

TEACHING INCENTIVES

Physician-faculty perceptions towards teaching incentives: A case study at a children's hospital

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Abstract

Purpose: This exploratory study examines affiliate physician-faculty perceptions and attitudes regarding a teaching incentive programme at a free-standing children's hospital in the United States. We describe the compensation model and present faculty interpretations of its influence on the institutional culture.

Methods: A case study methodology was applied to understand the sociological aspects of academic productivity interventions. In-depth interviews, direct observation of leadership meetings, teaching activity logs, organisational theoretical lens and survey results were used for methodological triangulation. Data from these multiple sources were coded and discussed between investigators iteratively to identify core themes.

Results: Of the faculty eligible for the incentive, 32 engaged in in-depth interviews (N = 32/107; 30%) and 88 (interviewees included) in the survey (N = 88/107; 82%). Findings suggest that while the implementation made some strides in mitigating barriers for some, for others gaps were identified that suggest further exploration within this domain of study is warranted. The incentive implementation was perceived as strategic, intending to encourage the academic culture of the hospital, though participants commonly expressed confusion about the rationale behind the omission of teaching allocations in formal contracts. However, high satisfaction levels for the programme as a conduit to change were evident. There was a perception of a shift in the collective faculty morale that reflected an evolving institutional culture that increased enthusiasm for teaching. Finally, faculty noted their perception that institutions that employ teaching incentives could positively influence faculty recruitment.

Conclusion: We found a modest incentive-based reward for teaching activity was successful in informing the perceptions of faculty regarding their institution's academic prestige goals and teaching recognition. Such programmes, while requiring a small investment of time and resources by institutional leadership, can convey that the educational mission remains a priority in this era of increasing clinical and administrative pressure and an institutional culture that may positively influence faculty morale and dedication to teaching.

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1 | INTRODUCTION

In recent decades, free-standing teaching hospitals in the United States (US) that train medical students, residents and fellows continue to receive limited financial support for the educational mission from affiliate medical schools, yet are still expected to meet intense clinical productivity targets. The Relative Value Unit (RVU) system, which is utilised by the vast majority of US hospitals to measure clinical effort and procedural productivity for physician reimbursement and compensation, is heavily emphasised by administrative leaders, and tends to overshadow academic productivity. As a result, time and compensation for required teaching are challenging to balance with clinical expectations given the financial realities of the current health care system.¹ Some clinical departments within academic medical centres (AMCs) measure and reward engagement in teaching activities with bonus pay incentives or a buy down (subsidised release time) of clinical schedules as an academic relative value unit (aRVU)² to recognise physician-faculty contributions to the educational mission.¹⁻⁷ Free-standing teaching hospitals are similar to AMCs where accreditation standards apply and the four missions (research, teaching, patient care, administrative service) must be met to keep clinical productivity afloat while adequately training learners. As executive leadership at these hospitals frequently look to national trends and regulatory entities to navigate the organisational course, institutions are increasingly adopting monetary teaching incentives for physician-faculty (from this point forward referred to as faculty) as a response.⁸

Teaching incentive programmes in medicine are an example of organisational behaviour that sociological theorists like DiMaggio & Powell⁹ define in their seminal work as *institutional isomorphism*. In the sociological context, isomorphism is the morphing of structure or process such that they become similar to other institutions. The motivation to become more similar can be due to the desire to imitate or respond to a set of shared constraints or conditions. Two isomorphic pressures that hospitals respond to via implementation are *normative* and *mimetic*. First, *normative pressure* is defined as pressure to adopt, remove or modify an office because of requirements from the profession. In this instance, normative pressure is observed in the expectation to keep pace with the basic requirements of national medical education accreditation councils that set curricular standards (eg Liaison Committee Medical Education). It is expected that faculty obtain academic appointments in order to lecture, mentor and engage in scholarship with medical students, residents and fellows. The profession demands that even affiliate faculty, who often carry heavy clinical loads, make time for uncompensated and underrecognised academic pursuits with learners.

Second, *mimetic pressure* is defined as stress experienced by the organisation through uncertainty or transitions in institutional priorities that result in mimicking peer institutions to remain competitive. Thus, hospitals behave similarly to individual clinical departments in AMCs who also implement teaching incentives as a way to increase instructional engagement and reward faculty for their contribution

to the educational mission. Institutional morphism frames how and why institutions, like hospitals, respond to external forces. This can, therefore, play an influential role in how the organisational culture, common values and beliefs around the value of education are developed and sustained. The organisational culture, then, will signal teaching expectations.⁹ Organisational motivation (as influenced by leadership's own motivations) and how it interacts and complements faculty motivations to value and participate in the teaching mission and engage in incentive models is a bilateral and complex dynamic that warrants greater attention.

