Understanding the Needs and Concerns of Senior Faculty in Academic Medicine: Building Strategies to Maintain This Critical Resource

Jeffrey Stearns, MD, Kelly M. Everard, PhD, Craig L. Gjerde, PhD, Marjorie Stearns, MPH, and William Shore, MD

Abstract

Purpose
The average age of medical school faculty is increasing, with 30% over age 55 in 2007. In 2012, 56% of Society of Teachers of Family Medicine (STFM) members were at least 50 years old. The authors sought to identify the transition and faculty development needs of this group of senior faculty.

Method
In 2012 the authors electronically surveyed 1,708 U.S. STFM members who were 50 or older, asking about demographics, highest degree, primary employer, career options considered in the previous year, issues of concern, mentoring needs, retirement plans, and likely activities in retirement.

Results
The response rate was 45%, with 73% MD/DOs, 62% men, 89% white, and 64% employed by academic institutions. The most frequent issues of concern were balancing personal and work time (67%), maintaining health (66%), and planning for retirement (60%). Nearly a third had considered career advancement, changing employers, or reducing full-time employment. Fifty-one percent were not receiving mentoring of any kind, but 47% reported they would like to have a mentor. Sixty-four percent were planning to retire; in retirement, 75% said they would like to remain active in teaching and 55% in mentoring.

Conclusions
Senior faculty in family medicine have significant career concerns and mentoring needs as they approach retirement, and these faculty can be valuable resources after retirement. As the age of faculty continues to rise, medical schools and specialty organizations can develop specific programs to meet the needs of these medical educators and better use this expertise in a time of limited resources.

Medical school faculties are aging. In 1967, when many professionals were retiring at the age of 65, the average faculty member was 41.7 years old, and only 9% of faculty members were over 55. In 1978, Congress enacted the Age Discrimination in Employment Act, which immediately abolished mandatory retirement before age 70 and, in 1986, abolished mandatory retirement altogether. Since then, the average age of medical school faculty has risen, to 44.7 in 1987 and 48.5 in 2007, and the percentage of medical school faculty over age 55 has grown, to 19% in 1987 and 29% in 2007.[1] This phenomenon and its meaning, for the faculty members as well as their institutions and the enterprise of medical education, is important to understand and address.

The literature on the specific needs, attitudes, and intentions of senior medical education faculty is not abundant, but we can find valuable information in wider studies. Corrice and colleagues,[2] for example, in their discussion of faculty retention at U.S. medical schools, described issues related to satisfaction with the quality and function of patient care and various aspects of the workplace culture. When Pololi and colleagues[3] surveyed 4,500 full-time faculty at 26 medical schools, they discovered that a quarter of the faculty were considering leaving academic medicine because of negative perceptions of their work culture, including absence of community, feelings of moral distress, and lack of engagement. In this era of resource challenge, understanding the dissatisfaction of faculty, both senior and otherwise, can help create strategies to retain these faculty as "medical school investments."

In research on faculty in higher education in general, Russell[4] notes that faculty have grown less satisfied over the past few decades and that senior faculty (defined as those with tenure), because they make up more than 50% of the professoriate, can significantly impact an institution's vitality. Factors that affect retention of senior faculty include respect for academic leadership, access to sufficient resources, a culture of collegiality, a competitive pay structure based on performance, autonomy and intellectual challenge, and workload satisfaction. Studies by Bland and Bergquist[5] and others confirmed that work–life activities and needs of midcareer and senior college faculty members are different from those

Dr. Stearns is professor of family and community medicine, University of Wisconsin School of Medicine and Public Health, Milwaukee, Wisconsin.

Dr. Everard is assistant professor, Department of Family and Community Medicine, Saint Louis University, St. Louis, Missouri.

Dr. Gjerde is professor emeritus of family and community medicine, University of Wisconsin School of Medicine and Public Health, Milwaukee, Wisconsin.

Ms. Stearns is clinical assistant professor, Department of Family Medicine, University of Wisconsin School of Medicine and Public Health, Milwaukee, Wisconsin.

