Defending Medicine:

Clinical Faculty and Academic Freedom

Report of the Canadian Association of University Teachers (CAUT) Task Force on Academic Freedom for Faculty at University-Affiliated Health Care Institutions

November 2004

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Executive Summary

The CAUT Task Force

Clinical faculty in Canada do not enjoy the same academic freedom protection as other members of the professoriate. Prompted by this inequity, and the growing number of clinical faculty approaching the Canadian Association of University Teachers (CAUT) with concerns about institutional interference with their ability to conduct research, speak freely and share findings with patients and colleagues, CAUT established a task force to examine academic freedom at university-affiliated health care institutions. The task force was asked to review the state of academic freedom for clinical faculty across the country and to recommend how academic freedom could be best enhanced and protected.

The members of the task force are **Dr. Philip Welch** (Chair), a medical geneticist and retired professor of pediatrics at Dalhousie University; **Dr. Carol E. Cass**, chair of oncology at the University of Alberta and associate director of the Cross Cancer Institute; **Dr. Gordon Guyatt**, professor of medicine at McMaster University; **Dr. Alan C. Jackson**, professor of medicine at Queen's University; and **Dr. Derryck Smith**, head of the division of child and adolescent psychiatry at the University of British Columbia and head of psychiatry at the Children's & Women's Health Centre of British Columbia.

This report is the first step of the task force in fulfilling its mandate.

Introduction

Excellence in academic medicine depends upon a work environment characterized by intellectual curiosity, relentless critical inquiry, and a desire to improve clinical practice and advance scientific knowledge. Academic freedom is an essential component of such an environment but, for various structural and historical reasons, clinical faculty enjoy far less of its protection than other university faculty.

Academic Freedom

Academic freedom is the right of academic staff to teach, study, and publish regardless of prevailing opinion, prescribed doctrine, or institutional preferences. It includes the freedom to express critical opinion about workplace institutions and broad public issues. It also includes the freedom of academic staff to participate in representative academic bodies and the governance mechanisms that regulate the functions of their workplaces. It is sustained by security of appointment and income.

Without academic freedom, the ability of clinical faculty to discover knowledge and to disseminate that knowledge to students, the scientific community, and society at large is diminished. By enabling faculty to engage in controversial research and critical inquiry,

academic freedom fosters the dynamic atmosphere required to advance human knowledge in health sciences and to protect the health and well-being of Canadians.

Clinical Faculty

The term “clinical faculty” is used in many ways across Canada. In this report, the term is used to refer to health sciences professionals, typically those with MD and/or PhD degrees, who hold simultaneous appointments at both a university and a teaching hospital or other health care institution. Membership spans the spectrum from full-time university professors to physicians in private practice who teach medical students on a part-time or occasional basis.

Vulnerability of Clinical Faculty

The work arrangements of clinical faculty differ from those of non-clinical academic staff in a number of important ways, differences that can compromise their academic freedom. First, the dual appointments (university and health care institution) that clinical faculty must typically maintain means they work under two sets of administrative rules—the collegial governance systems of universities and the hierarchical and increasingly “corporate” structures of health care institutions. As a result they must defend their academic freedom on two fronts—at universities, where its importance is acknowledged, and in health care institutions, where it is frequently poorly understood.

Second, unlike non-clinical academic staff who typically derive the bulk of their income from the university payroll, clinical faculty income is allocated in a variety of ways and in various combinations: sometimes through a practice plan; sometimes through an alternative funding arrangement; sometimes as a direct university salary or contract payment; and sometimes as clinical earnings paid on a fee-for-service basis. Because interference with income is a powerful form of action against faculty members for exercising academic freedom, the diffuse nature of clinical faculty income creates particular vulnerabilities.

Finally, many clinical faculty stand apart in that they are excluded by law, choice or tradition from the legal guarantees of academic freedom contained in collective agreements between universities and academic staff associations. With respect to health care institutions, clinical faculty, unlike almost all other groups in these institutions, typically have no collective agreements to protect their rights. This leaves many clinical faculty without effective representation and without access to the dispute resolution systems governed by natural justice that characterize collective bargaining relationships.