There is a paucity of documented, effective academic productivity compensation models. In addition, after over two decades of publication on academic incentives in medical education, there is no clear standard for models of compensation for academic activity, much less direct teaching activity.³ Existing publications are predominantly quantitative descriptive reports on compensation algorithms and productivity metrics to establish that teaching productivity can be measured.¹⁻⁷ Previous survey studies on teaching incentives focus on the general sentiments of faculty about monetary gain, reasons for getting involved with teaching or satisfaction with the navigation of electronic platforms for clinical teaching.¹⁻⁷ Demonstrative of isomorphism, these studies are informative in that they do capture the trend of incentive implementation to appeal to faculty extrinsically to increase participation and meet medical education training programme needs. Moreover, we know from prior studies the multiple intrinsic and extrinsic motivators faculty have for teaching as well as the commonly associated barriers. In a critical synthesis, seven barriers to teaching were identified that incentives are intended to mitigate: competing priorities that make balancing of workload difficult; lack of recognition; lack of faculty instructional development; unmotivated students; low interest in teaching; overly bureaucratic academic culture; and poor environmental factors, such as inadequate space and facilities for engaging learners.¹⁰ Previous literature suggests that there is a complex interplay between individual motivation to teach and the organisation's motivation to increase participation, as well as reward and cultivate a particular culture.^{1,2,10-13} However, we find that a nuanced contextual understanding about the perceived teaching culture at institutions, as it relates to teaching incentives, is an overlooked dimension. We wanted to examine what lessons can be learned from teaching incentive programmes, and, specifically how they inform faculty attitudes towards teaching recognition, recruitment, retention and morale. In addition, how do such programmes affect the perception of institutional culture by faculty? After all, faculty motivation to teach does not occur in a vacuum. It is informed by multiple environmental, intrinsic and systematic elements.¹⁰ A clear understanding of what faculty think and feel about the direction of the hospital as it relates to teaching and recognition has yet to be explored in-depth, especially with regard to the influence of teaching incentives in medical education. To address this gap, we prospectively conducted an exploratory qualitative study to examine faculty perspectives about the value of education, coincident with the introduction of a new incentive programme at our hospital.

Of particular interest is understanding the influence of teaching incentives on *affiliate* faculty (those employed by the hospital) associated with local US medical schools as they tend to have a significant footprint in the training continuum.^{14,15} Depending on the institution, faculty at such clinical affiliates are sometimes also termed 'volunteer' faculty. Engagement of such faculty across all specialties is a continual challenge, especially for free-standing hospitals partnering with medical schools. Further, for this study, the teaching incentive includes a broad range of academic activities that intersect with student, resident, fellow and faculty learning and service commitments related to the educational mission (Table 1).

In all, the influence of academic incentives on job satisfaction, morale and perception of institutional culture from an affiliate faculty member's perspective has been minimally addressed. Previous studies describe their various models be they bonus (which is common and perhaps path of least resistance in terms of implementation), stipend or buying down of clinical time that equals RVU productivity targets.^{1-7,14} However, none have examined, in-depth, faculty reception of the incentive compensation models and how and why the incentive might shape their understanding of culture and teaching expectations. Our purpose is to offer insight about the push-pull dynamic between faculty and organisational strategies and motivations as learned from reflection on our implementation and systematic examination of organisational behaviour interacting with the interpretations and experiences of faculty participating in the incentive programme.

We focused on a number of specific questions in our study. What are faculty perceptions about the implementation of our teaching incentive? How can these insights help to inform scholars and clinical leaders about the existing organisational culture relevant to teaching at a free-standing children's hospital? How and why does the implementation contribute to their perceptions about the overall academic culture?

2 | METHODS

Phoenix Children's Hospital (PCH) has served for nearly 40 years as a clinical teaching site. What led to the implementation of an incentive programme at PCH was the same isomorphic pressure faced by other institutions. As the institution evolved from an independent, community hospital (ie non-to-minimal academic provider) in 1983 to a free-standing, specialised paediatric hospital in 2002, the physician group at PCH grew from a small paediatric subdivision to a total of 34 clinical divisions, and now serves as an essential paediatric teaching hub for the Phoenix metropolitan area. There are three core ACGME residencies, nine ACGME accredited fellowships, and ten non-ACGME accredited fellowships comprising approximately 200 GME learners each year; in addition, 500 medical students, residents, fellows and graduate students from multiple local academic partner institutions rotate through annually.

