evident when we consider the award of tenure and promotion in rank. Tenure, the more-or-less guarantee of job security, is a time-honored academic reward. An appointment as a clinician-educator, with scant expectation of participating in scholarly activity, offers inherent obstacles to promotion and tenure. According to Levinson and Rubenstein: "Most often, these new tracks did not offer the possibility of tenure, partly because of the reluctance of academic institutions to make long-term financial commitments to faculty members with primarily clinical and teaching responsibilities."[2]

As far as promotion is concerned, the academic medical centers have done a cautious soft-shoe dance. Most medical schools have established special criteria for promotion of clinician-educators.[3] However, in the process, the institutions have added adjectives such as "clinical" to the designation of rank. Thus, instead of becoming an associate professor, one might be a "clinical associate professor," and we all know that this descriptor connotes lower scholarly achievement. (See Chapters 2 and 3 for more about the academic promotion process.)

In 1999, Levinson and Rubenstein recommended that the promotion requirement of a regional or national reputation be eliminated for clinician-educators. They also wrote, "Second, the requirement of publication in peer-reviewed journals should be eliminated."[2] They go on to state that, "Academic institutions should find new and creative ways to evaluate clinician-educators' teaching abilities and clinical excellence."[2] But, to me, this seems to perpetuate the two-tiered system.

Apparently, their proposed changes did not entirely satisfy Levinson and Rubenstein, either. The next year, writing in the journal *Academic Medicine*, they proposed "the development of a new faculty position, a 'clinician-educator-researcher' to foster the scholarship of discovery in medical education and clinical practice." This idea was appealing until I read on to find that the authors recommend that these physicians "receive advanced Master's or PhD-level training in the area of education." They go on to recommend that,

"Subsequent to such training, AMCs will need to support these faculty members, who will need to devote more than 75% of their effort to research endeavors concerning education or clinical care, similar to the effort of faculty conducting basic biomedical research."[4] I was on board until the proposed requirements for advanced degrees and 75% research effort. Also, "clinician-educator-researcher" has too many syllables for me. The phrase feels unwieldy.

For the rest of this book, I will use the term "academic clinician." It means what I wish Levinson and Rubinstein had proposed. In the pages to come, "academic clinician" describes a physician who treats sick people, teaches residents and students, and engages in scholarly activity—even if the three activities are not in equal balance.

Some have called this the "triple-threat academician," an allusion to the football player who can run, pass, and kick the ball. In today's specialized world, many medical faculty members choose not to be triple-threat and to emphasize a single facet of their career to the virtual extinction of the others. And many of these academicians become quite successful developing only one narrowly focused academic ability, usually research. In fact, some say that the triple-threat academician is now an anachronism. I believe that this might have been true when research ruled in AMCs, when teaching and clinical care were less valued. But today, with the increasing need for clinical income, AMCs are recruiting and hiring clinicians. We just need to find ways to help these newly hired clinicians achieve first-class academic status.

I am aware that I am not the first to use the term "academic clinician." For example the University of Pennsylvania School of Medicine uses the term to describe full-time untenured appointments with the word "clinical" added to designation of faculty rank. Johns Hopkins has "academic clinicians." I am sure some other AMCs also do.

I will deal later with how the academic clinician fits into the academic milieu, achieves appropriate balance, focuses his or her energies, gets promoted, and, who knows, maybe attains tenure. First, I will examine the decision to become an academic clinician.

BECOMING AN ACADEMIC CLINICIAN

It is time to leave semantics and controversy and to be practical. If you are now a medical student, resident, fellow, or practicing physician reading this page, I assume that you are considering (or perhaps have already made) a career-defining decision. If you are a newly minted junior faculty member, you have embarked on a transformational journey.

The Career Decision

The decision to seek an academic career is, in many ways, like choosing your medical specialty. In medical school, you and I pondered, "Shall I become a pediatrician, pathologist, or neurosurgeon?" First of all, there is the consideration of what you will give up: If you are a medical student and you choose to become, for example, an internist, you give up maternity care forever. If you become a psychiatrist, you forsake abdominal surgery. And, of course, each specialty has its own "personality profile," culture, and values.[5]

Choosing an academic career pathway also has profound implications for your life. An ill-informed decision will leave you frustrated every day at work. If you enter private practice, government service, military medicine, or any of several nonacademic careers, you might do a little teaching in your office and perhaps write a paper or two, but teaching and discovery will not be part of your "job description." On the other hand, if you choose to be an academic clinician, you forsake the autonomy you might enjoy with small group practice, in which you have some control of your scope of practice, equipment purchases, and even personnel hiring decisions. For example, in many AMCs the nurses and receptionists in the clinics work for the hospital and not for the clinicians; the latter have little say in staffing levels, the skills of those hired, and even in what hours nurses work. For residents and fellows entering academic medicine, limitations such as these may seem insignificant. For physicians who have had a taste of private practice independence, losing the ability to select your nurse co-workers, control your patient

scheduling, or even decide on what time you begin and end the workday can be a *big issue*.

