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EXPERIENCES OF MEDICAL FACULTY AS EDUCATORS AND PRACTITIONERS: IMPLICATIONS FOR EDUCATIONAL MANAGEMENT

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ABSTRACT

This qualitative study examined the experiences of eleven medical faculty members who simultaneously serve as clinicians and educators in selected Philippine medical schools, with emphasis on implications for institutional policy and educational management. Using purposive sampling and semi-structured interviews, the study employed reflexive thematic analysis following Braun and Clarke's six-phase approach to generate themes on faculty responsibilities, dual professional identity, workload strain, and the effects of institutional policies and support mechanisms. Findings highlight the multidimensional nature of clinician-educator work, persistent challenges in balancing academic and clinical duties, and the enabling or constraining role of policies on scheduling, workload, recognition, and welfare. The study recommends policy actions on workload rationalization, flexible scheduling and protected time, strengthened support and wellness programs, and promotion and reward systems that explicitly recognize educational contributions of clinician-educators in medical schools.

KEYWORDS: *Clinician-educators, dual professional identity, medical faculty workload, educational management, institutional support, faculty well-being, reflexive thematic analysis.*

INTRODUCTION

Contemporary medical education places increasingly complex expectations on faculty members. Beyond classroom instruction, medical faculty are often expected to supervise clinical training, assess learners, participate in curriculum planning, engage in scholarly activities, fulfill committee assignments, and maintain professional practice. Literature on medical educators has emphasized that the role of faculty extends across teaching, mentoring, assessment, role modeling, curriculum work, and institutional service, making it a broad and multidimensional professional undertaking (Brouwer et al., 2025). This complexity becomes more pronounced for clinician-educators whose academic work is closely intertwined with patient care responsibilities and who must balance educational commitments with the unpredictable demands of medical practice.

The need to examine the experiences of medical faculty members as both educators and practitioners emerges from this expanding role structure. Existing scholarship suggests that faculty perceptions of workload significantly influence morale, retention, and intent to stay in academic medicine. Recent evidence indicates that educators in medical schools often perceive their actual workload to exceed formally assigned effort across teaching, research, and service, reflecting possible inequities in workload distribution and recognition. Related studies also show that educational work is not always valued to the same degree as other institutional priorities, particularly when policies and reward systems emphasize clinical productivity or research output over teaching-related responsibilities (Pololi et al., 2015).

These conditions create important concerns for educational management. When medical faculty perform multiple overlapping roles without sufficient institutional recognition or support, the risk of role conflict, fatigue, and reduced professional sustainability may increase. Studies on faculty vitality and burnout in academic medicine have emphasized that institutional expectations, compensation structures, workload assignment, and promotion criteria can significantly affect faculty well-being and long-term engagement (Shah et al., 2018; Banerjee et al., 2023). Likewise, literature on educator support highlights the need for flexible scheduling, meaningful recognition, and systems that account for the actual time and effort required in educational work.

The rationale for the present study is further strengthened by the findings reflected in the current dissertation materials. The responses of the participants show that medical faculty responsibilities are not confined to lecturing but include assessment-related tasks, administrative and institutional functions, and clinical or practical supervision. The findings also indicate that many faculty members occupy an integrated professional identity as both educators and practitioners, yet experience this dual-role arrangement in different ways depending on workload, appointment structure, and personal circumstances. Moreover, participants described challenges related to schedule conflict, time pressure, workload strain, family-role tension, and uneven institutional support, all of which point to the need for closer inquiry into how medical faculty experience and manage their professional responsibilities.

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The present study is significant because it addresses a practical and underexamined concern in educational leadership within medical schools: how institutions understand, support, and manage faculty who operate simultaneously in academic and clinical domains. Although the literature has discussed clinician-educator roles, faculty workload, and burnout, there remains a need for qualitative inquiry that captures faculty members' own accounts of their responsibilities, challenges, and perceptions of institutional policy support in specific educational contexts. Such inquiry is particularly relevant in settings where medical faculty are expected to fulfill numerous institutional and professional duties while maintaining educational quality.

This study also responds to the need for context-sensitive evidence that may inform local institutional planning. The participants' accounts suggest that support mechanisms may be present in some forms yet remain inconsistent, limited, or poorly communicated across faculty contexts. In addition, the recommendations generated by participants point to a strong need for wellness-oriented support, greater flexibility, more explicit recognition of dual roles, and better compensation and promotion systems. These concerns imply that effective educational management should not be limited to assigning teaching loads; it should also involve strategic attention to policy design, faculty development, support systems, and role sustainability.