Many clinical faculty employed full time by the Phoenix Children's Medical Group (PCMG) at PCH who are involved in

TABLE 1 List of academic activities

I. Academic Service & Preparation of Materials
A. Advise Students, Residents or Fellows on Academic Planning/performance
B. Mentor Students, Residents or Fellows on career Goals; Professional Gals; Personal Goals
C. Attend Morning Report
D. Clinical Competency Committee meeting (CCC)
E. Program Evaluation Committee (PEC)
F. Scholarly Oversight Committee (SOC)
G. Review of ERAS applications
H. Interview PEDS Resident/Fellow Candidates
I. Participation in NRMP Ranking
J. Attend/Assist with Residency/Fellow Orientation
K. Review trainee manuscript drafts
L. Engaging in Research Project Activities with Resident
M. Writing Letters of Recommendation for Students/Residents/Fellows
N. Participation in GMEC meeting
O. Service on GMEC subcommittee as chair or participant
P. Participation in Medical Student interviews or applicant online screening
II. Faculty Development Relevant to teaching skills or academic administration
A. CoM-P Faculty Affairs LIFT mentoring programme
B. CoM-P Leadership development programme
C. Medical Education Research Skills Session
D. COM-P Faculty Development Session
E. AAMC National Conference-Session on teaching skills
F. APPD National Conference- Session on assessment
G. ACGME National Conference- Session on teaching
H. ACGME National Conference- Session on assessment
I. Internal PCH Faculty Development Online modules
J. COM-P Development Online series modules
III. Evaluation & Assessment
A. Compete Formal Written Evaluations on Fellows, Residents and/or Medical Students
B. Complete ACGME Faculty Program Survey
C. Revise/Craft Program Evaluations
D. Participation/preparation for ACGME or CLER Self-Study
IV. Teaching & Preparation Time
A. Academic Half Day lecture/Didactic
B. Preparation for learner presentation (QI/Patient Safety, etc)
C. Facilitate Board Review
D. Facilitate QI Project
E. Facilitation of a Professional Development session on education
F. Other lecture with residents (Simulation session, etc)
G. Lead Journal Club
H. Student didactic teaching session for clerkship

Note: Adaptation from 2016 University of Arizona College of Medicine-Tucson Department of Medicine's Office of the Vice Chair for Education.

teaching and who also possess a professorial title as affiliate faculty with the University of Arizona College of Medicine-Phoenix (COM-P) Department of Child Health, a partnering medical school, were eligible for incentive participation. Participation was not available to faculty currently serving as residency/fellowship programme directors, clerkship directors or already receiving compensated time for educational leadership roles. PCMG physicians receive annual contracts that articulate two components regarding the breakdown of time: clinical responsibilities and administrative tasks related to patient care. Teaching recognition and strategy to increase academic engagement, specifically for affiliate faculty with no formal educational role, was the rationale for organisational leadership to subsidise bonus pay for this sub-group of faculty.

In September 2016, the PCH Department of Medical Education (DME) and the University of Arizona College of Medicine—Phoenix's Office of Faculty Affairs and Career Development (OFAD) adapted and co-developed a list of academic activities (Table 1) and an e-logging system for tracking hours. At the time of incentive implementation, PCMG had 351 clinicians. 129 (129/351; 37%) of these faculty had an affiliate appointment with the college and were not already compensated for educational leadership roles and thus met eligibility requirements for participation in the incentive programme. 107 (107/129; 83%) of those eligible partook in the incentive programme.

Upon establishing a tracking platform, the educational leadership at PCH devised an original methodology of academic incentive pay constructed and funded by the physician medical group in December 2016. E-logs were monitored monthly by the OFAD at COM-P with reports provided to PCH. Hours logged were subsequently directly correlated to award dollar amounts. A \$450 000 allotment was broken into two parts. Part one allocated two-thirds (approximately \$300 000) to clinical divisions based on total number of learners who rotated through the division. Part two consisted of two portions: one for educational leadership positions (eg rotation directors) that were not otherwise compensated or given protected time (\$60 000; 40%); and another for e-logged academic activity hours (\$90 000; 60%). Implementation, distribution of programme details to division chiefs and e-logging began 1 January 2017 and continued through 31 December 2018. The annual teaching bonus pay distribution (N = 107) occurred in May 2018 and 2019 with a mean of \$1672.52 (\pm 1821.41).