At this time, let us examine what you really have in mind when you become an academic clinician. What is your dream? Do you see yourself being part of a patient care team that deals with the difficult cases referred from community hospitals to the AMC? This is not an unrealistic expectation. Do you see yourself as the doctor who serves the underserved, the beacon of hope for those who cannot pay for care? If this is your vision, then be sure that it is consistent with the mission of the AMC. (Of course, you can, as in private practice, serve the underserved during off-duty hours.) Do you see yourself spending your days sharing your accumulated wisdom with eager students? Some of this will happen but generally not as much as you might imagine. Instances of grateful feedback as I had from Jennifer (see the beginning of this chapter) don't occur daily. You may even see yourself performing research and writing important papers that receive critical acclaim. This is possible but will require learning some skills that they did not teach us in medical school.

One important caution: Beware of career choices seeking to emulate an attractive role model. You—as a sensitive, process-oriented medical student who likes spending time with your family and who really didn't like the messiness of procedures during your surgical rotation—would not choose cardiothoracic surgery as a specialty just because you spent time with a very charismatic and talented heart surgeon. A similar situation can happen in academics. You may have made the best possible specialty choice and are now in a psychiatry residency or gastroenterology fellowship. Your lead instructor and mentor is an academician who is seen as a rising star in his specialty. He invites you to apply for the faculty position that is now available. Should you do so?

Remember that what is right for one person may not be right for you. Although you may admire your teacher and mentor in academics, do not confuse admiration with solid decision-making. In career decisions, remember this: We clinicians who love what we do are always seeking to clone ourselves. I am sad to report that in this quest for cloning,

we medical educators often guide medical students into specialties for which they are temperamentally unsuited. Also, we sometimes encourage academic careers for some who would be better advised to enter private practice.

Learning About Life in Academia

Whatever your fantasy about life as an academician, you should talk to many who have walked the path before you. Spend time with both neophyte and seasoned faculty. Ask them about their lives in academia and especially about what they might not tell you unless asked. Ask the questions that I am going to describe next.

In preparing this book, I sought the participation of 20 academic physicians in a variety of specialties and academic settings. I asked them to respond to 10 open-ended questions, and I used the answers to help prepare this book. I include responses as examples throughout the pages that follow and in a number of the tables. Here are the questions and, in parentheses, the book chapters where responses chiefly appear:

Questions Answered by Contributors (and Chapters Where Responses Will Be Included)

- Tell about your decision to choose an academic medicine career. (1)
- How has your life changed since becoming an "academic clinician?" (1)
- What do you like about being an academic clinician? What don't you like? (2)
- What have been the surprises, pleasant and unpleasant, about your academic job? (2)
- What are important unwritten rules about academia? (3)
- How did you find your first academic position? (4)
- Have you had a mentor and, if so, how has that person influenced your career? (8)
- If you could do one thing differently in your career, what would it be? (9)
- What advice would you give the new academic clinician? (10)

- Will you please tell an anecdote—a story that is meaningful to you—about your experience in academic medicine? (10)

Why Choose an Academic Career?

Whenever considering a career change, you should always ask, "Am I changing to follow a dream *or* am I trying to escape a bad situation?" I earnestly hope that all who seek careers as academic clinicians are following their vision of the best career path and the best opportunity to serve humanity.

Table 1.1 tells some general reasons why we choose academic medical careers. Some are positive reasons; some are not. On the plus side, seeking a teaching role, yearning for the opportunity to seek new knowledge, or looking for a greater intellectual challenge are all reasons I find reassuring. The reasons in the "worrisome" column should arouse concern.

Residents and fellows might consider academics as a way to avoid the "business of medicine" or might even unconsciously seek to prolong the adolescence of being a learner. The "avoidance" reasons are not a firm foundation for an academic career. Physicians who enter academics to escape a current conflict with partners, a chaotic practice situation, or a messy divorce should perhaps consider other options.

