

# Peer-Reviewed Career Development and Compensation Program for Physicians in an Academic Health-Science Centre

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## Abstract

**Objective:** To develop a method to promote career development, and to evaluate and appropriately compensate physicians in an academic health-science centre (AHSC).

**Methods:** The members of the department of pediatrics at The Hospital for Sick Children and the University of Toronto, with the help of an external consultant, developed a peer-reviewed career development and compensation program (CDCP).

**Results:** The department implemented six job activity profiles, and uses a peer-review process to evaluate performance in clinical care, education, and research. Each area is also evaluated for leadership and administrative activities. Criteria indicating different categories of achievement provide guidelines for career development and benchmarks for evaluation. Total compensation consists of a guaranteed base salary, which is evaluated every three years, and an annual stretch bonus, which is determined through an annual career review and evaluation of the success in achieving established goals.

**Conclusions:** This article outlines the CDCP's development and implementation, and discusses its merits and opportunities for improvement. We suggest that a CDCP is a necessary development when an alternative funding plan is used as the funding source for physicians in an AHSC. The strategy may also be useful to physicians in a health maintenance organization or a comparable structure.

*This article has been peer-reviewed.*

## Résumé

**Objectif -** Mettre au point une méthode d'aménagement de la carrière des médecins d'un centre hospitalier universitaire (CHU); évaluer ceux-ci et les rémunérer correctement.

**Méthodes -** Les membres du département de pédiatrie de l'Université de Toronto exerçant à l'Hospital for Sick Children ont mis au point, avec la collaboration d'un consultant externe, un programme d'aménagement de carrière et de rémunération (PACR).

**Résultats -** Le département a défini six profils d'activité et a recours à un processus d'examen par les pairs pour évaluer la performance des médecins dans les domaines de la clinique, de l'enseignement et de la recherche. Dans chacun des domaines d'activité, on évalue également l'aptitude à diriger et les capacités administratives. Les critères correspondant aux différentes catégories de réussite ont permis la mise au point de directives portant sur l'aménagement de la carrière et l'évaluation. La rémunération totale comprend un salaire de base garanti reconsidéré tous les trois ans et un bonus annuel variable, qui est déterminé après un examen de la carrière et en fonction du succès obtenu dans l'atteinte des objectifs.

**Conclusions -** Le présent article décrit l'évolution et la mise en place d'un PACR; il décrit ses mérites et propose des améliorations. Les auteurs estiment qu'un PACR s'impose lorsque les médecins ont plusieurs sources de revenu dans CHU. Le PACR peut également être utile aux médecins dans le cadre d'un organisme d'assurance-maladie privé ou de toute autre structure apparentée.

*Cet article a fait l'objet d'une évaluation externe.*

## Introduction

The goal of an academic health-science centre (AHSC) is to promote the health of society through the generation, evaluation, dissemination, and application of health- and disease-related knowledge. In North America, however, the main source of funding for the research and educational activities of academic physicians is derived from their provision of medical care.

Although there is variability in Canada, the typical faculty of medicine usually contributes minimal amounts of money for

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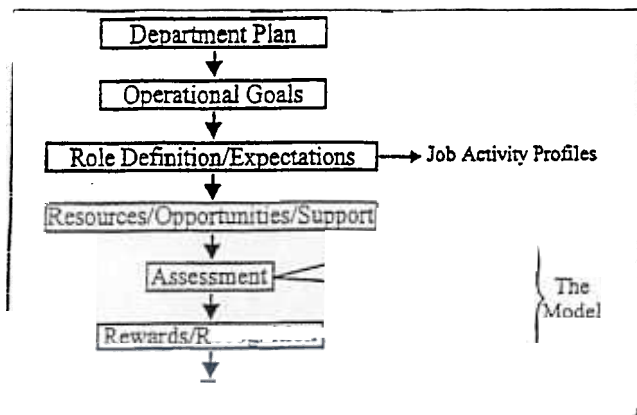


Figure 1. The model is built on key links where individual roles and expectations, and career growth, as outlined using JAPs, are congruent and synergistic with the department and its strategic goals.