Fostering Excellence

Through the course of its work the task force was able to identify vulnerabilities common to clinical faculty across Canada. To address these vulnerabilities, the task force has formulated six recommendations to ensure that clinical faculty have the academic freedom vital to their work.

Recommendations

The recommendations of this report—that universities and affiliated health care institutions make strong declarations of academic freedom rights, provide security of appointment and security of income, and allow access to dispute resolution systems characterized by natural justice; and that clinical faculty themselves form powerful representative organizations—will provide clinical faculty with the same academic freedom protections as other members of the professoriate and increase the ability of clinical faculty and the institutions where they work to advance the boundaries of human knowledge in health sciences and thereby protect the health and well-being of Canadians.

Strengthen Academic Freedom Rules for Clinical Faculty

The rules that govern the working lives of clinical faculty are set out in a variety of written instruments—mission statements, guidelines, policies, affiliation agreements, and employment contracts. A strong commitment to academic freedom in these documents is critically important for clinical faculty, both to establish a legal and policy basis for academic freedom rights and to foster a culture of institutional respect for academic freedom.

1. To ensure that academic freedom is a foundational principle of academic medicine, explicit references to, and protections of, academic freedom must be included in institutional mission statements, institutional policy, university-hospital affiliation agreements, funding plans, collective agreements, and employment contracts.

Protect Security of Appointment and Security of Income for Clinical Faculty

Termination of employment is a means of silencing critical opinion. The academic freedom of clinical faculty therefore depends upon security of position and security of income in respect to both universities and health care institutions.

2. To protect the academic freedom of clinical faculty

- *(i) clinical faculty members must be eligible for tenure in respect of university appointments and university income*
- *(ii) decisions in respect of health care institution appointments and privileges must follow established rules*
- *(iii) health care institution appointments and privileges must be for renewable terms and can only be terminated or not renewed for just cause*

(iv) health care institution rules must include protection for academic freedom, such that the exercise of academic freedom cannot be a justification for non-renewal, variance or termination of appointments and privileges

(v) procedures must be established to ensure that allocations of clinical income are made according to clear procedures and protected against arbitrary or capricious decisions

Ensure Access to Natural Justice for Clinical Faculty

In the absence of effective dispute resolution systems characterized by natural justice and procedural fairness, written guarantees of academic freedom and appointment and income security are insufficient to protect clinical faculty.

3. Universities, health care institutions, and clinical funding plans must ensure that clinical faculty have access to dispute resolution procedures characterized by natural justice and procedural fairness, including access to independent external arbitration for resolution of matters other than those covered by statutory prescription.

Strengthen Clinical Faculty Representative Organizations

Disputes between clinical faculty members and their university or health care institutions pit individuals against organizations. Unless clinical faculty have meaningful representation, workplace disputes are one-sided affairs, and academic freedom rights are difficult to enforce.

4. Clinical faculty should create effective representative organizations with respect to universities, health care institutions, and clinical funding plans. These organizations should be characterized by

- *democratic structure*
- *financial viability and independence*
- *a legally enforceable collective bargaining relationship with the institution*
- *the exclusion of persons in managerial positions*
- *participation in the broader academic staff community*
- *intimate knowledge of academic freedom issues*

Where membership in existing certified associations or creation of new certified associations is not possible, clinical faculty should create robust uncertified associations (similar to academic staff associations at non-unionized universities that negotiate collective employment contracts and enjoy access to dues check-off and independent grievance arbitration mechanisms).

Defending Medicine:
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Section One - Introduction

1.0 Context

Dr. Nancy Olivieri, a professor of medicine at the University of Toronto with an appointment at the Toronto Hospital for Sick Children, discovered unexpected risks in a new drug she was helping to develop for the treatment of thalassemia, a hereditary blood disease. When she moved to inform patients enrolled in the drug's clinical trials, the pharmaceutical company sponsoring the research terminated the trials and threatened her with legal action if she disclosed the risks to her patients or to anyone else.