2.1 | Study design and data collection

A case study methodology was applied in this cross-sectional study to understand the sociological aspects of academic productivity incentives. Such an approach optimally informs us on faculty perceptions about organisational culture, around the educational mission and attitudes towards the teaching incentive.^{16,17} The PCH Institutional Review Board approved our human subjects study.

Traditional to case study design, we utilised six sources along with a primary source to systematically conduct an in-depth exploration of a group of physician-faculty who voluntarily participated

in the first year of the incentive programme utilising methodological triangulation as defined in Denzin's (1978) seminal work. First, a primary source serves as the data closest to the origin of thematic results. Consistent with *Between-method* triangulation, the remaining sources buoy and assist with interpretation, synthesis and understanding of the issue from different dimensions to counter design weakness in and across sources.¹⁸ Our primary data source was individual, open ended, semi-structured interviews conducted with faculty using an original protocol (Appendix S1) to generate a robust understanding of their perceptions. Individual interviews ranged from 20 to 50 minutes and were conducted between May 2018 and May 2019. A supporting source was observational field notes from authors (GFM; BCW) who attended and observed various quarterly and monthly hospital leadership meetings made up of the division chiefs, department chair and hospital C-suite executives between January and December 2018. The observation setting included updates on the incentive for accountability and dialogue regarding the allocation process and anticipating faculty needs and desire for recognition. Contemporaneous field notes (Appendix S2) were taken by the co-lead author (GFM), a non-hospital employee, as part of observation to memorialise and understand the hospital's culture first hand as a 'participant-observer'.¹⁷ Additionally, meeting minutes served as documentation data for artefact analysis that were mapped back to the corresponding field notes. Fourth, monthly e-log trends, by division specialty, were tracked to confirm participation and note total hours allocated to teaching activities. E-log reports were generated on ongoing monthly basis between January and December 2018. Fifth, an anonymous three question online survey with an open comments section was distributed immediately after the second annual payout process to gauge satisfaction regarding: (a) the efforts of the education office to enhance teaching recognition and (b) compensation amount (Appendix S3). The survey was distributed in May, 2019. Finally, we used several organisational theories, including institutional isomorphism⁸ as aforementioned. Organisational culture theory (OCT) uses individual perceptions, opinions, norms and attitudes to define organisational culture, climate and trends.⁹ We turn to OCT to further frame the teaching culture that is unfolding as perceived by participating faculty in our study.

2.2 | Recruitment and participants

With the vast majority (107/129; 83%) of eligible faculty participating in the incentive programme, our recruitment process was informed by *critical case purposeful sampling strategy*,¹⁹ traditional to exploratory inquiry. This technique of purposive sampling is optimal because the entire group of faculty participating in the incentive programme are information-rich and can decisively speak about their experiences, attitudes and perceptions about the programme and its influence on the organisational culture when investigative resources are limited. Via the senior author (BCW), 100% (107) of incentive participants were emailed recruitment notices for our study

and the individual interview and survey consent form to review in detail prior to deciding on participation. Upon receiving recruitment materials and consent forms, faculty self-selected to volunteer for the study on the incentive.

2.3 | Data analysis

Interviews were recorded and sent for transcription to a third-party vendor, TranscribeMe®. E-log reports, observation field notes, meeting minute documentation and interview transcripts were imported into our data repository using the qualitative research software, Nivo 11®. Case study data analysis, informed by Miles & Huberman,²⁰ included open coding of interview transcripts and summaries by each of the authors and member-checked as an internal review mechanism. Initial, or parent, codes informed core emergent themes (Appendix S4). Transcript data were memo linked to participant demographics, individual e-log data, observation field notes, SurveyMonkey® frequency results and open-text survey comments as part of phase two to relate codes to each other (axial coding) or further break down data into child codes. Through iterative dialogues, the authors came to consensus on core themes and relationships. Division information is withheld and pseudonyms are used to assure anonymity.

3 | RESULTS

Of the participating faculty, 32 consented to and engaged in in-depth interviews (N = 32/107; 30%). Three core themes related to our research questions were identified: (a) a teaching expectation conundrum; (b) the collective faculty morale and (c) implications for national recruitment, promotion and retention. No notable differences emerged when stratified by years employed with the institution, gender or professorial rank. However, to further elucidate the interview participants' positionality, we note that the average amount of time they have been employed by PCH was 7 years. They are therefore likely to be equipped to interpret and inform investigators on the hospital's organisational culture over time. Slightly over half of the faculty participants identified as male (N = 17/15; 55%). The composition of all participants by professorial rank consisted of 72% (N = 23/32) at assistant professor; a quarter at associate professor (N = 8/32) and 3% (N = 1/32) at full professor. 88 faculty (interviewees included) participated in the supplementary satisfaction survey with optional open comments (N = 88/107; 82%; 46 male/42 female).