the compensation of academic physicians at its affiliated AHSCs. For example, the University of Toronto's base funding represents three per cent of the pediatrics department's financial resources. The discordance between the source and application of funds creates a challenge for, and often results in conflicts in an AHSC. Unless alternative strategies are developed, physicians who generate the most clinical-care income receive the greatest financial benefit regardless of their contributions to research, educational, and administrative activities. This is incongruent with the goals of a leading AHSC. As a result, most AHSCs have developed strategies to appropriately compensate physicians who participate in educational, research, and administrative activities. Two examples include the establishment of a group practice where members contribute to an "academic activities fund" or as is the case in our department of pediatrics, block funding is obtained to reimburse physicians for their clinical, educational, research, and administrative activities.

This approach is favoured by proponents of block-funding strategies, who also acknowledge that challenges remain even when there are enough funds for the department's academic pursuits. This article provides an overview of a process whereby an AHSC can promote the career development and enhance the performance of academic physicians, while fairly evaluating and financially rewarding their clinical, research, educational, and administrative activities.

In this article, we describe how our department of pediatrics developed a career development and compensation program (CDCP). Its objective is to enhance the career development of individual physicians, and improve the department's ability to achieve its strategic goals. Factors identified during the CDCP's development and implementation were the continual involvement of the department members, respect for the value systems of academic physicians, the use of a third party (William M. Mercer Inc., Philadelphia), and most importantly, the use of a "peer-group" to develop the criteria for achievement and assess performance in areas of clinical care, education, and research.

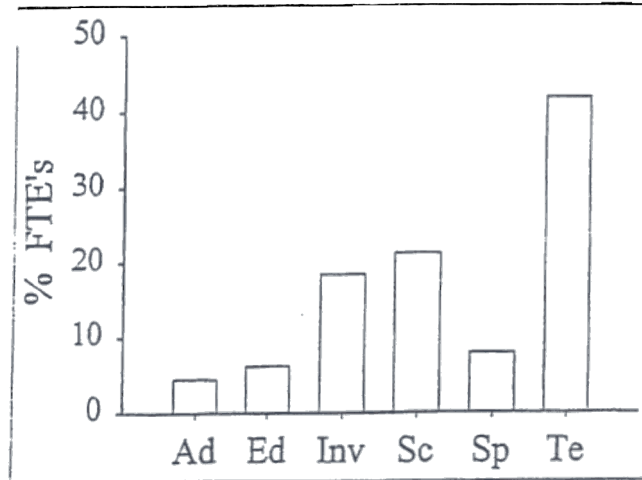


Figure 2. The distribution of different JAPs in the department of pediatrics during the 1997-1998 fiscal year. FTE=full-time equivalent, Ad=clinician-administrator, Ed=clinician-educator, Inv=clinician-investigator, Sc=clinician-scientist, Sp=clinician-specialist, and Te=clinician-teacher.

## Setting for Development of CDCP

### The Hospital for Sick Children<sup>1,2</sup>

The department of pediatrics at The Hospital for Sick Children is one of the largest academic pediatrics departments in North America. When the CDCP was developed, it had 65 male and 44 female geographical full-time (GFT) consultant general and subspecialty pediatricians whose professional activities were limited to the hospital and university. Of these pediatricians, 26 also held appointments as scientists in the hospital's research institute, Canada's largest hospital-based research centre. The department also has more than 150 consultant and subspecialty pediatricians. Most of their professional activities occur in their private practice offices. This CDCP has not to date been used for this group.

The University of Toronto's faculty of medicine has 177 students in each of its four years of medical school. Our department has fully accredited pediatric postgraduate training programs. In addition, many of our department's members are cross-appointed to departments in the school of graduate studies.

The Hospital for Sick Children is Canada's largest pediatric hospital. In 1997-1998, the hospital had 46,679 visits to its emergency room, 15,751 hospital discharges, 93,874 patient-days, and 159,161 visits to its outpatient departments. The department of pediatrics is responsible for virtually all patients who present to the emergency room, and for approximately two-thirds of all in-patient and outpatient activity. Although it provides primary and secondary care to the most central region of Toronto, its primary role is to be a regional, national, and international referral centre for tertiary and quaternary pediatric care.