In its subsequent efforts to license the drug for sale, the company tried to discredit not only Olivieri but also her use of liver biopsies as the procedure through which she had identified the risks, even though this procedure was the internationally accepted medical standard.

When Olivieri turned to the university and the hospital for help, it was to no avail. The University of Toronto failed to provide effective assistance and worse, the Hospital for Sick Children subjected her to harassment that escalated into actions that almost destroyed her career. Despite ongoing legal threats by the company and lack of institutional support, Olivieri published her findings on the drug in the *New England Journal of Medicine*.[1] This sparked an international scandal over the conduct of the pharmaceutical company and the two public institutions. Only then was it revealed that the University of Toronto had been engaged in negotiations with the same pharmaceutical company for what would have been its largest private donation ever, $20 million for the University and an additional $10 million for its affiliated teaching hospitals.[2]

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1 Olivieri NF, Brittenham GM, McLaren CE, Tampleton, DM, Cameron, RG, McClellan, RA, Burt, AD and Fleming, KA, "Long-term safety and effectiveness of iron-chelation therapy with deferiprone for thalassemia major," *New Engl J Med* 1998; 339 (7): 417-423.

2 Thompson J, Baird P and Downie J, *The Olivieri Report*. Toronto: James Lorimer & Co., 2001, p. 98.

While academic associations did rally to Olivieri's cause, these were voluntary efforts by organizations that had a limited representative relationship with her group of faculty, little or no contractual rights to enforce, and weak or non-existent access to effective dispute resolution mechanisms. The Olivieri case has come to symbolize the precarious nature of academic freedom for clinical faculty.[3]

Widely publicized academic freedom cases involving clinical faculty, such as Olivieri or, more recently, David Healy,[4] are the exception. Hidden from public view have been scores of other clinical faculty who have suffered in recent years for voicing concerns about prevailing orthodoxies within their specialties, for criticizing administrative decisions within their institutions, for questioning the priorities of their colleagues, or for upholding the academic freedom rights of fellow clinical faculty.

Regardless of whether such cases receive notoriety or remain unreported, they serve to illustrate an underlying fact; namely, clinical faculty, for various structural and historical reasons, have less academic freedom protection than other university faulty. The academic freedom rights of non-clinical academic staff were achieved after long years of effort, and they are maintained only through the constant vigilance of academic staff and their representative organizations.[5] To everyone's detriment, clinical faculty have not fully benefited from this work.

1.1 Clinical Faculty

The term "clinical faculty" is used in many ways across Canada. In this report the term is used to refer to health sciences professionals, typically those with MD and/or PhD degrees, who hold simultaneous appointments at both a university and a teaching hospital or other health care institution. Membership spans the spectrum from full-time university professors to physicians in private practice who teach medical students on a part-time or occasional basis.

Clinical faculty differ from non-clinical academic staff in that their dual appointment means they work under two sets of administrative rules—the collegial governance systems of universities and the hierarchical structures of health care institutions. Moreover, their income derives from a variety of sources: payment for clinical services, health care institution budgets, university operating budgets (which often provide only minimal funding for academic clinicians), and research awards. Their income is allocated in a variety of ways and in various combinations: sometimes as a direct university salary or contract payment; sometimes through a practice plan;

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3 Nathan DG and Weatherall D, "Academic freedom in clinical research," *New Engl J Med* 2002; 347(17): 1368-1371; Thompson, Baird and Downie, *The Olivieri Report*.

4 David Healy, a prominent Welsh psychiatrist, had been offered and had accepted a leadership position at a psychiatric hospital affiliated with the University of Toronto. After he gave a lecture in which he suggested that SSRI's—a family of anti-depressant drugs—may, under certain circumstances, be associated with increased risk of suicide, the hospital withdrew the job that Dr. Healy was to begin shortly thereafter. Less than two years later, regulatory authorities in Britain, the United States, and Canada have vindicated Healy's position.