Dr. Shore is professor of clinical family and community medicine, University of California, San Francisco, San Francisco, California.

Correspondence should be addressed to Dr. Stearns, 1020 N. 12th St., Suite 5120, Milwaukee, WI 53233; telephone: (414) 219-7467; fax: (414) 219-7044; e-mail: Jeffrey.Stearns@aurora.org.

Acad Med. 2013;88:1927–1933.
First published online October 14, 2013
doi: 10.1097/ACM.0000000000000010

Supplemental digital content for this article is available at http://links.lww.com/ACADMED/A165.

of junior faculty.[5] Seldin[6] found that midcareer and senior faculty members are frequently in transition with regard to how they spend their time, what products they generate, and the goals on which they focus. Berberet and colleagues[7] surveyed all university faculties, confirming that midcareer and senior college faculty have some common mentoring needs, including a desire for intellectual inquiry and flexibility to focus on their own areas of professional interest.

Faculties at nursing schools are also aging, which may be a contributing factor to the shortage of nurses. Falk[8] has suggested a series of commonsense solutions: building and sustaining a desirable work environment, acknowledging work value, setting realistic role expectations, and fostering job satisfaction. Intergenerational teaching and learning, workplace flexibility options, and reviewing and revising policies related to retirement are possible implementation strategies.

Asked explicitly by Perlmutter[9] and implied through much of the literature on senior faculty is an interesting metaphorical question: Are senior faculty "deadwood" (nonproductive consumers of limited resources who prevent the advancement of their juniors) or "icebergs" (deep, fresh sources of energy, wisdom, and experience)? To start answering this question, we secured a grant from the Society of Teachers of Family Medicine (STFM) Foundation. In 2012, 56% of STFM members were 50 years of age or over (of the 68% of STFM members who indicated their age). We sought to better understand the needs and challenges of these senior STFM faculty. In this article, we report on a variety of critical issues for senior faculty in family medicine and suggest retention strategies that will enable them to continue to be valuable resources, adding to the vitality of their institutions.

Method

In 2008, three of the authors surveyed senior faculty in family medicine[10]; on the basis of those findings, we conducted an updated survey in 2012. Our study also used data collected by the Council of Academic Family Medicine Education Research Alliance, and it was approved by the American Academy of Family Physicians' institutional review board.

Using Survey Monkey, we sent e-mail invitations to participate in the survey to U.S. STFM members who indicated that they were aged 50 or older (not required data in profile) and who had e-mail addresses on their STFM membership profile. Altogether, we sent 1,708 invitations with links to the survey; none of the e-mails were returned as undeliverable. The initial e-mails went out in January 2012; we sent the first follow-up e-mail two weeks later, and a second follow-up a month after that. We offered no incentives for completing the survey.

The survey consisted of 24 questions (see Supplemental Digital Appendix 1, http://links.lww.com/ACADMED/A165). We collected demographic data on age, gender, and race. To further characterize our sample, we asked questions regarding highest degree attained, year of first volunteer and paid faculty appointments, primary employer, and past and current administrative roles. To understand the needs of senior faculty, we asked questions about career options they had considered in the last year and issues that most concerned them at this stage in their careers. We also asked questions regarding mentoring and participation in STFM activities. We asked whether respondents were planning to retire and what activities they were likely to engage in during their retirement years.

Means and percentages were calculated for demographic and other variables used to characterize the sample. The chi-square statistic was used to examine the associations between variables of interest with age, gender, and type of employer. Four age groups were used: 50–54, 55–59, 60–64, and 65+. Type of employer was categorized as either academic/university or community for the chi-square analyses.

Results

We received 768 completed questionnaires of the 1,708 we sent, for a response rate of 45%. Two respondents reported having retired, so they were excluded from further analyses. The respondents were mostly male (478; 62%), white (681; 89%), and in the 55–59 age group (257; 33%). The response group was similar to that of the larger STFM population in terms of gender, race, and age (Table 1). The mean number of years a respondent had served as faculty was 21.9 (SD = 8.74); 176 (23%) had started as volunteer faculty. The mean number of years as volunteer faculty before becoming paid faculty was 7.9 (SD = 5.89). See Table 2 for degrees, employers, and administrative roles of the respondents.