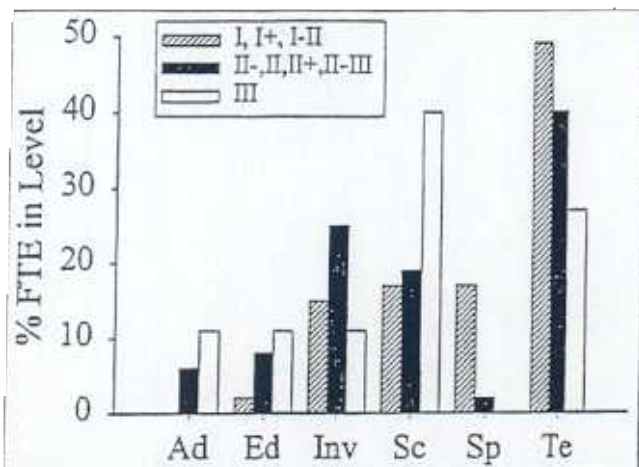


Figure 3A. The distribution of levels in the different JAPs. With the exception of the group of nine clinician-specialists who were only  $6.5 \pm 5.3$  SD years post completion of training, each JAP had level III physicians. For abbreviations, see Figure 2.

#### Financial Support for the Department of Pediatrics

During the 1980s, most of the funds available to the department of pediatrics were derived from the provision of professional services that were reimbursed on a fee-for-service basis from the province's "single-payer system," the Ontario Health Insurance Plan. The remainder was derived from the University of Toronto, hospital, and governmental agencies (for example, Medical Research Council of Canada). Before the CDCP, each department member had a fixed level of annual compensation that consisted of both a salary and a fee-for-service component. The process by which the level of compensation was determined, however, was poorly understood by department members.

The department, the hospital, and the University of Toronto entered into an alternative funding arrangement with the government of Ontario in 1990.<sup>1</sup> This arrangement was the first alternative funding plan (AFP) for a large academic medical department in Canada. A crucial factor in this agreement was the recognition that the department spent 50 per cent of its effort on patient-care and related administrative activities, with 30 per cent on research and 20 per cent on educational activities. The agreement immediately improved the compensation of physicians, and over the next few years provided financial stability, which allowed academic activities to flourish while enhancing the provision of clinical care.<sup>2</sup>

#### Environment Surrounding CDCP's Development

During the mid 1990s, the government of Ontario, with other governmental social contract initiatives, reduced the funding to the department by 4.4 per cent. Concurrently, the university continuously reduced its financial support. These reductions occurred when the department needed to recruit additional physicians to address advances in clinical care, such as transplantation, and to offset the reduction in the amount of pe-

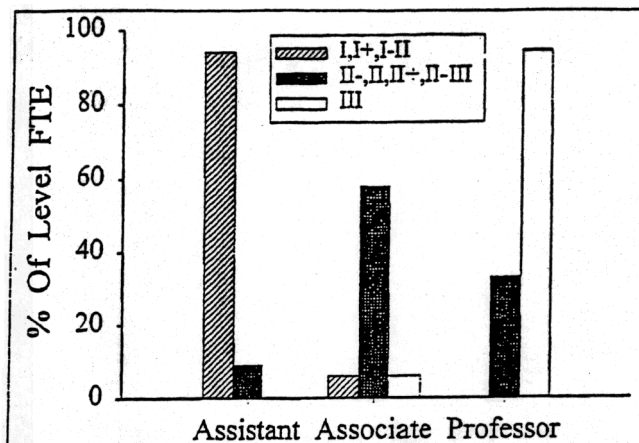


Figure 3B. The professorial ranking at the University of Toronto influenced but did not determine the assignment of physicians to levels.

diatric resident hours directed to patient-care. As a result of fiscal pressures, the department's faculty complement was reduced by 10 per cent during the 1996-1997 academic year through a voluntary departure or retirement plan (details available upon request to H.O.). The financial difficulties occurred at the same time that the government was reducing the global budget for all Ontario hospitals, requiring bed closures and reduced support services. As a result, the department became demoralized.