5 Horn M., *Academic Freedom in Canada*. Toronto: University of Toronto Press, 1999.

sometimes through an alternative funding arrangement; sometimes as clinical earnings paid on a fee-for-service basis. Finally, many clinical faculty stand apart in that they are excluded by choice, tradition, or law from membership in university academic staff association bargaining units covered by the provisions of collective agreements between associations and universities. With respect to health care institutions, clinical faculty stand apart from virtually everyone else who works in these institutions, in that they are typically not covered by collective agreements, having individual contracts of employment instead.

1.2 Academic Freedom

Academic freedom is the life blood of modern universities and, by extension, their affiliated health care institutions. It is the right of academic staff to teach, study, and publish regardless of prevailing opinion, prescribed doctrine, or institutional preferences. It includes the freedom of academic staff to express critical opinion about broad public issues and the institutions at which they work, including, for clinical faculty, the quality of clinical care provided. It also includes the freedom to participate in professional or representative academic bodies and the mechanisms of governance that regulate the core functions of their institutions.

Without these freedoms, faculty members and their universities cannot fulfil their functions of discovering knowledge; disseminating that knowledge to their students, the scientific community, and the society at large; and instilling in their students a mature independence of mind. By protecting faculty from retribution for engaging in controversial research and teaching, and in critical inquiry, academic freedom fosters the dynamic atmosphere needed to advance human knowledge in health sciences, as in all other fields.

The indices of academic freedom for clinical faculty are:

- a work environment where respect for academic freedom is an intrinsic part of institutional culture—where academic freedom rights are declared and protected in both policy and employment contract language and inform the actions and decision making of administrators and academic staff alike
- security of employment for academic staff
- access by academic staff to independent dispute resolution systems bound by the rules of natural justice and procedural fairness
- the presence of independent and adequately funded representative organizations through which academic staff can enforce their academic freedom rights

For clinical faculty to have academic freedom, these protections must apply not only in their relationships with university administrations, but also with the health care institutions at which they hold appointments and with the administrations of their clinical income. Academic freedom disputes for non-clinical faculty typically play out between the faculty member (backed by a strong academic staff association and contractual guarantees of academic freedom) and the university administration through grievance arbitration. In contrast, clinical faculty may need to fight these battles on three distinct fronts—universities, health care institutions, and funding mechanisms—and they must have effective protection on all three.

1.3 Clinical Faculty Academic Freedom Rights and Public Health

The work and careers of clinical faculty are as important as those of non-clinical academic staff, but in many cases clinical faculty fall outside the contractual, policy, and cultural guarantees of academic freedom enjoyed by other academic staff.

This must be changed. While the work of all academic staff is important, the work of clinical faculty plays a special role in society because it is intimately connected with the immediate health and well-being of the people of Canada. The academic freedom of clinical faculty has an urgent importance: human lives can depend directly on the ability of clinical faculty to do their work, speak their minds, and publish their findings free from interference. Academic freedom allows the pursuit of exemplary research and medical practice to supersede vested interests, whether they be financial, political, or bureaucratic. It advances the hospital missions of patient care and institutional achievement and is essential to enhancing the health of residents of Canada.

To allow clinical faculty equal access to the academic freedom enjoyed by other academic staff the following must occur:

- Clinical faculty must be guaranteed the same rights of academic freedom and security of appointment enjoyed by non-clinical academic staff in relation to universities, health care institutions, and funding sources.

- Clinical faculty must have access to independent dispute resolution systems bound by the rules of natural justice and procedural fairness, in their disputes with universities, health care institutions, and funding sources.

- Clinical faculty must have organizations that can effectively represent their interests and ensure their academic freedom and other rights in respect to universities, health care institutions, and funding sources.

Section Two - Strengthening Academic Freedom Rules for Clinical Faculty

2.0 The Framework

The rules, both formal and informal, that govern the working lives of academic staff are set out in a broad collection of mission, guideline, policy, and contractual statements that establish the norms of university life. The presence of a strong commitment to academic freedom in these documents is an important factor in determining the rights of clinical faculty. As these documents also reflect in a more intangible way the culture of a work environment, it is equally important that they forcefully espouse the principles of academic freedom.

