FACULTY SENATE
UNIVERSITY OF MICHIGAN

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Clinical Faculty Concerns

Summary and Forward Path

Clinical track faculty were admitted to the University of Michigan Faculty Senate in 2023 (at the same time that lecturers, curators, and archivists were admitted). There are ~2,150 clinical track faculty in the Senate from 16 schools and colleges, though the vast majority of them are in Michigan Medicine. Altogether, clinical faculty comprise about 28% of the total Senate (~7,800 members). There is no union representing clinical faculty, and working conditions vary from school to school.

The Faculty Senate Office convened four sessions over the course of academic year 2025-26 to take the temperature of clinical colleagues: one in the Towsley Center (targeting Michigan Medicine Pediatrics), another in the University Hospital (targeting Michigan Medicine adult medicine), a third on Zoom (which included diverse faculty across the health sciences), and a fourth in Ruthven (targeting non-Michigan Medicine colleagues, with representation from nursing, architecture, education, and law), and included clinical faculty from Dearborn and Flint regional campuses. Each occasion began with a presentation from the Senate Vice-Chair and first ever clinical track member of the Senate Advisory Committee on University Affairs (SACUA), Dr. Soumya Rangarajan, who laid out the architecture of faculty government for attendees. Discussion ensued, organized around the question "What ought the faculty government be advocating for?" The points of discussion varied widely. The following matters appear to us to be matters of concern across the whole body of clinical faculty:

1. In some schools there is a mismatch between the kind of work that clinical faculty do and the criteria by which they are judged for promotion. Most clinical faculty are engaged in practical work: they work with clients needing legal representation, they see sick people needing medical care, they design buildings or develop curriculum for schools, and they do a great amount of teaching of future practitioners in their fields. When they come up for promotion, however, the criteria in some schools are drawn up by tenured faculty, who expect them to conduct original research and publish it in leading journals. In some units, the practical work of Clinical faculty in their fields does not count toward promotion at all. Clinical teaching loads can vary from school to school, with teaching loads that can unfairly burden clinical faculty, especially early in their career, making it difficult to find time for publishing research. Some faculty report having to teach >20 credits per semester, but this teaching load does not count or is of minimal value toward promotion. There is little reward or recognition for high quality teaching. Moreover, in some schools and colleges the external letters solicited by

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tenure and promotion committees come from tenure-track faculty, who have little sense of what clinical faculty do. And the vote taken at the College level is usually made by tenure-track faculty, because clinicians are under-represented in the executive committees of schools and colleges.

In short, both the mechanics of tenure and promotion and the criteria by which decisions are made make it difficult for clinical faculty to make their work fully visible, and creditable, in the eyes of those making life-changing decisions about tenure and promotion. Clinical faculty reported not seeing a feasible path to promotion, including to clinical associate professor, if they remain predominantly clinical. And there are financial considerations at stake, too: one group of colleagues pointed out that the narrow gate for promotion means that clinical faculty are often stuck at lower pay scales and are compensated considerably less than their contemporaries who work in private practice in their respective fields.

Our view is that, when schools and colleges are weighing promotion decisions, the criteria should be reworked to take account of the value of the practical work that clinical faculty perform, including through providing clinically excellent service. The promotion criteria aimed toward evaluating a candidate's national reputation should be re-evaluated.

2. The support for research offered to clinical track faculty is often considerably less than that furnished to tenure-track colleagues. We learned that, at one school, new clinical assistant professors are offered a $5,000 start-up package, while new tenure-track colleagues are given $50,000. Moreover—and this is an overriding concern—most clinical track faculty are not eligible for sabbaticals. At one school, a colleague who asked about a sabbatical was told "that will never happen." Clinical faculty are paid in correspondence to the work they do in their clinics. If they want to pursue avenues for professional development, that is unpaid time, and they take a marked pay decrease to "pursue their passions." It seems that—with only a few exceptions—schools and colleges at UM have not made financial resources available for clinical faculty wishing to take sabbaticals.

   This is a further disadvantage for clinical faculty coming up for promotion and tenure.

3. Faculty working at Michigan Medicine describe increasing and sometimes unsupportable workloads, with overwhelming hours spent in clinics and the hospital. Clinical time is measured in RVUs—Relative Value Units—that form

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the basis for Medicare's physician fee schedule. Medical doctors are scheduled strictly, and the time spent with individual patients is increasingly compressed. This creates both pressure and tension within clinics and the hospital, and faculty report that patients sometimes express anger about the time constraints that make it impossible for them to receive the care they expect. In addition, for those faculty who *do not* have direct clinical roles with the university, they are nonetheless still required to maintain their clinical excellence. They therefore must work to maintain clinical excellence on their own time, in addition to their UM workload, in order to meet UM's employment expectations. For example, clinical faculty at the School of Nursing are required to bring in 20% of their salary via faculty practice, even when the focus of their UM work is research and teaching. As a result, faculty who do not work in a clinical setting are forced to seek outside clinical appointments, oftentimes at clinics that have very little to do with their UM research and that may not have much incentive to pay 20% of a UM salary for four days of work per month.