TABLE 1.1. Seeking an academic career: Positive reasons and worrisome reasons

Positive reasons	Worrisome reasons
Wanting to teach students and residents	Seeking to escape a difficult practice or personal situation
Wanting the intellectual enrichment of the academic life	Becoming tired of hard work and night call
Seeking the diversity of activities that is found in academic medicine	Looking for an escape from patient care
Wishing to do research and write	Searching for a less stressful life
Looking for a new professional challenge	Wanting to earn a high income

Some older physicians will seek academic life as a way to "retire into teaching"; such a move is unfair to learners, who deserve our best efforts at all times.

The new academician from community practice who aims to get away from a hectic schedule may be disappointed to learn that, whereas in private practice one has only to attend to patient care, the academic clinician finds responsibilities in the three major spheres of clinical practice, teaching, and scholarship. It is common for new academicians to say "yes" to far too many opportunities and soon feel scattered and overwhelmed. So much for avoiding a busy schedule and stressful professional life.

And in case there is any question about the pay, an academic medical career is seldom a ticket to the Lifestyle of the Rich and Famous. A few academicians, generally surgeons who work very hard, become wealthy. Most academic physicians find that they must earn most or all of their own salaries while also earning enough to underwrite the time spent teaching. Finding funding support for research time is a special issue that I will discuss in Chapter 6. Do not expect an academic institution to support your research for more than a short time, if at all.

A survey of physicians identified the top 10 reasons physicians leave their current job.[6] The top reason given was the need for a higher salary. Seeking better compensation may be a valid justification for leaving a job, but it is a very poor reason to seek a position at an academic medical center.

The Decision

I asked our contributors to, "Tell about your decision to choose an academic medicine career." Here are some of the responses:

- "I have wanted to teach ever since I was toilet trained. . . ."
- "Contrary to your caution about emulating a charismatic mentor, my decision came when, fresh out of college, I stumbled into an opportunity as an American Heart Association Fellow that allowed me to work with

TABLE 1.2. Books, articles, and Web sites where you can learn more about academic medical careers

Books

Bland CJ, Schmitz CC, Stritter FT, Henry RC, Aluise JJ. Successful faculty in academic medicine: essential skills and how to acquire them. New York: Springer, 1990.

Boice R. Advice for new faculty members. Needham Heights, MA: Allyn and Bacon, 2000.

Douglas KC, Hosokawa MC, Lawler FH. A practical guide to clinical teaching in medicine. New York: Springer, 1988.

McCabe LRB, McCabe ER. How to succeed in academics. New York: Academic Press, 2000. (This is a short [147 page] book on general academic skills: grant applications, leadership, lecturing. But there is nothing specific about academic medicine.)

Schwenk TL, Whitman N. The physician as teacher. Baltimore: Williams & Wilkins, 1987.

Scott M. Planning for a successful career transition: the physician's guide to managing career change. Chicago: American Medical Association, 1999.

Articles

Jones RF, Gold JS. The present and future of appointment, tenure, and compensation policies for medical school clinical faculty. Acad Med 2001;76:993–1004.

McGuire LK, Bergen MR, Polan ML. Career advancement for women faculty in a U.S. school of medicine: perceived needs. Acad Med 2004;79:319–325.

McLennan G. Is the master clinician dead? Acad Med 2001;76:617–619.

Levinson W, Rubenstein A. Integrating clinician-educators into academic medical centers: challenges and potential solutions. Acad Med 2000;75:906–912.

Web sites

Academic Physician and Scientist: available at http://www.acphysci.com/aps/app/.

The Association of American Medical Colleges: available at http://www.aamc.org/.

The Accreditation Council on Graduate Medical Education: available at http://www.acgme.org/.

The Riley Guide (to job listings in health care and medical fields): available at http://www.rileyguide.com/health.html/.

an inspiring physician. Knowing next to nothing about a career in academic medicine (and obviously having little insight about my own values and motivations), seeing this individual enjoying challenging rewards as a clinician, teacher, researcher, and activist was mesmer-

izing. I remember thinking I wanted a job exactly like his!"

- "The primary reason I chose academics was to create a balance in my career that would allow me to remain clinically active and simultaneously participate in basic science and clinical research related to the care of my patients. My job is ego gratifying, high energy, and intellectually stimulating, all of which are additive to the day-in and day-out work of an orthopedic surgeon."
- "I had a typical midlife crisis, decided I was in a rut, and left private practice mostly in search of a change and to prove to myself that I could still change."
- "I took an American College of Physician Executives course on Career Choices. Academic medicine met most of my goals of teaching, practicing medicine, and using my administrative skills."
- "My decision to become an academic was based on factors other than a large amount of intellectual curiosity, or an overwhelming desire to teach at the time I was hired. A big factor was a personality match with the department chairman. I trusted and admired the man."
- "I love teaching, and being able to make an impact on the next generation of physicians is very satisfying. Also, I entered academics in order to have some influence on reform of our health care system and medical education."