Strengthening, and where necessary, establishing, academic freedom rights in this language is an important step in protecting clinical faculty. Because of the relationships that clinical faculty

have with universities, health care institutions, and perhaps other funding sources, the language that defines these three relationships must be strengthened in respect to academic freedom.

2.1 Academic Freedom in the Context of Universities

2.1(a) *University Mission Statement*

One of the most visible expressions of a university's institutional culture is its mission statement. Although of little legal significance, the mission statement is a deliberate public declaration by the university about its priorities. The University of Toronto has excellent language:

> **University Statement of Institutional Purpose**
>
> Purpose of the University
>
> The University of Toronto is dedicated to fostering an academic community in which the learning and scholarship of every member may flourish, with vigilant protection for individual human rights, and a resolute commitment to the principles of equal opportunity, equity and justice.
>
> Within the unique university context, the most crucial of all human rights are the rights of freedom of speech, academic freedom, and freedom of research. And we affirm that these rights are meaningless unless they entail the right to raise deeply disturbing questions and provocative challenges to the cherished beliefs of society at large and of the university itself.
>
> It is this human right to radical, critical teaching and research with which the University has a duty above all to be concerned; for there is no one else, no other institution and no other office, in our modern liberal democracy, which is the custodian of this most precious and vulnerable right of the liberated human spirit.[6]

All universities need language as strong as this. Unfortunately, few have it.

2.1(b) *University Policies*

Of greater practical importance than the mission statement in establishing the rules that govern faculty are the policies and guidelines promulgated by university boards and senates. As with mission statements, these documents are of general application to all members of the university community and set the tone of the university's culture. Unlike the mission statement, however, in the absence of direction from other legal instruments, such as collective agreements and hospital bylaws, these documents can set specific and binding rules of conduct.

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6 University of Toronto, Statement of Institutional Purpose, October 15, 1992. Retrieved May 27, 2004, from http://www.utoronto.ca/govcncl/pap/policies/mission.html#_Toc468159530

Specific academic freedom policies, such as at McMaster University, are an important expression of university respect for academic freedom:

> **University Senate Statement on Academic Freedom**
>
> McMaster University is dedicated to the pursuit and dissemination of knowledge. Its members enjoy certain rights and privileges essential to these twin objectives. Central among these rights and privileges is the freedom, within the law, to pursue what seem to them fruitful avenues of inquiry; to teach and to learn unhindered by external or non-academic constraints; and to engage in full and unrestricted consideration of any opinion. This freedom extends not only to members of the university but to all who are invited to participate in its forum. All members of the University must recognize this fundamental principle and must share responsibility for supporting, safeguarding and preserving this central freedom. Behaviour which obstructs free and full discussion, not only of ideas which are safe and accepted but of those which may be unpopular or even abhorrent, vitally threatens the integrity of the University, and cannot be tolerated.
>
> Suppression of academic freedom would prevent the University from carrying out its primary functions. In particular, as an autonomous institution McMaster University is protected from any efforts by the state or its agents to limit or suppress academic freedom. Likewise, neither officers of the University nor private individuals may limit or suppress academic freedom.
>
> The common good of society depends upon the search for knowledge and its free exposition. Academic freedom does not require neutrality on the part of the individual; on the contrary, academic freedom makes commitment to a position or course of action possible.
>
> Academic freedom carries with it the duty to use that freedom in a manner consistent with the scholarly obligation to base research and teaching on an honest search for knowledge.[7]

Again, all universities need policy language asserting the importance of academic freedom. Unfortunately, not all universities currently have such language.

In addition to institutional academic freedom policies, academic freedom protection can also be augmented in appointment, tenure, promotion, and publication policies:

> **Queen's University - Regulations Governing Appointment, Renewal of Appointment, Tenure and Termination for Academic Staff**

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7 McMaster University, Statement on Academic Freedom, December 14, 1994. Retrieved May 27, 2004, from http://www.mcmaster.ca/senate/academic/acafreed.htm

> Queen's University recognizes academic freedom as indispensable to the purposes of a university. Freedom of faculty members to study, to teach and to record knowledge according to their best judgement is necessary if a university is to fulfil its role in society. Accordingly, academic freedom is the right of every faculty member from the time each is first appointed. [8]