For academic health professionals, in particular, there is a tension between institutional financial considerations and promotion criteria. At Michigan Medicine, we are rewarding academic health professionals to see fewer patients (and spend more time obtaining grants and publishing papers) while we also need academic physicians to see more patients for the medical operation's survival. Increasingly, highly paid senior physicians are being shifted to protected administrative roles, while clinical support staff are being reduced due to financial constraints, adding to clinical workloads. There is difficulty in recruitment and retention of junior faculty, who often choose higher compensating jobs with fewer academic requirements in other academic centers or in private practice. This leads to a vicious cycle of overwork in caring for both a much higher number of and significantly sicker patients for full-time junior clinical faculty, providing no time for academic endeavors. Our operational needs and our reward system for promotion in both tenure and clinical track are out of alignment in the health professions.

4. Clinical faculty do not have the same freedoms that tenure track faculty in principle enjoy. Clinical faculty are at-will employees brought in on a year-to-year basis. They are therefore poorly positioned to exercise the free expression that all academic institutions must encourage and defend. At a time when all faculty at U-M are under scrutiny, it's important that the institution be clear that the protections of academic freedom apply to clinical faculty. Clinical faculty also need institutional support for engaging in a healthy academic dialogue within an environment where ideas can be contested without fear of rejection. Academic health professionals, in

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particular, need institutional support for practicing evidence-based medicine. If we fail to recognize how academic freedom extends also to Clinical faculty, we risk stifling innovation and losing our ability to provide the excellent clinical services that individuals come to us to provide.

5. Because clinical faculty are in large part "on the clock" when it comes to pay (as discussed above), it is difficult—and costly—for them to carve out time for university or college-level service work. The time that clinical faculty spend serving on Senate Assembly committees, for example, is time that they might otherwise spend in clinic, seeing patients and earning income. There is a strong financial disincentive for clinical faculty who wish to volunteer for work in faculty government. In the long run, this will lead clinical faculty to disinvest their time and energy in shared governance. Can the University find a means (beyond goodwill) of compensating clinical faculty engaged in the work of shared governance?

6. There is a significant pay disparity between clinical faculty and tenure track faculty that is not obvious from reviewing published salaries. A comparison of published pay scales makes it appear as though clinical faculty and tenure track faculty are paid roughly equally. But tenure track faculty serve on 9-month contracts, while in some schools clinical faculty serve on 12-month contracts. Clinical faculty are also not equally compensated for overload teaching. Tenure track faculty receive flat rates per credit hour while clinical faculty may receive a percentage calculation based only on their teaching load, providing them with less compensation than LEOs and Adjuncts for teaching the same class. UM Clinical faculty salaries should also be compared to Clinical faculty salaries at peer institutions. The disparities of compensation are even more apparent in some departments than others. At Michigan Medicine, where clinical faculty are based on RVUs, the dollar amount of an RVU can vary dramatically between departments, even for substantially similar work, causing certain fields (e.g., Pediatrics) to be even more undercompensated when compared to tenure-track faculty or to Clinical faculty at other institutions.

   There is also a disparity in general well-being. Clinical faculty are often working with clients and teaching courses that expose them to adverse physical and mental health conditions. However, Clinical faculty generally enjoy fewer vacation days and less flexibility in schedules, leading to less time to recuperate from oftentimes mentally and physically taxing work. They also face workspace challenges, such as not being afforded their own

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designated desk/workspace and needing instead to rent a shared space, with the cost coming out of the Clinical faculty member's compensation.

After speaking with Clinical faculty over the course of the academic year, drafting this report, sharing an earlier draft of this report for feedback from all of the UM Clinical faculty, and engaging in review of that feedback, we suggest the following points of focus for the Faculty Senate leadership to pursue:

- The mismatch many Clinical faculty reported between their work and the requirements governing their promotion, especially for faculty with heavy clinical or teaching work;
- Reports of excessive Clinical faculty workloads, leading to difficulties in recruitment and retention of junior faculty;
- Concerns that the University disincentives Clinical faculty service, such as faculty governance;
- Various disparities that Clinical faculty report as existing between faculty tracks, including in compensation, availability of sabbaticals, research support, recognition of research excellence, academic freedom, and support for their well being.

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