3.1 | Motivation to 'pay it forward' amid perceptions of a teaching expectation conundrum

In interviews, all faculty reflected on their academic identity and described a sustained sense of altruism regarding teaching despite

intense clinical workloads and the origins of the hospital as a community facility. When asked about identity and their motivation to teach, Dr Lopez responded, 'Most of us here want to teach and... remember being residents ourselves and want to...give back. I think we're committed to making good residents and knowing that how the residents come out of this program reflects on us because we trained them...It's part of us'.

Survey responses illustrate that just over 60% of participants reported feeling satisfied or very satisfied with the amount of pay while the remaining 40% of survey participants reporting dissatisfaction had concerns about allocation details for the sake of transparency as well as the relative size of the bonus when compared to compensation practices at other hospitals. For example, an open survey comment stated, '(the) (a)mount of incentive seems small compared to number of learners we work with and amount of time involved. Many institutions get 10%-20% of their salaries from teaching activities'.

Interestingly, for a quarter of interviewees, the compensation was not a core motivation to participate in the programme, but rather, they chose to participate to stand in solidarity with the attempt by the educational leadership to garner additional recognition for teaching efforts. Observation notes from one particular leadership meeting recorded the anticipation of faculty advocacy in official minutes and the perception of advocacy was confirmed through several interviews. Dr Deil lamented,

Somebody is kind of fighting for education. Some of us are true clinical educators. The incentive is a very small part of my salary, but it's good for the faculty coming up...the hospital's grown and now it's in that growing adolescent pains of trying to be a community teaching hospital to an academic center...It's in the best interest of the hospital that we do this. (The medical education office leadership) is taking us in that direction...The amount of money is just-- it's not that. That almost doesn't matter.

The implementation was thought of as a form of fresh faculty advocacy necessary to further nurture the academic culture.

Despite the motivation to pay it forward, a small minority of faculty found it problematic that teaching is expected by all, but not described in their formal employment contract. Teaching preparation and execution was described as often left to their free time, evenings and weekends. Although there was an appreciation for the incentive, about fifteen per cent of participants expressed preference for a buy-down model over a bonus incentive. Even though only five faculty brought this issue to light in interviews and one in the survey exercise, preferences among the two models is worth noting as it further explains survey responses expressing dissatisfaction and adds a different dimension to understanding the reception of the incentive and the culture. Dr Hillyard commented, 'The teaching incentive... doesn't take the clinical pressure away ... it just doesn't answer the question of where are you going to get the time from'. In a similar critique, again, Dr Green stated,

I would be much more interested in not getting an extra incentive, but just getting paid in terms of time... as part of the intrinsic culture...because the whole point is not taking time in the evening, right? (The incentive) is not something that is addressed in our contracts so its extra...I don't want extra.

Others countered this sentiment with a different perspective on a buy-down vs incentive approach. Dr O'Connell offered,

I don't think that that is a realistic expectation for every single physician here [to get time buy down] ... But I do think an ability to target some individuals that have the potential in growth and interest in developing that aspect of their career is possible.

Despite discord regarding the optimal means of monetary translation of the value-perceived in teaching, and clarity that the hospital places on teaching expectations in contracts, the motivation of participants to teach and to give back is evident. OCT concludes that the omission of teaching expectations from the contract with the implementation of an incentive in a teaching hospital setting presents a misaligned message to faculty. It is also worth noting that leadership meeting minutes and observation notes omit discussion about contract boilerplate language or section revision to match expected academic participation.

3.2 | Perceptions about collective morale

For many participants, the mere concept of introducing the incentive communicated the importance of teaching and illustrated the extent to which recognition for education was increasing at the hospital. Nearly half of the interviewed faculty perceived an organisational culture shift that prioritises teaching. Faculty expressed individual improvement in morale as a result of the recognition. For example, Dr Raksanaves stated,

The emphasis is on how much we can produce in terms of our clinical load and so then if we [teach], it's at the expense of seeing patients in our clinic...it's going to be during my lunch hour or I'll have to come in early to do it or I'll have to create that time and if I create that time and it's not recognized by the institution or I'm not getting additional time to build upon the small amount of teaching that I'm doing, then it's frustrating...the incentive helps curb that frustration and rebuild my morale.

In response to the incentive, the majority (80%) of survey respondents reported feeling satisfied to very satisfied about both teaching efforts being valued by the hospital as well as the advocacy efforts undertaken by the department of medical education.