Career options considered and issues of concern

The career or employment options respondents had most frequently considered in the past year were advancing their career (221; 29%), changing their employer (220; 29%), cutting back from full-time employment (208; 27%), and decreasing clinical time (194; 25%). The issues that most frequently concerned respondents at this stage in their lives were balancing personal and work time (514; 67%), maintaining health (503; 66%), and planning for retirement (459; 60%). Regarding participation in STFM activities, participants were interested in receiving small-group or personal mentoring at meetings (234; 31%), receiving electronic communications from STFM (229; 30%), and participating in special interest groups on retirement planning (214; 28%) and career transitions (186; 24%).

Age differences

To examine age differences, we combined age groups into two categories: ages 50–59 and ages 60 and older. Results for career options considered in the past year by age group can be found in Table 3. The career options most frequently considered for the younger age group were advancing their career and changing employers. The career options most frequently considered by respondents in the older age group were retiring and cutting back from full-time employment. There were no significant associations between age group and considering stepping down from a leadership position or decreasing clinical time.

We found associations between age groups and issues that concerned them at this stage in their lives (Table 3). The significant issues that most frequently concerned respondents in the younger age group were balancing personal and work time and advancing their career.

Table 1
Demographics of Senior Faculty Members of the Society of Teachers of Family Medicine (STFM) Invited to Participate in a Survey, 2012

Characteristic	No. (%) of 1,708 invitees*	No. (%) of 766 respondents†
Age group		
50–54	435 (25.4)	211 (27.5)
55–59	581 (34.0)	257 (33.6)
60–64	467 (27.3)	192 (25.1)
65+	225 (13.1)	80 (10.4)
Did not respond	0 (0.0)	26 (3.4)
Gender		
Male	987 (57.8)	478 (62.4)
Female	504 (29.5)	260 (33.9)
Did not respond	217 (13)	28 (3.7)
Race/ethnicity		
White	437 (87.5)	681 (88.9)
African American	11 (2.2)	15 (2.0)
Asian	20 (4.0)	15 (2.0)
Did not respond	1,209 (71)	50 (6.5)

*Age is not required profile data in STFM profiles; of the 68% of STFM members who indicated age in their profile, 1,708 (56%) were ≥50 years old.
†768 STFM members responded to the survey; two of those had already retired and so were eliminated from the analysis.

Respondents in the older age group were most concerned about planning for retirement and decreasing their hours. There were no age group associations with concerns for building a legacy, finding a mentor, creating a new niche, or maintaining health.

Employer differences and gender differences

To further characterize our sample, we used the chi-square statistic to examine the associations of employer and gender with career options considered and issues of concern in the past year. Respondents employed by academic medical centers or universities were more likely than those employed in community settings to consider advancing their career (115 [33%] versus 65 [25%]; $P = .029$) and changing employers (153 [32%] versus 64 [24%]; $P = .028$). There were no associations between employer and seeking a career outside of academics, changing positions within the institution, stepping down from a leadership position, decreasing clinical time, increasing clinical time, considering retirement, or cutting back on full-time employment. Respondents employed by academic health centers or universities were more likely to be concerned about advancing their career than those employed in community settings (116 [25%] versus 46 [18%]; $P = .033$). No other issues of concern were associated with employer.

There were no associations between gender and career options that respondents considered in the past year. However, women were more likely than men to express concerns about finding a mentor (19 [7%] versus 14 [3%]; $P = .008$). Men were more likely than women to be concerned about financial planning for retirement (263 [55%] versus 121 [47%]; $P = .031$).