> **University of Alberta - Research Publications Policy**
>
> The University of Alberta recognizes that one of the main purposes of University research is the discovery and dissemination of new knowledge. University research, therefore, which is pursued under conditions which restrict publication either in terms of content or beyond limits established from time to time by the General Faculties Council is not compatible with University policy.[9]

Publication policies are taking on an increasingly important role in protecting academic freedom. The ability of faculty to disseminate their findings is a critical component of scholarly independence and integrity. This is formally recognized in policy at a number of universities, albeit most allow exceptions that limit the policy's effectiveness, as in the above example from the University of Alberta.

In the increasingly commercialized university environment the right of academic staff to disseminate research results, whether in the ordinary course of scholarly publishing or for the specific purpose of disclosing information about risks to research participants or to the general public, needs strong protection. University policies, collective agreements, and employment and research contracts must ensure (1) the right to publish by banning the university from accepting or administering any funding that limits the right to publish research findings, except in unusual circumstances and for no longer than 60 days; and (2) the absolute right of academic staff to disclose information immediately about risks to research participants or the general public and threats to the public interest that become known in the course of their research.[10]

2.1(c) *The Collective Agreement*

Collective agreements between academic staff associations and university administrations contain the strongest guarantees of academic freedom because they are legally enforceable documents. The agreement between the Queen's University Faculty Association and Queen's University, for example, contains the following language:

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8 Regulations Governing Appointment, Renewal of Appointment, Tenure and Termination for Academic Staff, Last Amended March 2, 1995. Retrieved May 27, 2004, from http://www.queensu.ca/secretariat/senate/policies/appointm/appointm.html

9 University of Alberta Research Publications Policy. Retrieved May 27, 2004, from http://www.uofaweb.ualberta.ca/vpres_policies/nav02.cfm?nav02=11201&nav01=11159

10 This was the first and principal recommendation made by the Committee of Inquiry on the Case Involving Dr. Nancy Olivieri, the Hospital for Sick Children, the University of Toronto, and Apotex, Inc. See Thompson, Baird and Downie, *The Olivieri Report*, p. 41

14.1 Generally:

(a) The unimpeded search for knowledge and its free expression and exposition are vital to a University and to the common good of society.

(b) Members have the right to academic freedom which shall include the freedom, individually or collectively, to develop and transmit knowledge and opinion through research, study, discussion, documentation, production, creation, teaching, lecturing and publication, regardless of prescribed or official doctrine, and without limitation or constriction by institutional censorship.

(c) The Parties agree to uphold and to protect the principles of academic freedom, not to infringe upon or abridge academic freedom as set out in this Article, and to use all reasonable means in their power to protect that freedom when it is threatened.

14.2 Academic freedom includes the following interacting freedoms: freedom to teach, freedom to research, freedom to publish, freedom of expression, freedom to acquire materials. Academic freedom ensures that:

(a) Members teaching courses have the right to the free expression of their views, and may choose course content, use teaching methods and refer to materials without censorship or reference or adherence to prescribed doctrine.

(b) Members have the freedom to carry out scholarly research without reference or adherence to prescribed doctrine.

(c) Members have the right to publish the results of their research without interference or censorship by the institution, its agents or others.

(d) Members have the right to freedom of expression, including the right to criticize the government of the day, the administration of the institution, or the Association.

(e) Members have the freedom to exercise professional judgment in the acquisition of materials, and in ensuring that these materials are freely accessible to all for bona fide teaching and research purposes, no matter how controversial these materials may be.

14.3 Academic freedom does not require neutrality; rather, it carries with it the duty to use that freedom in a manner consistent with the scholarly obligation to base research, teaching, publication and other forms of scholarly expression in an honest search for knowledge. Academic freedom does not confer legal immunity; nor does it diminish the obligation of Members to meet their responsibilities to the

> University. In the exercise of academic freedom, Members shall respect the academic freedom of others.[11]

In contrast to university policy statements, collective agreements are legally binding contracts with powerful built-in dispute resolution systems. Their enforcement is assured by strong representative organizations—in the form of academic staff associations.