MYTHS ABOUT ACADEMIC CAREERS

What We Do All Day

One day I was speaking with one of my colleagues in community practice, and I mentioned a difficult diagnosis I was facing with one of my patients in the hospital. My physician colleague asked, incredulously, "Do mean that you guys see patients?" He, and many like him, believed that we spent our time teaching, doing some research, traveling to medical meetings, and thinking deep thoughts—but no actual patient care.

In fact, all academicians, except those fully funded on research grants, must see patients to generate most or all or

their salaries. In the next chapter, I will tell some detail about how salaries are determined. Here I will tell you now that one of the eye-opening facts I learned after moving from private practice to academic medicine is that there is no pot of money available to pay your salary year after year. What your academic appointment gets you—and your department—is a "hunting license" to go out and search for your salary support through practice income or grants.

More Curious Myths About Academia

The belief that academic clinicians do not see patients is just one of several myths that exist about academic careers. Here are some more:

Myth: The Skills That Make You a Successful Practitioner Are Just What Are Needed for Success in Academic Medicine

In academia, being a good clinician is not enough. I entered academic medicine with, I modestly believe, excellent clinical practice skills. In my first years on faculty, I received several resident teaching awards based on my patient care abilities that I brought from private practice. Residents are a tough audience and do not give such awards frivolously. But I found that I was sadly lacking in other academic survival skills.

Let's talk about management decisions, for example. In my private solo office, I had been the unquestioned chief. Policies were what I decided. Changes were rarely "negotiated." I set the work hours, salaries, and even how the telephone would be answered. But upon entering academic medicine, I discovered that almost every decision, however minor it might seem, affected others who demanded a voice. If I wanted to see two more patients each half day, I needed to discuss this with the office manager, scheduler, and nurses. Once when I announced a plan to have a research assistant interview patients in the waiting room (this was, of course, pre-HIPAA), I nearly caused a revolt.

Unions, when they get involved, generally make the problem more complex. Once our academic practice had a

successful year financially and we decided to give a bonus to our office staff. Then the employee union learned of our intention. "No, you can't give a bonus to employees in your clinic. Other clinics in the medical center are not doing so, and therefore it would be unfair for your staff to receive bonuses." Incredible, but true!

Myth: Medical Schools Seek and Reward Great Teachers

Medical students and residents appreciate dedicated and energetic teachers. However, of the three main missions of the AMC—clinical care, teaching, and scholarship—guess which one brings in little or no funding. The answer is, of course, teaching. For this reason, medical school departments tend to lose great teachers and retain successful clinicians, researchers, and grant writers who can bring in salary support. The latter group may not be the best teachers and, in fact, may be reluctant educators.

A study from one academic medical center looked at recipients of a "Teacher of the Year" award in a department of internal medicine.[7] The researchers found that teaching award winners left the department sooner than those who did not receive the award, even after adjustment for age, rank, and career track.

Myth: Your Job Description Includes a Lot of Time to Think, Do Research, and Write

If much of your time is spent earning your salary, then when do you do your creative thinking, research, and writing? The candid answer: For most academicians, scholarly work is done weekends and evenings. In fact, it is now Saturday morning as I type these words. Over the years, some young faculty members have become angry when I have told them about the need to do scholarly work on personal time. But with the many clinical, teaching, and administrative duties that compete for time during work hours, there is never enough time for scholarship. It works out as follows: patients cannot be neglected, student and resident teaching obligations must be met, and administrative tasks require timely attention. Scholarly projects

just keep being moved to the bottom of the pile at work. This happens over and over until you see the light and begin to take the research study or writing project home for the weekend.

Myth: You Will End Each Workday by 5 p.m.

This is a cruel joke. The truth is that, with the array of competing obligations faced by the academician, your workday may actually be longer in a teaching setting than in private practice. Only the most compulsively well organized or the most slothful get out the door by 5 p.m. Furthermore, in AMCs there are many events that occur in the evening: administrative meetings, faculty social events, resident and student activities, and more.

Yes, you can declare that your evenings and weekends are your own and refuse participation in all after-hours activities. This is, however, a bad career move. It quickly marks you as one who is really not committed to the department and institution, and this perception of your being "not committed" becomes reflected in opportunities that might have been yours being passed to others.