From a broader perspective, the study contributes to current conversations about faculty work in academic medicine. The literature increasingly recognizes that sustaining medical educators requires more than individual commitment; it also requires institutional structures that support faculty vitality, equitable workload, and professional growth. A realist review on clinicians as teachers further underscores that the dual role of clinician and teacher creates important value for institutions and learners but also depends on conditions that enable such roles to be sustained effectively (Brouwer et al., 2025). Similarly, guidance on clinician educator review criteria and faculty workload policies indicates that institutions need clearer systems for accounting for educational contributions and clinical teaching responsibilities (AAMC, 2025).

In this light, the present study is warranted both theoretically and practically. Theoretically, it deepens understanding of the lived realities of clinician-educators by identifying how their roles, challenges, and support experiences are organized within the context of medical education. Practically, it offers a basis for improving educational management by highlighting the institutional factors that shape faculty performance and well-being. By focusing on the experiences of medical faculty members as educators and practitioners, the study seeks to generate findings that may guide more responsive policies, better support systems, and more sustainable faculty engagement in medical schools.

MATERIALS AND METHODS

The study adopted a qualitative research design to explore the experiences and perspectives of medical faculty members who simultaneously serve as educators and practitioners. This design was suitable because the inquiry centered on participants' accounts of responsibilities, role challenges, workload demands, and perceptions of institutional policies and support, which required rich, contextual description rather than numerical measurement. The research was conducted in medical schools where the researcher had professional affiliation or legitimate access, chosen for their relevance to clinician-educator work rather than for institutional comparison.

Eleven clinician-educators were selected through purposive sampling based on the following criteria: they taught in a medical school accessible to the researcher, functioned as educators in medical education, were currently or recently engaged in medical practice, and voluntarily consented to participate. Data were generated through semi-structured interviews guided by questions aligned with the study objectives, covering usual responsibilities, dual-role experiences, difficulties in balancing academic and clinical duties, perceived most demanding tasks, institutional policy effects, available support mechanisms, and recommended policy improvements. Participants were informed of the purpose of the study, participation was voluntary, informed consent was obtained, and confidentiality was maintained using non-identifying labels.

Data were analyzed using reflexive thematic analysis following Braun and Clarke's six phases: familiarization, initial coding, construction of candidate themes, review and refinement, definition and naming of themes, and report production. Codes were developed from meaningful segments of interview responses and iteratively clustered into themes related to faculty responsibilities, dual-role identity, workload strain, institutional policy effects, support systems, and educational management implications. In line with the reflexive orientation of this method, themes were treated as interpretive constructions shaped by the research questions and the researcher's informed judgment, with rigor supported through systematic coding, careful theme development, and transparent reporting.

Role of the Researcher

In this qualitative study, the researcher acted as the primary instrument for data collection and analysis, selecting participants, conducting interviews, organizing responses, coding data, and developing themes in line with the study objectives. The research was conducted in medical schools where the proponent had professional affiliation or access, which facilitated recruitment but also required reflexive attention to how prior experiences and relationships might influence interpretation. Throughout the process, the researcher practiced reflexivity by grounding interpretations in the interview data and the methodological framework, treating subjectivity as an inherent element to be managed through transparency and critical self-awareness.

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Methods of Validation

To strengthen the trustworthiness of the study, assessed through credibility, transferability, dependability, and confirmability, several strategies were observed. Alignment was maintained among the title, research questions, interview guide, analytic procedures, and presentation of findings to ensure coherence. The researcher engaged in prolonged familiarization with the data through repeated reading and careful review of participant responses before and during coding and theme development, supporting credibility by staying close to participants' meanings. Verbatim excerpts were used in the results and discussion to demonstrate how themes were grounded in the data, thereby enhancing confirmability. In line with reflexive thematic analysis, the researcher practiced reflexive transparency, acknowledging subjectivity as integral to analysis and managing it through openness, theoretical consistency, and clear documentation of analytic decisions. Validation thus rested on coherence of analysis and consistency between data excerpts and interpretations.