The CDCP is part of a strategy to promote the development of the individual physician's career, regardless of whether the physician's focus is in excellent patient-care, research, or education. The CDCP assists in directing available resources to members of the department who, regardless of the number of years post-graduation, are making the most rapid progress and most important contributions to clinical care, research, education, and efforts to optimize operational efficiencies and resource management.

#### Development of CDCP

The development of a CDCP was influenced by several factors. The department had a strategic plan and operating goals. It was recognized that resource availability had affected the career development and compensation opportunities of physicians. It was believed that resource allocation must occur at the level of faculty members, and that this would define how their time would be spent, how their career was evaluated, and how they would be compensated. The model for the CDCP linked an individual's contributions to the departmental plan (Figure 1).

Many faculty members were uncertain about their role in the department. Moreover, expectations and goals were often incongruent with the nature of their daily duties. Six job activity profiles (JAPs) were developed: clinician-teacher, clinician-educator, clinician-scientist, clinician-investigator, clinician-administrator, and clinician-specialist. They outlined the expectations for a faculty member in clinical care, research, ed-

**TABLE 1**  
**THEMES FROM 1996 FOCUS-GROUP SESSIONS GUIDING SUBSEQUENT DEVELOPMENT OF CDCP**

Global environment	Skepticism about the likelihood of any positive changes being made
Institutional issues	How do the missions of the department and the hospital integrate?
Departmental issues	The big issue is equity. How can the department set consistent expectations across and in divisions? Can we avoid "deal making"?
Job and role issues	More clarity is needed. The individual physician should be involved in defining expectations. The physicians whose primary role was to provide clinical care felt undervalued.
Performance evaluation	Interest centred on: <ul style="list-style-type: none"> <li>• establishing objectives and meaningful measures</li> <li>• differentiating superior from average performance</li> <li>• using an objective process ("more than just impressions")</li> <li>• having money to recognize performance</li> </ul>
Compensation issues	The preliminary focal points were: <ul style="list-style-type: none"> <li>• opportunity</li> <li>• a fair process</li> <li>• openness</li> </ul>

ucation, and administrative activities. The amount of time that each individual was to devote to each of these activities was negotiated annually between the physician and the division chief, with the physician's subsequent expectations being commensurate with the allocation of time to each area (Figure 2).

The first step in the CDCP's development involved the consultants holding confidential focus-group sessions with the department's members. The focus groups, which were held in early 1996, provided an assessment of what physicians expected from the CDCP and outlined their concerns to the leaders (Table 1). The identification of several themes also helped guide the CDCP's development, and provided a reality check against which the final CDCP could be judged.

Several principles guided the CDCP's development. It was important to reward comparable performance equally in each JAP; the underlying assumption was that it would be equally challenging to improve one's capabilities in each JAP. Since the desired goals included the promotion of excellent evidence-based patient-care and effective use of resources, it was essential to develop a CDCP which, although influenced by, would not be determined by the university's academic promotion track. For the CDCP to be fair, a structured evaluation process was required that was understood by the faculty members, and respected by the participants.

The process to develop criteria for what was achieved, was led by the associate chairs in clinical care, research, and education. Each associate chair formed an advisory committee

whose members were representative of their respective peer groups. These clinical, research, and educational advisory committees (CAC, RAC, EAC) served as working groups that developed the criteria for categories of achievement in clinical care, research, and education. The pediatric executive and members of the department's finance committee continuously monitored, evaluated, and revised the recommendations of the CAC, RAC, and EAC to ensure that it was equally rigorous to advance through the three categories of achievement in each area (Tables 2-4). The pediatric executive and the finance committee developed the criteria for "citizenship," which reflected leadership and administrative activities including resource management. The criteria for leadership and administrative activities were revised subsequent to the CDCP's implementation (Table 5).

#### **Linkage of Performance to Compensation**

The total compensation for each member of the department consists of a guaranteed base compensation and an annual stretch bonus.