Drs. Morrison and Weiss echoed this perception and support survey results,

It can be a little draining for some people who feel like there is no external appreciation for going beyond the clinical... I think it's changing [pause]. I think that morale is better because I think people feel that change with (new education leadership) coming in and really working on the incentive, but also within our own division. said Morrison.

I do think where it has some value is just as a token of acknowledgement to say, 'We value what you're doing! You are respected!' ... again it's not some overwhelming amount [of money] that's going to blow everybody away, but still-- it's a message.,

said Weiss. In the same vein of survey responders, another wrote, 'I appreciate the ongoing effort to help recognise all the hard work being demonstrated by many of our providers'. Yet, in stark contrast, another survey responder, representing approximately 20% of negative comments on this topic responded, 'Division chief unable to provide breakdown. It appears to be very subjective and instils a sense of mistrust between staff and administration'. Such a sub-theme suggests that the details about the methods used in monetary allocation by the programme may not been communicated effectively to all participating faculty in some divisions.

The same proportion (47%) of interviewees who reported a positive shift in culture that prioritises teaching also described a shift from an expectation of modest academic involvement to a culture that expected increased academic contributions. The shift promoted enthusiasm for teaching and committee service related to the academic mission. Representative of the group's expressions, again, Dr Morrison said,

I think that changing the mindset that this is not just a community hospital with really good clinical care, but that's also an educational training center and a powerhouse, and that it's going to involve actually teaching... The incentive goes a long way with helping that and I think they're doing it.

A tenth of interview respondents brought up a very specific shift from intense priority on the hospital's clinical prowess nationally to the teaching mission as a next phase of focus. Dr Green commented,

I think there's momentum that is moving in the direction that PCH needs to go in...I think that we're eventually going to get there, but it's going to take a while because, I think, [pause] PCH still has a lot of community hospital genes in it... We're making improvements. We're in US

News and World Report. We're getting more recognition, but it's a process, you know? And I think that we are never going to get more recognized if we don't move more towards emphasizing the importance of teaching and research...it's not going to happen if we continue to rely on clinical RVUs to define ourselves only.

The same sentiment resurfaced in almost half of survey responders open comments. One survey participant wrote, 'I think it is a good start! A huge disparity remains between reimbursement and cultural recognition within the organization of clinical vs teaching effort'. Expressions from faculty such as these capture an optimistic orientation that appears to take note of progress over perfection. By and large, the introduction of the incentive shaped participating faculty's perceptions about the academic direction of the hospital that furthered enthusiasm for the teaching mission.

When considering interview and survey responses, we infer that differences in perceptions among faculty in one hospital and specialty could be grounded in their individual need for detailed information, appropriate promotion of the programme, and support for teaching engagement at divisional levels. In this case, we find that the immediate teaching environment and subculture may not be signalling recognition from leadership or could be indicative of inefficient flow of information downstream.

3.3 | Perception on implications regarding national recruitment, promotion and retention

One third of interviewed faculty stated that the continuation of the incentive could positively assist with career planning and professorial promotion as a positive by-product. This perception was shared by division leaders attending the regular leadership meeting of the hospital. Dr Spencer said, 'I'm putting my promotion dossier together and doing these logs helps me think about what I need to put in my teaching portfolio'.

Among this subset, faculty expressed hope that the incentive could be a strong selling point in continuing to both attract and retain paediatric academicians to the institution; thus, increasing the prestige of the hospital.

I think we're moving in that direction slowly. Because I think that is going to be the only way that they are going to be able to recruit the people that they want to recruit.... Because we've been hiring more people who are highly interested in academics and we're trying to get that up and running, but it's a process. But I will tell you that we've been trying to incentivize teaching... It is a big leap of faith that administration approved this...and I'm encouraged by it,

noted Dr Green. This theme also surfaced in the observation of two leadership meetings. Discourse between division chiefs and hospital

leadership exchanged statements about the expectation and anticipation of the incentive implementation potentially heightening visibility of the commitment by the hospital to teaching and faculty recognition, thereby emphasising the importance of the symbolic effect the incentive could have on faculty recruitment, promotion and retention. Discussions at the final observed meeting concluded with a statement advocating for the prioritisation of recruitment and retention of both affiliate faculty and those with formal and visible educational leadership roles (eg residency directors; clerkship directors). This reflected the recognition of the financial consequences of faculty turn over, the creation of new training programmes, and expanded alliances with multiple competing medical schools, and that these considerations are being placed at the forefront of the strategic plan of the organisation.