Mentoring

We asked senior faculty about the areas in which they were receiving mentoring and the areas in which they would like mentoring (see Table 4). The mentoring they most frequently received was for leadership (160; 21%). Whereas 393 (51%) respondents reported that they were not receiving mentoring of any kind, 185 (47%) of those reported that they would like to. The most frequently desired type of mentoring was for career advancement (213; 28%). The plurality of mentors (220; 29%) was found outside of the respondents' institution; however, 206 (27%) reported that their mentors were located within their department, and 111 (15%) stated that their mentors were in a different department within their institution. The most frequent method that senior faculty used to connect with mentors was in person (328; 43%), followed by e-mail (214; 28%), telephone (149; 20%), non-STFM conferences (112; 15%), and STFM conferences (80; 10%).

When looking at mentoring received and desired by type of employer, we found no associations for types of mentoring received. Senior faculty employed by academic medical centers were more likely to desire mentoring for balancing their work and personal life (93 [20%] versus 36 [14%]; $P = .044$). There were no other associations between mentoring desired and type of employer.

Balancing personal and work time

Because the issue of concern most frequently cited by senior faculty was balancing life and work, we used chi-square statistics to examine the association between that concern and career options considered in the past year. Senior faculty who expressed life balance concerns were more likely than those who didn't express such concerns to consider changing their employer (170 [33%] versus 50 [20%]; $P < .0001$), seeking a career outside of academics (122 [24%] versus 34 [14%]; $P = .001$), changing positions with the same employer (127 [25%] versus 40 [16%]; $P = .005$), stepping down from a leadership position (134 [26%] versus 31 [12%]; $P < .0001$), decreasing clinical time (152 [30%] versus 42 [17%]; $P < .0001$), increasing clinical time (66 [13%] versus 17 [7%]; $P = .013$), and cutting back on full-time employment (164 [32%] versus 44 [18%]; $P < .0001$).

Retirement activities

Most of our respondents (489; 64%) reported that they were planning to retire. The average age of planned retirement was 66.6 years (SD = 3.8), with a range of 55 to 85. When asked in which areas associated with their profession they would like to remain active, most reported teaching (365; 75%) and mentoring (267; 55%). Other areas were clinical work (197; 40%), professional organizations (171; 35%), research (92; 19%), and admissions committees (50; 10%). Thirty-one (6%) said they would not remain active in any of these areas. Men were more likely than women to want to continue teaching (243 [78%] versus 121 [70%]; $P = .049$) and doing research (70 [22%] versus

Table 2

Degrees, Employers, and Administrative Roles of 766 Senior Faculty Members of the Society of Teachers of Family Medicine Who Responded to a Survey, 2012

Characteristic	No. (%)
Highest degree	
MD or DO	558 (72.8)
MD and PhD	14 (2.2)
Other doctorate	125 (16.3)
Master's degree	57 (7.4)
Bachelor's degree	9 (1.2)
Primary employer	
Academic/university	473 (63.6)
Community	262 (35.2)
Government	9 (1.2)
Current administrative role	669 (87.3)
Unit director	252 (32.9)
Residency director / associate residency director	142 (18.5)
Clerkship director / director of medical student education	90 (11.7)
Chair	84 (11.0)
Clinic director	69 (9.0)
Vice chair / associate chair	62 (8.1)
Dean / assistant dean	57 (7.4)
Past administrative role	673 (87.9)
Unit director	332 (43.3)
Residency director / associate residency director	280 (36.6)
Clinic director	264 (34.5)
Clerkship director / director of medical student education	212 (27.7)
Chair	153 (20.9)
Vice chair / associate chair	146 (19.1)
Dean / assistant dean	79 (10.3)

[13%]; $P = .011$) when they retired. There were no associations between gender and the other areas. Senior faculty who were employed by academic medical centers were more likely to report that they would remain active in research when they retired (75 [24%] versus 17 [10%]; $P < .0001$) than those working in community settings. There were no other associations between retirement activities and employer type.