The physician's base compensation is determined by his or her assignment to a level (and sub-level) in the CDCP. Levels I, II, and III represent early career development, an established career, and exceptional performance in an established career respectively. To permit appropriate steps in a physician's career development and provide financially appropriate increments in base compensation, the department chose eight compensation steps within the CDCP. Less than 15 per cent of the

**TABLE 2**  
**CATEGORIES OF ACHIEVEMENT FOR CLINICAL CARE**

	Category i	Category ii	Category iii
Patient-care	Assumes appropriate responsibility for clinical care	Clinical skills acknowledged by divisional peers	Exemplary and well rounded clinician
	Developing or building on clinical expertise	Established goals have positive impact on clinical activities of others	Recognized leader with consistent, durable career path of continuous high standard
	Developing long-range goals in area of expertise	Recognized as team contributor	Team leader facilitates local, national collaboration
Application	Collaborates in refining clinical care	Initiates collaboration with other clinicians	National or international presence
	Brings new techniques	Applies or develops new techniques	Leads in application of clinical evaluative methods
	Participates in scholarly application of knowledge to clinical practice (EBM type)	Application of evaluative methods to clinical practice with demonstrated impact	Develops new techniques
Mentorship and career advice	Supportive of students, trainees, and peers	Mentor role established	Leader in application of novel clinical techniques Outstanding mentor
Clinical scholarly activity	Initiates or seeks guidance in evaluation of clinical practice	Critical reviews of clinical practices, demonstrates impact	Leadership in development of clinical standards

Examples and descriptions that illustrate aspects of each item are provided to physicians.

faculty members are expected to achieve or stay in level III, the only level that does not have a pre-determined cap to the amount of compensation. Every three years, each department member undergoes a "tri-annual review" to determine their movement through the base compensation steps of the CDCP.

Up to 10 per cent of the base compensation rate is paid in an annual stretch bonus payment after the physician has undergone career review and determination of their success in achieving established goals for that year. The annual goals are designed to improve the department member's category of achievement by increasing their performance beyond that previously achieved.

### **CDCP's Implementation**

#### **Initiation Stage of the CDCP**

The CDCP's implementation began in the spring of 1998. The process was outlined to department members through a series of open forums, and written communications. The first step in the implementation required the assignment of a level of performance for each member of the department. This was done based on an assessment of achievements ("results") since their first appointment at any AHSC. To maximize fairness, all members of the department, except individuals who had not com-

pleted their first three years at an AHSC, were evaluated during this step.

Each member's achievements were evaluated by reviewing an updated curriculum vitae (CV) and information from previous departmental annual surveys for the preceding two years. Independently and confidentially, each faculty member and the physician's division chief provided the chair with an assessment of achievements. The division chief could use any previous career reviews. The CAC, EAC, and RAC independently and confidentially provided the chair with the assessment of each physician's category of achievement in their respective areas of clinical, educational, and research expertise. The method of deliberation used by each advisory committee was similar to one used for a grant review. Primary and secondary reviewers each independently reviewed the randomly assigned physician's dossier. At a subsequent meeting of the committee, the primary and secondary reviewer each recommended assignment to a category of achievement. After discussion by the committee, a final recommendation was made. No committee was in place to evaluate the quantitative aspects of citizenship, and a category of achievement was assigned based on the self assessment, the division chief's recommendation, and a review of the physician's CV and annual surveys.

**TABLE 3**  
**CATEGORIES OF ACHIEVEMENTS FOR EDUCATION**

	Category i	Category ii	Category iii
Teaching effectiveness	Establishing and improving effective teaching skills	Consistently demonstrates effective teaching skills	Consistently demonstrates outstanding teaching skills
Impact on learning	Positive impact on learning at local sphere of influence Increasing load, variety, complexity of assignments	Positive impact on learners outside local sphere Recognition by frequent invitations to teach	Positive impact on learners at national or international level Recognized as expert teacher for all levels of learners
Educational development and evaluation	Participates in: <ul style="list-style-type: none"> <li>• curricular development</li> <li>• evaluation</li> <li>• teaching strategies</li> <li>• faculty development</li> <li>• self-directed learning</li> </ul>	Demonstrates leadership or has primary role in: <ul style="list-style-type: none"> <li>• curricular development</li> <li>• evaluation methods</li> <li>• teaching strategies</li> <li>• faculty development</li> <li>• self-directed learning</li> </ul>	Develops innovative, creative curriculum activities Recognized nationally
Mentorship and career advice	Demonstrates interest in learner	Mentoring role clearly defined	Mentoring skills widely recognized