Collective agreements also differ from policy in that their application does not extend to all university personnel, but rather only to members of academic staff association bargaining units. In most universities, clinical faculty are not members of these bargaining units and thus do not enjoy the protection afforded by collective agreements.

This does not mean that collective agreement language is irrelevant to excluded clinical faculty. Rather, it underlines the importance of bringing more clinical faculty within collective bargaining structures. Short of this goal, the existing collective agreement language also serves to reflect a university's broader commitment to academic freedom; to set a high standard of protection that clinical faculty can use as a benchmark; and to function as a potent reminder of the lesser status of clinical faculty *vis-á-vis* the rest of the professoriate.

2.2 Academic Freedom in the Context of Health Care Institutions

2.2 (a) *Health Care Institution Mission Statement*

Reference to academic freedom is absent from the mission statements of university-affiliated health care institutions, although the statements of a number of such institutions do make broad reference to an academic role. This is not a substitute for a strong declaration of support for academic freedom. Academic freedom language is similarly absent from bylaws, regulations and policy statements of university-affiliated health care institutions, underscoring the cultural differences between universities and health care institutions. The insertion of such language into these documents is a priority. Teaching hospitals and other university-affiliated health care institutions derive legitimacy and prestige through their affiliations with universities. As truly equal partners, such institutions must conform to the most basic of university values—academic freedom—and reflect this respect in their foundational documents.

2.2(b) *University/Hospital Affiliation Agreements*

The legal relationships between universities and affiliated hospitals/health care institutions are set out in documents commonly referred to as "Affiliation Agreements."

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11 Collective Agreement Between Queen's University Faculty Association and Queen's University at Kingston, 11 May 2002 to 30 April 2005. Retrieved May 27, 2004, from http://www.queensu.ca/qufa/Collective_Agreement/candx.htm.

Few, if any, of these agreements contain even indirect references to academic freedom, and most contain provisions that actively limit the security of faculty appointments. Specific language on the right to disseminate research findings is noticeably absent.

The best existing affiliation agreement language (although the words "academic freedom" are not actually used) is found in the University of Saskatchewan and the Saskatoon District Health Board agreement:

> An atmosphere that fosters inquiry and research is essential to sustain good clinical teaching. Creating an atmosphere of curiosity, critical inquiry, keen observation, and precise expression encourages the teacher to continue to grow professionally and intellectually. Furthermore, this atmosphere is important for the long-term well being of clinical service itself. Clinical service needs researchers who actively seek out the short-comings of present day practice, and try to suggest improvements. Good clinical practice also depends not only on personal and interpersonal skills, and a sound grasp of established and new knowledge, but a respect for what is still unknown, a desire to improve that which is not good enough, and a disciplined experience in problem solving, development and quality control.[12]

Currently, many affiliation agreements contain clauses requiring university recognition of the particular demands that clinical care places on the staff and management of health care institutions. Because affiliation agreements reflect the core commitments of both universities and health care institutions, it is essential that universities insist that affiliated health care institutions explicitly recognize the academic freedom of clinical faculty, including the right to be critical of institutional leadership and clinical practices.

2.2(c) *Employment Contracts*

In the absence of collective representation, the employment relationship between clinical faculty members and their employers is often a matter of individual contract. Some clinical faculty have no defined relationship, other than their university appointment. Where contracts do exist, they frequently simply set out the technical terms of the relationship between the parties. At the University of Western Ontario, however, academic freedom language has been inserted:

> **Clinical Academic Contract**
>
> Introduction:
>
> The essential functions of a University are the pursuit, creation and dissemination of knowledge through research and other scholarly activities and by teaching. These activities cannot be performed without academic freedom which ensures the right of every faculty member regardless of rank or status, to teach, investigate

[12] University of Saskatchewan and the Saskatoon District Health Board Affiliation Agreement, June 18, 1996, - Section 2, Paragraph 4 - Understanding of Purpose