We also asked senior faculty who were planning on retiring to identify ways in which they would like to remain active in STFM activities after they retired. The most frequent choices were receiving communications and reports (238; 49%) and reading journals (226; 46%). Less frequent responses were to attending meetings (141; 29%), participating in special interest groups (119; 24%), and participating in listserves or blogs (112; 23%). In contrast, 124 (25%) said they did not plan on participating in STFM when they retired. Senior faculty employed by academic medical centers were more likely than those working in community settings to report that they would remain active in STFM by receiving communications (174 [55%] versus 61 [37%]; $P < .0001$), attending meetings (103 [32%] versus 37 [22%]; $P = .026$), and participating in blogs or listserves (83 [26%] versus 29 [17%]; $P = .040$). Senior faculty employed in community settings were more likely than those in academic settings to say that they did not plan on participating in STFM when they retired (57 [35%] versus 65 [21%]; $P = .001$). We found no associations between gender and planning to participate in STFM after retiring.

Discussion

Baldwin and colleagues[11] studied midcareer, tenured faculty and department chairs to ascertain issues affecting job satisfaction and to make recommendations for improving the work environment. Although their study omitted faculty of professional schools, such as clinical medicine and legal practice, to "minimize the influence of confounding variables," the overlap of our study group with theirs is likely sufficient for us to build on their insights. Among the challenges they defined were expectations of the department and the university, "neglect" (midcareer faculty get less attention), relief (tenure achievement removes pressure), "what's next?" adapting to change, and unclear goals. They developed a useful structure to categorize "promising practices" for the institution, for personnel and promotion/tenure committees, for department chairs, and for the faculty person. Adopting this structure, we will comment on possible strategies relating to senior faculty, based on the findings of our survey and reflections from the literature.

One opportunity falls within training and development. Senior faculty desire mentoring, so institutions or departments may want to establish competency-based mentoring programs for senior faculty. Mentoring has traditionally been offered to more junior faculty, but our survey revealed that, of the respondents who did not have mentors (>50%), nearly half of those wanted one, particularly related to career advancement and balancing work and personal lives. This request was more prevalent among the academic faculty responders. Senior faculty who expressed concern about balancing their work and personal lives were more likely to be those who had considered changing employers, seeking a career outside of academics, changing positions within the same employer, stepping down from leadership positions, decreasing clinical time, increasing clinical time, or cutting back on full-time employment in the last year. Many of these considerations that senior faculty had in the past year involved leaving or changing a job. This situation can be costly for institutions, not only financially, but also in terms of resources such as knowledge base and experience. Institutions could provide programs to senior faculty who are looking for mentors; this would not only benefit the senior faculty but also the institution, the junior faculty, and the learners.

A second promising institutional practice suggested by our study relates to retirement planning. A survey at the Stanford School of Medicine of faculty who were 50 and older found that 47% had not engaged in personal financial planning and lacked information on topics relevant to retirement.[12] This included understanding Stanford's actual retirement process and the implications of cutting back in areas of work, such as research. In our current survey, nearly a quarter of faculty had considered retirement in the past year, and over half indicated that planning for retirement and financial planning were areas of concern. Two areas might be foci: educating senior faculty about the actual rules of the institution regarding retirement, as well as addressing the realities of finances and support for retirement. (Subsequent to their study, Stanford implemented this education process.) Courses on the process and implications of retirement might also be useful. Whereas Baldwin and colleagues[11] suggested that the home institution could provide these resources, it is possible that national institutions, such as STFM or the Association of American Medical

Table 3

Differences by Age in Career Options Considered and Issues of Concern in the Past Year by 740* Senior Faculty Members of the Society of Teachers of Family Medicine (STFM) Who Responded to a Survey, 2012