Examples and descriptions that illustrate aspects of each bullet are provided to physicians.

The chair made the final decision about the physician's achievement in each of the clinical, research, educational, and citizenship areas. The final assignment to a given level (and sub-level) for each physician was influenced by their achievements in each area, and the duration of sustained and consistent performance. One innovative method for delivery of clinical care or one paper in a high-impact journal does not make a physician either the highest level clinician-specialist or clinician-scientist. This raises the question of "how much time represents sustained and consistent"?

The approach used an assumption that the time required for promotion through the university's academic ranks is a reasonable yardstick for sustained and consistent performance in research and education. An assessment in 1994-1996 showed that in the faculty of medicine at the University of Toronto, it took a median of eight years to be promoted from assistant to associate professor, and an additional median of eight years to be promoted from associate to full professor. Thus, it was assumed that to move from entry level I to a level II would require a median of eight years. To move from level II to level II-III/level III would take an additional median of eight years. Physicians who had not completed three years at an AHSC were assigned to level I.

An appeal process was set up. The appeal was assessed by the pediatric executive, and when further input was deemed necessary, by the CAC, RAC, or EAC with the final decision resting with the chair. Of the GFTs who appealed, approxi-

mately a third had some component of their assessment changed, or were scheduled for an early tri-annual review.

The physician's final level assignment was then compared to their existing total compensation. If this was below the base compensation associated with their level and sub-level, their base compensation was increased, and they were eligible for the annual bonus. If their previous compensation was comparable or modestly above that predicted by the assigned level, their base compensation was unaltered, but they were eligible for the annual bonus. If their previous compensation was significantly greater than that associated with their level, they did not have their base compensation changed, and they were ineligible for the annual bonus. On average, a department member received an 11 per cent increment in total compensation.

Several of the CDCP's goals were met. Each JAP, except for the newly created clinician-specialist, had physicians who were assigned to level III (Figures 3A, 3B, 4). Also, compensation was influenced but not totally determined by university rank. More female than male physicians (81 versus 59 per cent) received an increment in total compensation (either base compensation or eligibility for a stretch bonus).

#### CDCP's Steady-State Stage

The CDCP's steady-state phase has two components. Each year, faculty members are eligible for an annual bonus based on their career performance relative to their level, and their achievement of the goals and objectives that they had established with their division chief. Faculty members are encouraged to structure concrete measurable goals that will serve

**TABLE 4**  
**CATEGORIES OF ACHIEVEMENT FOR RESEARCH**

	Category i	Category ii	Category iii
Presentations	Presents at national or international meetings	Invited speaker at national or international meetings	Organizes international research meetings, symposia
Publications	Develops research and scholarly publications	Demonstrated independence	Senior corresponding author
	Prepares and submits first authorship publications	Regular invited contributor to textbooks, journal articles	High impact in the field
Funding	Involved in applications for extramural grants	Holds competitive grants	Holds competitive national grants
			Develops group grants
Stature	Establishes research	National, emerging international program	Internationally recognized research program
			Exemplary investigator
			Recognized leader
Mentorship and career advice	Supportive of students, trainees, and peers	Effective mentor role established	Outstanding mentor
	Summer students	Postdoctoral fellows, graduate students	Leader in cross-appointed unit or faculty
	Interdisciplinary research	Holds cross-appointment	

to move them up their categories of achievement. The second component of the CDCP involves a "tri-annual review," which allows movement between levels with commensurate changes in base compensation. One third of the department's physicians are evaluated each year. The first review was completed in the spring of 1999. It used a peer-review process. Information used for this review included the faculty member's CV, educational dossier, and a newly created clinical dossier.