Ethical Concern

Ethical considerations were strictly observed throughout the study. Participation was voluntary, and prospective participants were informed of the study's purpose, the nature of their involvement, and their right to decline or withdraw at any time without penalty. Informed consent was obtained prior to interviews, and confidentiality was protected through the use of non-identifying labels (e.g., Participant 1 to Participant 11), with no personally identifying details reported beyond what was necessary for interpretation. Given that the study involved professional colleagues or participants within institutions accessible to the researcher, particular care was taken to uphold voluntary participation, avoid coercion, respect professional boundaries, and use the data solely for academic research purposes. The researcher also remained sensitive to participants' professional roles, workload conditions, and institutional contexts, seeking to represent their experiences fairly, respectfully, and accurately, especially in discussing role strain, workload challenges, and institutional support concerns.

RESULTS

This study examined the experiences of medical faculty members who simultaneously function as educators and practitioners and analyzed their implications for educational management. The findings are organized by research question.

Usual responsibilities

Medical faculty responsibilities were found to be broad and multifaceted. Four themes emerged: instructional responsibilities, assessment-related tasks, administrative and institutional functions, and clinical or practical supervision. These show that faculty work extends beyond classroom teaching to include preparation and administration of assessments, curriculum and committee work, documentation and coordination, and direct supervision of students in laboratories and clinical settings. The role of medical faculty is therefore inherently multidimensional rather than purely instructional.

Faculty status and dual roles

Most participants identified themselves as both educators and medical practitioners, reflecting a dual professional identity. Two themes were derived: dual-role professional identity and differentiated faculty engagement. While many faculty members integrate academic and clinical roles, they do so under diverse arrangements (e.g., part-time faculty with full-time clinical practice, full-time faculty with reduced clinical practice). Thus, medical faculty generally occupy integrated academic–clinical roles, but the extent and structure of engagement vary.

Balancing faculty and practitioner duties

Balancing academic and clinical responsibilities emerged as a major challenge. Four themes were identified: schedule conflict and time pressure, workload strain and fatigue, competing personal and family roles, and manageable or absent conflict. Most participants reported overlapping schedules, limited preparation time, heavy administrative load, and strain from managing professional and family obligations. A few reported minimal conflict due to carefully structured schedules or favorable work conditions. Overall, maintaining dual roles is often complex and demanding.

Most demanding aspects of work

The most demanding aspects of participants' work arose from multiple sources. Three themes were identified: academic and teaching demands, clinical practice pressures, and administrative or extra-role obligations. Examination preparation, maintaining teaching quality, emergency or unpredictable clinical work, documentation, seminars, travel, and other non-teaching tasks were experienced as particularly demanding. The burden of work stems from the cumulative effect of academic, clinical, and institutional responsibilities rather than from a single domain.

Effects of institutional policies

Institutional policies were found to influence clinician-educator work in varied ways. Three themes emerged: policies as enabling structures, policies as constraints, and policies with minimal perceived effect. Some participants viewed policies as

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supportive when they provided flexibility, resource access, and alignment with dual-role practice. Others experienced policies as restrictive because of rigid schedules, administrative requirements, or limitations on external practice. A few reported that policies had little perceived impact, relying instead on personal time-management strategies. Policies can thus either facilitate or complicate dual-role performance depending on design and implementation.

Presence of institutional support

Experiences of institutional support were heterogeneous. Three themes were identified: presence of support, inconsistent or limited support, and absence of support or non-applicability. Some participants reported access to support mechanisms such as training, emergency coverage, and faculty development. Others described support as incomplete, uneven, or poorly communicated, while a number perceived little or no direct support relevant to their situation. Institutional support for dual-role faculty exists but is not consistently experienced.

Most helpful support policies

Support policies were perceived as most effective when they addressed the practical realities of balancing academic and clinical work. Four themes emerged: flexibility and protected time, emergency coverage and leave accommodations, benefits and incentives, and limited awareness or non-applicability. Participants valued flexible scheduling, protected time for teaching and research, and concrete assistance during emergencies. Some also highlighted the importance of benefits and incentives, while others were only vaguely aware of existing support. Effective support is therefore practical, accessible, and clearly communicated.

Suggested additional policies

Participants proposed several policy directions to strengthen institutional support. Four themes emerged: wellness and workload support, greater flexibility and recognition of dual roles, improved compensation and promotion systems, and no additional recommendations. Suggestions included wellness-oriented initiatives, better staffing and administrative assistance, more flexible teaching loads, and clearer recognition of clinician-educator roles in salary and promotion. Faculty envision institutions that are more responsive, supportive, and sustainable for dual-role professionals.