Variable	Age groups: No. (%) of 468 STFM members aged 50–59	Age groups: No. (%) of 272 STFM members aged ≥60	*P* value
Career options considered			
Advancing career	172 (36.8)	45 (16.5)	<.0001
Seeking career outside academics	116 (24.8)	39 (14.3)	.001
Changing employer	164 (35.0)	56 (20.6)	<.0001
Cutting back full-time employment	114 (24.4)	94 (34.6)	.004
Decreasing clinical time	128 (27.4)	64 (23.5)	.260
Seeking different position with same employer	122 (26.1)	44 (16.2)	.002
Increasing clinical time	64 (13.7)	19 (7.0)	.005
Retiring	67 (14.3)	106 (39.0)	<.0001
Stepping down from leadership	101 (21.6)	64 (23.5)	.583
Issues of concern			
Advancing career/promotion	129 (27.6)	29 (10.7)	<.0001
Balancing personal and work time	343 (73.3)	169 (62.1)	<.002
Building my legacy	127 (27.1)	85 (31.3)	.239
Creating a new niche	112 (23.9)	49 (18.0)	.065
Decreasing my full-time employment	72 (15.4)	70 (25.7)	.001
Planning financially for retirement	241 (51.5)	144 (52.9)	.760
Finding a mentor	25 (5.3)	8 (2.9)	.087
Losing my role identity	56 (12.0)	60 (22.1)	<.0001
Maintaining my health	314 (67.1)	187 (68.8)	.684
Planning for retirement	267 (57.1)	189 (69.5)	.001

*Of 766 respondents to the survey, 740 indicated their age.

Colleges (AAMC), could also provide offerings in these areas.

Our data indicated that 489 (64%) respondents planned to retire, and 293 (60%) of these indicated that they had concerns about planning for retirement. There is no databank or resource that compares retirement benefits and plans at different academic institutions.[13] Institutions offer a wide variety of retirement contribution plans to faculty during their years of employment. Some institutions allow faculty to return to work after retirement, often at less than full-time, while they continue to receive retirement benefits and salary. Other institutions pay a salary but offer no benefits to reemployed retirees. There may be a mandatory period of no-work separation before the person can be rehired. Any rehiring is typically done at the discretion of the department head; thus, not all retirees who want it are offered reemployment. With such great variability among retirement plans and benefits at academic institutions, and because these conditions change frequently, senior faculty should regularly, perhaps annually, check with their respective retirement offices to keep current on their retirement benefits and options. Larger institutions hold general retirement information sessions to assist faculty in keeping current about retirement plans and benefits. Given that faculty contracts may involve variable components of clinical compensation, research, administration, and education, one retirement construct may be different from others. Information sessions might be best handled one-on-one with appropriate experts as the retirement time approaches.

Linked with understanding of the institutional rules governing retirement, institutions might take a serious look at developing creative options for work flexibility in terms of hours, types of appointments, and defined opportunities for "retired" faculty to return to teach, mentor, or do clinical work. One example of this, implemented by the University of North Carolina (UNC), is the UNC Phased Retirement Program.[14] According to a survey in 2003, the program is fulfilling its dual purposes of providing UNC faculty members an opportunity to transition into retirement gradually and improving UNC institutions' personnel planning related to retirements. Although not a standard area of focus for faculty development or mentoring in medical education, both our survey and the Stanford survey suggest that support for senior faculty relating to retirement and financial planning may be a productive endeavor. These institutional practices have implications for department chairs, personnel and promotion committees, and the individual faculty members.

Department chairs can engage senior faculty during the annual review process. Far too often, such reviews are poorly structured and unfocused, and therefore less than useful for senior faculty. Reviewing current areas of interest, setting goals for the next time period, and delineating tasks that serve the individual, the department, and the institution can

Table 4

Types of Mentoring Received and Desired by 766 Senior Faculty Members of the Society of Teachers of Family Medicine Who Responded to a Survey, 2012

Mentoring type	No. (%) received	No. (%) desired
Leadership	160 (20.9)	164 (21.4)
Career advancement	111 (14.5)	213 (27.8)
Research	89 (11.6)	113 (14.8)
Financial planning	86 (11.2)	119 (15.5)
Education	67 (8.7)	72 (9.4)
Life balance	62 (8.1)	131 (17.1)

be accomplished in a more purposeful and outcome-oriented way. Eliciting a better understanding of the satisfaction level, challenges, and goals of each senior faculty not only renews their focus and engagement but also adds to the vitality of the department. Personnel and promotion committees need to consider and be willing to negotiate flexible work options for their growing group of senior faculty.