### Discussion

This is the first member-developed CDCP that uses peer review to assess performance in clinical care, education, and research, and directly links an academic physician's performance to compensation. It provides a template for the physician's career development while enhancing the department's ability to align the physician's activities and compensation with the department's strategic goals.

We do not provide data to evaluate the relative merits of block or alternative funding arrangements versus fee-for-service funding for academic physicians. The AFP for our department of pediatrics<sup>1</sup> has been in place for a decade. Haslam<sup>2</sup> outlined the merits and challenges of such arrangements; during the first five years of our department's AFP, the clinical activity modestly increased, and the data suggested that there were improvements in both educational and research productivity. Haslam<sup>2</sup> outlined one of the challenges with AFPs — the difficulty in getting the government bureaucracy

to respond to the rapid changes in health care provided by a tertiary care AHSC and hence alter the faculty complement in an appropriate and timely manner. The development of the CDCP addresses another challenge: how does the department appropriately compensate excellence in each of the clinical, research, and education areas? It seems preferable to use this system rather than the clinically driven "market forces" represented by fee-for-service billing.

Our experience indicates that input from "focus groups" before starting the CDCP's development was integral to its success. First, it indicates to the leaders what the department members want — a different method to assess performance and determine compensation (Table 1). It also provides a historical backdrop against which to compare the CDCP. This point is emphasized in a recent publication. Although there are limitations to the study, it suggests that there are differences between the perception of deans of medicine and their junior faculty members about the problems involved in a faculty member's evaluation.<sup>3</sup> Similarly, Cotter and Bonds<sup>4</sup> note that measures of performance should be developed by the physician's peer group. We found that it is useful to often update the entire department as to the CDCP's status. The use of a preliminary model also allowed for subsequent refinement and an appropriate iterative process.

There was a variable response to the CDCP's introduction; it was accepted by many, while others were distressed.

**TABLE 5**  
**REVISED CATEGORIES OF ACHIEVEMENT FOR LEADERSHIP-ADMINISTRATION**

	Category i	Category ii	Category iii
Education	Participates in education-related activities at division, program, cluster, or department level	Important role in educational administrative activities	Leadership role in education committees at national or international levels
	Assists in initiatives to improve operational efficiencies, resource management in division, cluster, or department	Develops advances, or assumes leadership role in improving operational efficiencies, resource management at regional level	Leads in strategic development of education at organizational and national or international levels
Clinical	Participates in clinical related activities at division, program, cluster, or department level	Important role in clinical administrative activities	Leadership role in clinical committees at national or international levels
	Participates in initiatives to enhance clinical systems and improve operational efficiencies in division, cluster, or department	Enhances clinical improvements in systems, services, and operational efficiencies at regional or provincial levels	Leads in strategic development of clinical improvements at organizational, national, or international levels
Research	Participates in activities at division, program, cluster, department, or research institute level	Important role in research-related administrative activities	Leadership role in research committees at national or international levels
	Participates in initiatives to enhance promotion of research infrastructure in division, cluster, department, or research institute	Develops or initiates enhancements to research infrastructure and support at provincial or national levels	Leads in strategic development of promotion of research at organizational, national, or international levels

This may reflect several factors. First, although all department members indicated that they wanted the features of a CDCP (Table 1), a few found that their formal assessment under the CDCP was discordant with their self-assessment. Other than the academic promotion process, many of our faculty members had not undergone a detailed evaluation of their overall performance since they completed their training anywhere up to 25 years earlier. As described by Souba,<sup>5</sup> it has been difficult for some physicians to adapt to the changes in how health care is delivered and how decisions are made. It is also difficult for physicians to undergo peer-review performance evaluation when they are being compared with high achievers. Finally, measurement tools are being improved through ongoing assessment.