DISCUSSION

The findings confirm that the work of medical faculty who serve as clinician-educators is inherently multidimensional, spanning instructional responsibilities, assessment-related tasks, administrative and institutional functions, and clinical or practical supervision. Participants' accounts show that teaching in medical education includes not only lecture delivery but also mentoring, facilitation, exam preparation, grading, curriculum work, committee service, and hands-on supervision in clinical and laboratory settings. This pattern reinforces literature describing clinician-educators as key actors in teaching, assessment, curriculum, and program management, and supports calls for workload models that recognize the full breadth of faculty responsibilities.

The study also highlights a complex dual professional identity in which participants understand themselves simultaneously as educators and practitioners, but with differentiated configurations of engagement depending on whether they are full-time faculty with modified clinical practice or part-time faculty with full-time clinical work. Many participants described clinical practice as a foundation for their teaching, providing authentic cases and experiential insights that enrich instruction, while also acknowledging that dual-role engagement generates schedule conflicts, workload strain, and personal sacrifice. These findings align with scholarship on clinician-educators and faculty vitality, which emphasizes that dual roles can be meaningful and professionally sustaining but become a source of tension when institutional systems fail to accommodate their realities.

Across the themes on role balance, the results show that schedule conflict, time pressure, cumulative workload, and competing family responsibilities are central challenges for clinician-educators. Overlapping academic and clinical timetables, emergency clinical demands, high-stakes examination preparation, and administrative burden together produce a cumulative workload that many participants experience as physically and emotionally exhausting, with risk of burnout. At the same time, a small group reported minimal conflict when they were able to separate teaching and clinical days or when their workload and institutional arrangements were favorable, suggesting that role tension is not inevitable but structurally contingent. These patterns echo broader literature linking faculty well-being to realistic workload design, protected time, and institutional support.

The findings on institutional policies and support mechanisms further underscore the central role of educational management in shaping clinician-educator experience. Participants described policies as both enabling and constraining: flexible scheduling, protected time, and aligned institutional values were experienced as supports, while rigid schedules, restrictive appointment rules, and heavy administrative requirements were perceived as barriers to effective performance in both roles. Similarly, support mechanisms ranged from meaningful provisions—such as faculty development programs, emergency coverage, and departmental solidarity—to inconsistent or absent supports, with some participants unaware of available policies. These results suggest that the mere existence of policies is insufficient; their practical implementation, consistency, and communication determine whether they function as real supports or as additional sources of strain.

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Taken together, the themes converge on a set of educational management implications for medical schools and related institutions. First, workload systems need to be redesigned to account for the multidimensional and cumulative nature of clinician-educator work, including instructional, assessment, administrative, and clinical supervision functions rather than only classroom contact hours. Second, policies on scheduling, protected time, leave, and coverage must explicitly recognize the unpredictability of clinical work and the diversity of faculty employment arrangements, particularly for part-time faculty with substantial clinical responsibilities. Third, institutional support should move beyond informal collegial help toward structured wellness programs, staffing augmentation, streamlined administrative processes, and equitable compensation and promotion systems that value educational contributions alongside clinical productivity. Finally, the variability in participants' experiences and recommendations points to the need for ongoing dialogue and participatory policy development, ensuring that clinician-educators' voices directly inform institutional reforms intended to sustain their dual roles over the long term.

CONCLUSIONS

Based on the major themes and patterns across participants' accounts, the following conclusions are drawn:

The role of medical faculty is intrinsically multidimensional. Medical faculty members do not function solely as classroom teachers; they concurrently undertake instructional, assessment, administrative, and clinical supervisory roles. Any management system that treats faculty work as primarily "contact hours" will underestimate their actual responsibilities.

Medical faculty commonly embody a dual professional identity as both educators and practitioners, but this identity is not experienced uniformly. Variations in appointment status, clinical load, and personal circumstances shape how faculty participate in academic and clinical domains. The clinician-educator identity is therefore both integrated and differentiated.

Balancing faculty and practitioner responsibilities is a persistent challenge for many clinician-educators. Role conflict is driven largely by schedule overlap, time pressure, heavy workload, and competing family and personal obligations. Although some faculty manage demands through deliberate scheduling strategies, the overall experience is one of complexity and strain rather than simple role combination.