In all, findings suggest that recognition for teaching by incentive could be a vital component in faculty recruitment, retention and satisfaction, if such initiatives were prioritised in hospitals with a similar context to that of PCH. Survey questions did not include a specific prompt on the topic of recruitment, promotion or retention. As such, related trends in the survey comments were absent. In line with OCT, findings highlight a culture where faculty perceive that the incentive could improve faculty recruitment, assist with much-needed teaching and academic service portfolio documentation for promotion dossiers and annual performance reviews, and faculty retention rates.

4 | DISCUSSION

The results from our study both illustrate and underscore the importance of carefully following conceptual recommendations set forth by the literature¹⁰ when implementing and re-calibrating teaching incentive programmes. In a critical synthesis of teaching incentive literature, Wisener & Eva (2018) turn to psychology organisational behaviour, and behavioural economists to highlight different approaches to counter unintended and negative consequences to motivation.¹⁰ They offer guidelines to best position incentives for success as defined by positive motivational factors amongst the faculty. To our knowledge, our study is the first of its kind to provide in-depth individual experiences about a shared clinical education space, while the organisation pushes its own motivational factors for implementing an incentive. We illustrate the complexity of the push-pull dynamic and interpretations that need to be considered by leaders and policymakers. This led us to further consider questions about the potential influence incentives can have on organisational culture and faculty interpretations of the culture, which leaders can use to guide the framework of their own incentive plans. Consideration should be given to a number of specific questions. What is the hospital really trying to accomplish with the teaching incentive? What, at the end of the day, does the institution desire—for retention and the sake of institutional reputation—to do to assure happy, productive, recognised and engage faculty? Are we attracting the right type of faculty that fit in and have a place here? Results from our study informed us that these are critical questions to reflect upon prior

to embarking on incentive designs that are part and parcel with Wisener & Eva's¹⁰ practical guidelines for deliberately implementing teaching incentives as schools promote teaching excellence.

Based on overall participant responses, the incentive was well-received. In answering our research questions, we found that the incentive was mostly perceived as a strategy to encourage the academic culture of the hospital. From previous literature, we know organisational leadership groups often introduce incentives to modify faculty behaviour and tend to default to a bonus model.^{1,2,6,11} It generally seems that the type of incentive, in bonus form or otherwise, has little impact on the medical education mission, but often leads to increased job satisfaction. There is a similar assumption about teaching participation drivers and forms of recognition made by organisational leadership in our study. However, we find that this may not be the case for some. A minority of respondents reported a general lack of transparency to the faculty about distribution details, which led to dissatisfaction with the incentive.

The design of the incentive as a bonus distributed from a pre-determined total allocation pool assumed that most faculty would interpret the implementation as recognition for their teaching contributions in a transparent fashion. A number of faculty who did not broadly favour the incentive approach expressed preferences for buy down of time over any kind of incentive bonus. There was also a common theme of consternation regarding the omission of teaching time allocation in formal contracts. In the attempt to both increase teaching participation and reward faculty, this misalignment between employment contracts with the desired teaching culture revealed a nuanced understanding of teaching culture barriers^{12,13} that has not been noted in current literature. Despite the institution having evolved into a teaching hospital, interestingly, contracts remain bipartite (eg clinical and administrative) while the mission of free-standing teaching hospitals and their faculty are tripartite or even fourfold, and universally include teaching and research efforts. The misalignment suggests that the organisational culture is not explicit in relating clear teaching expectations in support of teaching participation. This can be interpreted as an example of an incomplete or memetic response still progressing to match peer institutions. Despite these issues, high satisfaction levels and a general appreciation for the programme as a conduit for change were evident.

In addition, the very attempt at the creation of an incentive contributed to the internalisation by faculty of a renewed appreciation for teaching at a time when the institutional emphasis on the clinical enterprise continued. This internalisation led to an improvement in morale for a majority of participants. OCT could explain differing perceptions on the stagnation or progressive state of morale by considering the specific subcultures from within which interview participants exist. Amid the efforts of hospital leadership to communicate and promote the programme, findings from unsatisfied faculty suggest the lack of allocation details gave rise to the perception that the incentive implementation was, to a degree, disingenuous. This led to a relative minority of participants describing the incentive as being suboptimal in creating greater transparency and communication flow between faculty and administration.

Finally, there was increased hope for strategically utilising the incentive as a recruitment, promotion and retention tool. These are all components faculty participants trusted could contribute to increasing the national prestige of the hospital and keep pace with peers and other AMCs. This then supported an underlying expectation for PCH to maintain its course towards *memetic isomorphism*. The majority of perceptions from interviews and surveys culminated in a collective view of the institution as one that is advancing in a more academic and teaching-focused direction.

