

# School of Medicine Compensation Guidelines

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The University appropriately asks that each Department and Center articulate compensation guidelines. Indeed, a requirement for such is specifically described in the Faculty Handbook. In turn, there needs to be consistency among these compensation policies within the School of Medicine. This document is an attempt to define the principles that drive compensation decisions throughout the School. An individual department or center may either adopt these guidelines as is, or they can adapt and build on them for their individual departmental policy.

The School of Medicine comprises substantial heterogeneity across departments and centers in terms of size, composition and responsibilities. For example, the clinical departments differ from the basic science departments in having practice plans that contribute to the overall compensation of faculty. Therein a first **principle** is *that any compensation policy refer to all components of a faculty member's salary—IU, practice plan, VA, etc.* However, the University's responsibilities under tenure and tenure track apply only to the Indiana University component of the salary. A second **principle** is *that a faculty member's total compensation should be aligned with productivity.* This principle mandates a third **principle** *that faculty are accountable for their time*, which will be allocated among different academic missions. They should be productive in all areas of the academic mission according to their faculty track. Faculty members in the tenure track are expected to be active in all three academic missions and faculty in the clinical track are expected to be active in two of the three missions. Linking compensation to expectations of productivity implies that compensation can vary in both directions; namely, there can be both increases and decreases in overall compensation.

How does one decide appropriate compensation? A fourth **principle** is *that overall compensation should be determined by three factors:*

1. *External equity:* Faculty at the IU School of Medicine should be paid comparably to their peers at other academic institutions in the Midwest and the nation. Department specific data therein are readily available through surveys such as those from AAMC and MGMA. The external marketplace is dynamic and can move this frame of reference upwards or downwards. This means that an increase in the external marketplace may require substantial increase in compensation to remain competitive for top faculty. It also means that decreases in the external marketplace may result in decreases in compensation. External equity also means that compensation levels will differ among specialties; for example, a cardiovascular surgeon today makes considerably more than a primary care physician because of the marketplace and reimbursement system in which we operate. We do not control these external forces, but we must be responsive to them.

2. *Internal equity*: Faculty of similar rank, seniority and productivity should be compensated similarly. This does not mean that a surgeon and a biochemist of similar rank and seniority have the same compensation; such is precluded by the external equity frame of reference noted above.
3. *Merit*: Merit links productivity to compensation. Faculty who are productive should be rewarded appropriately. As noted above, productivity needs to be evaluated in multiple academic missions. This means that productivity in one area can be neutralized by lack of productivity in another. This also means that poor productivity can result in decreases in compensation. It also means that highly productive faculty will have greater increases in compensation than less productive faculty. The vital importance of merit in determining compensation also mandates a fifth **principle** *that each department must define the basis on which merit is defined*. These definitions will then become components of faculty annual reviews that translate to compensation. Determinants of merit may and probably will differ among departments. This fact emphasizes the importance of each department and center articulating the definition of merit so that faculty members know what is expected of them.

In defining merit/productivity expectations, the following are elements that should be considered:

1. Education:
  - a. Quantity
    - i. Lectures/didactics
    - ii. Clinical Attending
    - iii. Student, resident and postdoctoral trainee advising
    - iv. Graduate student dissertation committees
  - b. Quality/awards
  - c. Mentoring
  - d. Program development
  - e. Leadership
2. Research
  - a. Extramural support (success but also attempts)
  - b. Publications
  - c. Program development
  - d. Mentoring
  - e. Collaboration
  - f. Leadership
3. Service
  - a. Clinical
    - i. Patient satisfaction
    - ii. Referring physician satisfaction
    - iii. Co-worker/staff satisfaction

- iv. Team play
- v. Program development
- vi. Leadership
- vii. Mentoring
- viii. Resource utilization
- ix. Clinical productivity at all sites of practice
- b. Institutional
  - i. Committees
  - ii. Administrative responsibilities
  - iii. Leadership
- c. Professional organizations
- d. Community

Another issue that is particularly germane to clinical departments is the distribution of overall compensation among different salary sources. The focus of a compensation policy should be on overall compensation, not just one component. Each department may use different methodologies in determining the distribution among sources. For example, a faculty member who is primarily research-oriented might have more salary on the “IU check”, because this component of salary can be included on NIH grants and potentially be defrayed from extramural sources. Some departments may wish to develop formulas that drive the component of salary that derives from practice income. Finally, some may have combinations where a part of compensation is incentive-derived. Importantly, distribution among multiple compensation sources may vary over time. For example, a research-oriented faculty member may change focus and become more clinically oriented. Therein, the percentage of overall compensation that derives from an IU check may decrease and the absolute amount of dollars in the IU check may decrease. Assessing compensation in such a scenario obviously requires assessment of overall compensation, not just that which derives from IU, which in such cases can be misleading.