Nevertheless, department chairs have competing priorities and may not be able advocate for the senior faculty person. Hall[15] reported that, in Canada, pediatric chairs felt constrained from supporting their senior faculty members by institutional pressures for space, salary monies, and the need to recruit new faculty members. Although the chairs recognized the value of the skills and expertise of senior pediatricians, they did not often use them after the age of "retirement." If programs want to allow clinically inactive physicians to return to active practice, they will need both to ensure the appropriateness of the clinical skills and to negotiate the work-level satisfaction of senior physicians.

Of our respondents, 40% indicated that they would like to do clinical work after retirement. However, our survey did not differentiate between clinicians who were clinically active versus inactive. In a study of retired and inactive physicians, Jewett et al[16] found that 83% of them thought it would be difficult to reenter practice; among the physicians who had reentered practice, 35.9% reported it was difficult. In 2011, the American Medical Association (AMA) House of Delegates Senior Physicians group discussed policies for senior physicians and developed a list of licensing requirements (which varied by state) for physicians who have been out of clinical practice for an extended time.[17] The AMA has published a monograph, "Physician Re-entry to the Workforce: Recommendations for a Coordinated Approach," working with leaders in licensure, board certification, and medical education as well as directors of reentry programs.[18] Among these recommendations is a call to educate medical students, residents, faculty, and practicing physicians on career-planning strategies and resources, should they need to take a hiatus from clinical practice. Although employing retired physicians could address some physician shortage issues, the overriding public concern relates to continued clinical competence following a period with significant focus on education, administration, or research activities.

Finally, the senior faculty themselves will need to explicitly reflect on their personal needs, strengths, and opportunities to engage in meaningful academic and clinical activities. It is imperative that this discussion (like creating an advance directive) take place at multiple levels in an open, nonjudgmental, and meaningful manner.

The clearest limitation of our survey is that it involved only family medicine educators who were members of STFM. It would require further studies more broadly in academic medicine to understand whether the issues and concerns of teachers in family medicine were similar to those of their colleagues in other specialties, administration, or in the basic sciences. Family medicine training started in the early 1970s; many of the first residency graduates and still a few early faculty are just now nearing retirement age. This is not true for most other disciplines. When four of the authors presented preliminary findings at the 2012 AAMC annual meeting in San Francisco by leading a small-group discussion, attendance was larger than anticipated, and individuals from many specialties and academic roles and institutions were present.[19] This suggests that these challenges are more broadly common among senior faculty in academic medicine. The current literature regarding senior faculty in medicine is limited, providing future opportunities for research.

Conclusions

With the reality of the aging of faculty in U.S. medical schools, it becomes increasingly important to understand the hopes and concerns of these colleagues. In our era of increasingly constrained resources for medical education and growing medical school enrollment to address the physician shortage, the percentage of senior faculty—those approaching retirement—is increasing. As in nursing, a shortage of medical educators may limit the rate at which we can expand the physician workforce. Over time, there has been a huge investment in these senior faculty as a resource for clinical productivity, teaching, and research. It is encouraging that our survey showed that a high percentage of STFM senior faculty wanted to remain active in teaching and mentoring after retirement, as well as in clinical work.

Although our survey queried senior faculty in family medicine who belong to STFM, there are likely generalizable lessons for medical school faculty. The results of this survey have raised a number of points that may improve our understanding of senior medical school faculty and point to strategies and areas of research that enable us to better understand their hopes and concerns.

In these times of economic uncertainty, changing retirement benefits, and dwindling institutional resources, the issues of faculty nearing retirement will likely be great and in flux for the foreseeable future. Institutions should address these concerns and benefit from the high percentage of senior faculty members who report that they want to remain after retirement. These individuals represent an important resource to our teaching communities. Both academic institutions and specialty professional organizations need to find new mechanisms to engage senior faculty's expertise and experience in meaningful and mutually fulfilling ways.

Funding/Support: Funding for this study was provided by the Society of Teachers of Family Medicine Foundation.

Other disclosures: None.

Ethical approval: Ethical approval was granted by the American Academy of Family Physicians IRB.

Previous presentations: Data were presented at the Association of American Medical Colleges Annual Meeting, San Francisco, California, November 6, 2012.