The demands experienced by medical faculty are cumulative and multidimensional. Academic preparation, the unpredictability of clinical work, and growing administrative and extra-role obligations converge to create a high overall workload. The most demanding aspects of their professional lives arise from the combination of responsibilities rather than from any single task in isolation.

Institutional policies significantly shape the day-to-day realities of clinician-educators. Policies can operate as facilitators when they are flexible, context-sensitive, and aligned with dual-role realities, or as barriers when they are rigid, administratively heavy, or misaligned with clinical and academic demands. Policies are thus active determinants of role effectiveness, not neutral background conditions.

Institutional support for medical faculty exists but remains uneven in availability, consistency, and visibility. Some faculty benefit from structured support mechanisms, while others experience them as partial, unclear, or absent. The mere existence of support structures is insufficient unless they are consistently implemented and effectively communicated.

Support policies are experienced as most effective when they directly address time-sensitive and practice-based realities of clinician-educator work. Flexibility, protected time, emergency coverage, practical leave accommodations, and tangible benefits help reduce role strain and enable faculty to fulfil dual responsibilities more sustainably.

Medical faculty members express a clear desire for institutional reforms that are more responsive to their lived realities as dual-role professionals. Their recommendations emphasize the importance of wellness support, flexible and realistic workload systems, explicit recognition of dual roles, and more equitable compensation and promotion structures.

Recommendations

The following recommendations are proposed for higher education institutions, educational managers, policy makers, and future researchers.

For Higher Education Institutions and Medical Schools

Develop explicit workload frameworks that account for the full spectrum of medical faculty responsibilities, including instructional, assessment, administrative, advisory, and clinical supervisory functions—not only classroom teaching.

Provide protected time for teaching, assessment, mentoring, research, and scholarly work to reduce competition between educational and clinical obligations.

Review and revise institutional policies so that they support rather than constrain clinician-educators, particularly in scheduling, appointment status (full-time/part-time), external practice, compensation, and promotion.

Strengthen institutional support systems by formalizing emergency coverage, administrative assistance, and leave accommodations, and by expanding faculty development opportunities relevant to clinician-educator roles.

Institutionalize wellness-oriented policies and programs that proactively address workload strain, burnout risk, and the personal well-being of faculty members.

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For Educational Managers and Administrators

Recognize the multidimensional workload of medical faculty and avoid assigning responsibilities solely on the basis of teaching units or class hours.

Implement more balanced, practice-aware scheduling systems that minimize overlap between teaching and clinical commitments and allow for adequate preparation time.

Improve communication and orientation about existing support policies so that faculty clearly understand what assistance, benefits, and accommodations are available to them.

Strengthen faculty development initiatives in key areas such as learner assessment, mentoring, curriculum implementation, clinical teaching, and educational leadership.

Foster a supportive, humane work environment that values flexibility, collegiality, and explicit recognition of dual professional roles in evaluations and everyday management.

For Policy Makers and Institutional Leaders

Revisit appointment, promotion, and compensation systems to ensure that educational work—including teaching, assessment, and clinical supervision—is meaningfully recognized alongside clinical service and research.

Design faculty policies that are explicitly responsive to dual-role realities rather than based on assumptions suited only to traditional, single-role academic appointments.

Embed clinician-educator well-being as an explicit institutional responsibility, integrating it into strategic plans, governance discussions, and performance indicators.

For Future Researchers

Conduct studies with larger and more diverse samples across multiple institutions to examine whether similar patterns of experience and support needs appear in different contexts.

Undertake comparative research (e.g., full-time vs. part-time faculty, public vs. private institutions, different specialties) to analyze how organizational conditions shape clinician-educator experiences.

Use quantitative or mixed-methods designs to investigate relationships among workload, protected time, institutional support, burnout, and indicators of faculty effectiveness.

Pursue in-depth qualitative studies of specific subgroups (e.g., early-career faculty, surgical faculty, part-time educators, or faculty with heavy caregiving responsibilities) to capture nuanced role challenges.

Design and evaluate intervention-based studies (e.g., wellness programs, workload restructuring, flexible scheduling policies, tailored faculty development) to determine which institutional strategies most effectively support clinician-educators.

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