Myth: You Can Plan on a Funded Sabbatical Every Seventh Year

This may be true at a medical school somewhere in the United States, but I don't know what school that is. With the economic squeeze on AMCs today. the opportunities for sabbatical time are becoming increasingly limited.

A sabbatical is still a possibility at many institutions under certain circumstances: First of all, there probably won't be full funding for your time away. The responsibility for paying you any salary at all will probably fall to your department, which is likely to be having trouble making its annual payroll as it is.

If you wish a sabbatical experience, be prepared to present a compelling case as to how your time will be spent doing something that will ultimately benefit the institution. This means that, after the sabbatical, you should plan to return with a fundable grant proposal, a new and much-

needed clinical skill, or the high probability of launching a new (and, again, fundable) research endeavor. Coming back from a sabbatical feeling renewed and energized is no longer enough.

Myth: Working in an AMC Offers More Job Security Than Private Practice

This is quaint legend about academia. Unless you hold a tenured position, you are vulnerable, and even tenured faculty can see funding disappear (see Chapter 3). If you do not have tenure, you are likely to be on a year-to-year contract. Each year, at the anniversary of your hiring, your chair may decide not to renew your contract.

IMPORTANT QUESTIONS TO BE ANSWERED

If I haven't scared you away by now, there are other important questions to be answered. The answers concern what you need to know and how you think and feel. Here are some of these questions.

Am I Ready for Academic Life?

Only you can decide that you are temperamentally suited to life as an academic clinician. The means that you must take a hard look at yourself.

Favorable Traits

You may be ready and might even be quite successful in academic medicine if you possess the following traits:

- Flexibility—the ability to adapt to new situations. Remember that in the theory of evolution, the species that survived were not the strongest or fiercest but those who could adapt to change.
- Vigor—a high level of energy is required to meet the challenges of multiple responsibilities in the domains of clinical care, teaching, scholarship, administration, mentorship, and more.

- Curiosity—because wondering "Why?" is the basis of scholarship, as I will discuss later in Chapters 5 and 6.
- Self-confidence—which is needed to hold your own in meetings, to weather criticism of your teaching, and to withstand disagreement with your scholarly opinions.
- Integrity—to compel you to make the right decisions, even in difficult circumstances. Right, but tough, decisions might include disciplining the poorly performing resident, failing the student who refuses to show up for class, telling a colleague that he made a clinical error, or informing a colleague that she has reached unjustified conclusions in a paper she has written.

Unfavorable Traits

You may want to take a long time deciding on an academic career if you have the following personal traits:

- Independence—connoting a fierce tendency to work best alone. This is an excellent trait for writers, hermits, and physicians in solo practice. It is not helpful in academic medicine, when you work side by side with others in almost all settings. Sometimes, very successful clinicians enter an academic setting with the idea that they can practice exactly as they did in the private world. They eventually—and painfully—learn that an academic group practice must be one in which all physicians conform to agreed-upon rules of how the practice will be conducted.
- Selfishness—thinking of your own interests before those of others. The academic clinician must often put learners or other faculty first. A physician who is seen as always out for his or her own interests is soon shut out of research proposals, writing projects, event planning and new opportunities.
- Rigidity—the inability to adapt to the needs of others and to the changes about you will predict a short academic career. The cry of the rigid physician is, "I don't care what the group decides. I won't do it that way!" This attitude—in relation to patient care, teaching methods, or research planning—is poison to effective group decision-making and will not long be tolerated by colleagues.

How Will My Life Change as an Academic Clinician?

Medical Students, Residents, and Fellows

If you are a student, resident, or fellow, your life will almost certainly improve. You will have more authority, respect, and pay. You will probably have a more favorable night and weekend call schedule, especially because residents and fellows (which you were just recently) will take care of much routine after-hours work; you will be contacted for "important problems." You will even have an office, although it may be shared with others. You will also have some newly acquired expectations to teach and engage in scholarship.

Practicing Physicians

If you are a practicing physician entering academic medicine, I believe that the changes will be more profound than those experienced by residents and fellows moving directly to academic careers. You, the practicing doctor who has been recruited to academics because of your patient-care skills, will need to fit into the academic mold in the many ways described in this book. The impact will vary directly with your years away from medical school and residency.

On balance, you will bring to the AMC your knowledge of efficient practice models, real-world clinical experience, and a patient-centered ethic.