References

1 Alexander H, Liu CQ. The aging of full-time U.S. medical school faculty: 1967–2007. AAMC Analysis in Brief. October 2009;9:1–2.
2 Corrice AM, Fox S, Bunton SA. Retention of full-time clinical M.D. faculty at US medical schools. AAMC Analysis in Brief. February 2011;11:1–2.
3 Pololi LH, Krupat E, Civian JT, Ash AS, Brennan RT. Why are a quarter of faculty considering leaving academic medicine? A study of their perceptions of institutional culture and intentions to leave at 26 representative U.S. medical schools. Acad Med. 2012;87:859–869.
4 Russell BC. Stress in senior faculty careers. New Dir Higher Educ. Autumn 2010:61–70.
5 Bland CJ, Bergquist WH. The vitality of senior faculty members: Snow on the roof—

fire in the furnace. ASHE-ERIC Higher Educ Rep. 1997;25(7). http://www.ericdigests.org/1998-2/snow.htm. Accessed April 1, 2013.
6 Seldin P. Tailoring faculty development programs to faculty career stages. In: Chadwick-Blossey S, Robertson DR, eds. To Improve the Academy: Resources for Faculty, Instructional and Organizational Development. Bolton, Mass: Anker; 2006:137–146.
7 Berberet J, Brown BE, Bland CJ, Risbey KR, Trotman CA. Planning for the generational turnover of the faculty: Faculty perceptions and institutional policies. In: Clark RL, Ma J, eds. Recruitment, Retention, and Retirement in Higher Education: Building and Managing the Faculty of the Future. Cheltenham, UK: Edward Elgar; 2005:80–100.
8 Falk NL. Strategies to enhance retention and effective utilization of aging nurse faculty. J Nurs Educ. 2007;46:165–169.
9 Perlmutter DD. The senior professor: Deadwood or iceberg? Chron Higher Educ. July 30, 2010:B49–B51.
10 Shore WB, Gjerde C, Stearns JA, Frey JJ 3rd. Mentoring and career transition needs of senior faculty in family medicine. Fam Med. 2010;42:466.
11 Baldwin R, DeZure D, Shaw A, Moretto K. Mapping the terrain of mid-career faculty at a research university: Implications for faculty and academic leaders. Change. September/October 2008. http://www.changemag.org/Archives/Back%20Issues/September-October%202008/abstractmapping-the-terrain.html. Accessed April 1, 2013.
12 Stanford School of Medicine. Task force and survey report. August 25, 2008. http://med.stanford.edu/academicaffairs/senior-faculty/task-force.html. Accessed April 1, 2013.
13 Personal communication, University of California, Office of the President: March 2013.
14 Brown BE. Report to the Personnel and Tenure Committee, UNC Board of Governors. Survey of Phased Retirement Program Participants. November 11, 2004. http://www.northcarolina.edu/reports/index.php?page=download&id=183&inline=1. Accessed April 1, 2013.
15 Hall JG. The challenge of developing career pathways for senior academic pediatricians. Pediatr Res. 2005;57:914–919.
16 Jewett EA, Brotherton SE, Ruch-Ross, H. A national survey of "inactive" physicians in the United States of America: Enticements to reentry. Hum Resour Health. 2011;9:7. http://www.human-resources-health.com/content/9/1/7. Accessed April 1, 2013.
17 Stagg Elliott VS. AMA seeks clear path for doctors' re-entry into medicine. Am Med News. February 28, 2011. http://www.amednews.com/article/20110228/business/302289973/2/. Accessed April 1, 2013.
18 American Medical Association. Center for Transforming Medical Education. Physician Re-entry to the Workforce: Recommendations for a Coordinated Approach. 2010. Monograph 10-0509:12/10. http://www.ama-assn.org/ama1/pub/upload/mm/40/physician-reentry-recommendations.pdf. Accessed April 1, 2013.
19 Stearns JA, Gjerde CL, Shore W, Muller J. Senior faculty in medical education: Resource and/or challenge? Small group discussion at AAMC Annual Meeting; 2012; San Francisco, Calif.