Informed by divergent points of view, we see that implementation of incentives continues to prove that receipt can simultaneously satisfy and dissatisfy faculty for varying reasons. Prospective systematic evaluation of our programme yielded a better understanding of the gap between the perceptions of faculty and administration. Our findings illustrate the importance of bridging both organisational and individual faculty values. This means ensuring that both entities align in the definition, recognition, compensation and time allocated for teaching. It is apparent that teaching is valued, but messages are not largely consistent and do not effectively permeate through every dimension of faculty life. From hiring and onboarding, as reflected in employment contracts, to the opportunity for shared governance between faculty and organisational leadership to develop and apply culturally aligned compensation models and reward systems, we recommend consistent messaging of organisational commitment to the educational mission. Such messaging should touch each of these dimensions for incentives to be perceived as fair and transparent.

4.1 | Limitations

The size of our primary data source pool is similar to previous quantitative academic incentive literature¹⁻⁴ and common to case study design.^{16,17} However, our study could have been strengthened with an additional breakdown of demographics that included ethnicity and race to be able to further investigate differences in the reception of the incentive. Additionally, interview and survey data collection tools in the area examining recruitment, retention and promotion needed to have aligned better. There is a survey design omission in this area. A significant bias is the lack of data from those eligible for the programme who chose not to participate. Had we somehow been able to include such data, a potentially different and deeper understanding of motivation and perceptions about the organisational culture could have surfaced.

5 | CONCLUSION

Institutional priorities reflect organisational culture and manifest in resource allocation as distributed by executive leadership.²¹ Allocations not only reflect responses to external pressures, but reflect the collective values of the leadership. When leadership changes are frequent, organisational values, direction, timelines

and ultimately allocations typically alter; sometimes causing confusion, frustration and uncertainty of the institutional fit for some individuals. It is important to remain cognisant that many physicians in free-standing hospitals consider themselves academicians—hence, their professorial appointments. These appointments are not only because of normative isomorphic pressures from national medical education accreditation agencies, but for some, their identity remains grounded in being a clinical educator. This particular identity is meaningful to their happiness, sense of respect, job satisfaction and motivation to pay it forward, as we noted frequently in our study.^{1,4,7} We can infer that there is potential for institutional leaders to reap the socio-psychological benefits of retaining faculty and increasing teaching participation if they invest in teaching incentive models. Our study further solidifies that that hospitals are strengthened by deliberate and coordinated institutional philosophy and organisational goals that consider the significance of faculty perceptions and morale around teaching, since faculty are the backbone of any teaching institution.²²

Our study is applicable to an array of specialties. It is particularly relevant to any community hospital or clinical training site that has moved from hosting the occasional learner to becoming a bona fide stand-alone teaching hospital. Such institutions, that often have robust training programmes largely staffed by affiliate or volunteer faculty and are loosely coupled with local medical schools, may significantly benefit from examining the reactions of their faculty.

Future research could consider three points. First, a longitudinal examination of long-standing teaching compensation models and how faculty expectations, perceptions and attitudes have changed or remained the same. Second, methodological triangulation should expand further than what we provided by applying congruent qualitative data collection instruments to not just the recipients or direct beneficiaries of incentive compensation, but to include senior institutional and division leadership. The addition of their perspective would provide a much-needed voice and greater clarity and first-hand information on the purpose of the implementation. Finally, a mixed-methods approach to confirm direct links between incentive programmes and their effects on recruitment, retention and promotion among not just affiliate faculty, but among all faculty, would be very useful. Such analyses could continue to assist leadership with important decisions to continue or modify their current compensation models and recruitment strategies.

ACKNOWLEDGEMENTS

We thank Phoenix Children's Hospital and the University of Arizona College of Medicine-Phoenix faculty and leadership for covering transcription expenses, time, forum and permission to execute on the study.

We also thank Kenneth S. Knox, MD, Francisco Lucio, JD, Jonathan Snyder, MBA, and Terrence L. Stull, MD, for critical review of previous manuscript drafts.

ETHICAL APPROVAL

Approved by Phoenix Children's Hospital IRB.

PREVIOUS PRESENTATIONS

Podium presentation of findings presented 9 November 2019 AAMC Learn Serve Lead National Conference in Phoenix, Az.

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SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section.

How to cite this article: Martinez GF, Giblin CR, Willis BC. Physician-faculty perceptions towards teaching incentives: A case study at a children's hospital. *Med Educ*. 2021;55:604-613. <https://doi.org/10.1111/medu.14418>