What the Contributors Report

I asked our book's contributors to tell, "How has your life changed since becoming an academic clinician?" In reading the responses below, keep in mind that the contributors represent a broad spectrum of specialties, academic experience, and pathways to their current careers. With that said, here are what I consider the most helpful responses (with a few editorial comments in italic):

- "I am challenged daily with learners (and colleagues) from every level of training. This challenge has given me the passion to stay current, more so than I believe I might in private practice."
- "I was amazed at how much time was spent in meetings. As a resident and fellow, we had some teaching seminars

and grand rounds, but as a new academic doctor, I have more meetings than I ever imagined. I guess the meetings are important, but they get me behind on seeing my patients and getting my chart work done." (*The respondent is a gastroenterologist in his second year of an academic position.*)

- "I now have a much more scheduled lifestyle. It is easier clinically, although clinical challenges are still there and I'm sure will be until I retire. I'm on tenure track and so there is the pressure of getting grants and publishing. But I get home at 6 p.m. instead of 9 p.m., and patients never call me at home now, as they frequently did when I was in private practice." (*Yes, this response seems at odds with the third myth described above. No two academic jobs are alike, and a difference of opinion is accepted in academics.*)
- "Life is more structured with dedicated teaching and research time. Specific goals can be identified and met."
- "The intellectual stimulation is great, and having close friends and colleagues from around the country is very rewarding."
- "I read more yet still feel like I never quite know my field as well as I should. I'm a bit rusty in some of my clinical skills (starting IVs, doing lumbar punctures, attending deliveries), because house staff do most of those."
- "I've spent all of my professional life in academic medicine. As I've learned how things work in the academic environment, I've had an easier time knowing how to react. But the overall attraction of creating a learning environment has been a constant. As a department chair, I now simply do this for faculty instead of just for residents and students."
- "Working closely with residents and students keeps one on one's toes and up to date."

Do I Know as Much as I Need to Know About the Academic Career I Am Considering?

The answer to this question will, of course, always be "no." After 27 years in academic medicine, I don't know all there is to know. But I keep trying to learn and so should you.

In conversations with junior faculty members, I find that what they wished they had known more about falls into two large categories. The first category is somewhat theoretical; it concerns the true pluses and minuses of academic life and the surprises new faculty members encounter. The second category of I-wish-I-had-known items is more practical and is focused on job descriptions, faculty tracks and ranks, and compensation issues.

These two categories of topics are covered in Chapter 2.

REFERENCES

1. Branch WT, Kroenke K, Levinson W. The clinician-educator: present and future roles. J Gen Int Med 1997;12(Suppl. 2): S1–S4.
2. Levinson W, Rubenstein. Mission critical—integrating clinician-educators into academic medical centers. N Engl J Med 1999;341:840–843.
3. Jones RF, Gold JS. Faculty appointment and tenure policies in medical schools. Acad Med 1998;73:212–219.
4. Levinson W, Rubenstein. Integrating clinician-educators into academic medical centers: challenges and potential solutions. Acad Med 2000;75:906–912.
5. Taylor AD. How to choose a medical specialty, 4th ed. Philadelphia: WB Saunders, 2003.
6. Abdo W, Broxterman MP. Why physicians change jobs: survey shows salary tops the list. Physicians Practice 2004;14(7):34.
7. Aucott JC, Como J, Aron DC. Teaching awards and departmental longevity: is award-winning the "kiss of death" in an academic department of medicine? Perspect Biol Med 1999; 42:280–287.

Deciding on an academic career. Life in Academe. Jaimelee Iolani Cohen beautifully captures the â€œwonderfully rewarding satisfactionsâ€ of. the academic life in her statement (see p 3). The motivations to seek such a career are. many and varied. Some professors of chemistry and chemistry-related fields report that. they decided on an academic career while they were undergraduates. Often they were. influenced by stimulating teachers, mentoring faculty, undergraduate research, or their.Â A Resource Book for Chemists Considering Academic Careers 5. Deciding on an academic career. regular salaries with proceeds from consulting, textbook writing, patents, or new compa-. nies. For a successful career in decision-making research â€¦ Hogarth writes in an e-mail that both Trujillo and Karelaia have what it takes to be good scientists--"curiosity, passion, good academic training in basic disciplines [in our case, economics, statistics, and psychology] openness to new ideas, and the stamina to work hard." Both are also creative, he writes. "Both attracted my attention because they were obviously very bright and came up with interesting ideas [on their own]." The two young scientists found, in Hogarth's lab, the intellectual richness and freedom the