A CDCP should be sensitive to the values held by the group being evaluated. We chose a peer-review approach, since it is viewed as valid and appropriate by academic physicians. Although it is customary to use this approach for the scientific review of publications and grant applications, others have shown its utility in the evaluation of a physician's clinical<sup>6,7</sup> and educational<sup>8</sup> skills. The data of Ramsey et al<sup>7</sup> suggest that when a Likert scale is used, approximately 10 to 12 individuals were required to assess physicians' clinical skills. Each of our CAC, EAC, and RAC is composed of nine members, and when combined with the division chief's review, provides additional credibility to our peer-review process.

We expect that this CDCP is gender-neutral. One study has suggested that, even after adjustment for co-variables such as time at work or differential attrition from academic medicine, there is an unexplained disadvantage for females when being considered for academic promotion.<sup>9</sup> Similarly, a study evaluating the acceptance of scientific publications suggests an unexplained disadvantage for female scientists.<sup>10</sup> Although the results of our CDCP showed that more women received increments in their compensation, this is likely explained by the demographics. The female physicians in the department have a lower median age than their male counterparts, and many female physicians joined the department shortly before or during the governmental social contract financial reductions. During that period, their achievements and career development could not be recognized as a result of financial limitations. Thus, the apparent gender imbalance likely represents appropriate "catch-up" rather than the CDCP being a program that discriminated against male physicians.

Our department does not provide differential rates of compensation among subspecialties. This poses the risk of our department being financially uncompetitive, relative to other institutions, in certain subspecialties. If such a differential is required, one potential strategy would be to provide an underlying base "subspecialty" top-up financial reward.

The CDCP's implementation revealed several opportunities for improvement. One example is to confidentially evalu-



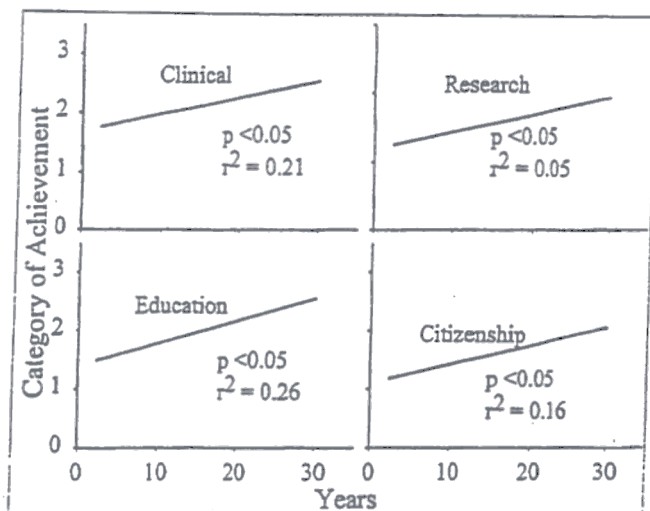


Figure 4. In each of clinical, research, education, and citizenship areas, there was a statistically significant ( $p < 0.05$ ) but weak correlation between years of service and category of achievement.

ate (sub)specialty division peers. In addition,<sup>6,7</sup> it is important to obtain opinions from non-physician health-care professionals. We have begun a pilot project where there is a MD peer and non-MD assessment of a department member's clinical performance. A few department members also expressed concern over their category of achievement in citizenship or the method of assessment. This may reflect a poor choice in nomenclature. A lower achievement was interpreted by a few to mean that they weren't a "good person," as opposed to the correct interpretation that such achievements are often low as our department's members spend, on average, only 12 per cent of their time on administrative activities. Since implementing our CDCP, a departmental committee has revised the citizenship categories of achievement and renamed it leadership-administration (Table 5). The leadership-administration achievements in clinical care, education, and research will be determined by the CAC, EAC, and RAC respectively. The competency assessment component of the evaluation is also being refined with the objective of developing a reliable and validated tool to evaluate competencies.

The development of this CDCP is the latest step in the evolution of funding mechanisms for GFT physicians at this AHSC. The CDCP, when combined with JAPs and appropriate mentorship and advice, provides career development and fair compensation of faculty members based on their performance.

Its key features include the CDCP's development by the department's members, the use of a peer-review system, and an awareness of the value system of a leading pediatric AHSC.

### Acknowledgments

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