> and speculate without deference to a prescribed doctrine. Because a university's essential concerns are intellectual, academic freedom involves the obligation of the university to appoint and promote members of the faculty regardless of race, sex, religion or politics. Academic freedom ensures the right of every faculty member to criticize the university and to take controversial stands on public issues. The right to academic freedom carries with it the duty to use that freedom in a responsible way. A member of the faculty is entitled to all reasonable freedom in research and in the publication of the results, subject to the adequate performance of his or her other duties.[13]

Because this language does not specifically mention the hospital's responsibilities *vis-à-vis* academic freedom, it is far from perfect. However, it is an important step in the right direction and the insertion of similar language (including a reference to the responsibilities of the health care institution) in all clinical faculty employment contracts would be an important advance.

2.3 Funding Sources

Reference to academic freedom is not common in the documents that spell out arrangements for funding clinical faculty. Yet, loss of salary or failure to receive an appropriate salary increase can be a means of reprisal for the exercise of academic freedom. It is therefore essential that academic freedom be specifically addressed in the mechanisms that govern the flow of clinical income, so that inappropriate use of such mechanisms to deny academic freedom can be more easily addressed. One example of such language:

> 4.1.5 The academic freedom of physicians shall be preserved and protected. They shall be free to discharge their professional responsibilities in accordance with the law, contemporary medical standards, professional culture and the requirements of their profession and the communities they serve. [14]

In some cases, the university is not a even signatory to such plans or arrangements. Clinical faculty cannot carry out the academic mission of the university if their academic freedom cannot be effectively protected because the university has no jurisdiction with respect to funding plans.

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13 Clinical Academic Contract of the Faculty of Medicine & Dentistry [of] the University of Western Ontario and its Affiliated Hospital/Institution and the Appointee, effective July 1, 1999; revised March 1, 1999. Retrieved May 27, 2004, from http://www.med.uwo.ca/dean/A&R/append6.htm.

14 Agreement between the Province of Ontario, the Hospital for Sick Children, the University of Toronto and the Ontario Medical Association on behalf of participating physicians in the Pediatrics Specialties Association, August 4, 1994. This clause was significantly weakened in the successor agreement (2001), with the reference to academic freedom being removed, and the university agreeing to no longer being a signatory—diminishing its ability to offer protection for clinical faculty.

Section Three - Security of Appointment and Security of Income for Clinical Faculty

3.0 Good Words are not Enough

Academic freedom requires a foundation in written policy and employment contract language at universities, university-affiliated health care institutions and in clinical income plans. The strengthening, or in some cases establishment, of such language is a core task for clinical faculty. However, written promises of rights, although an essential preliminary step, are in and of themselves insufficient. The University of Toronto serves as a sober reminder in this regard. Although its mission statement is a powerful and eloquent expression of the fundamental importance of academic freedom to the university, perhaps the strongest in the country, it did not prevent the problems with the exercise of these rights that arose in the Olivieri and Healy cases. Academic freedom rights on paper must be backed up by additional protections, including employment security.

Security of employment for academic staff is closely connected to academic freedom and together the two are the cornerstone of the modern university. Security of employment has two components—security of position and security of income. The latter is intimately connected with the former, for the promise of indefinite employment without any guarantee of continuing income is of limited value.

3.1 Security of Employment at Universities

In the university context, job security is normally provided through tenure. When university professors achieve tenure, their services can only be terminated for just cause, upon reaching the age of retirement, or because of financial exigency (an imminent financial crisis which threatens the survival of the institution as a whole). Before tenure, it was not uncommon for academic staff to be dismissed from employment for expressing views critical of their employer or of political, economic, religious, or scholarly orthodoxy. This chronic job insecurity encouraged conformity, rather than the dynamic atmosphere needed to advance human knowledge. Tenure was developed to protect academic freedom, and thereby advancement of knowledge, by preventing faculty from being fired for exploring controversial or unorthodox areas of research or for speaking out on controversial issues. Tenure is essential for academic freedom and to ensure the dynamic intellectual environment necessary for universities to fulfill their roles in society.

3.2 Security of Employment for Clinical Faculty

The security that tenure provides is as important for clinical faculty as it is for all other academic staff, but tenure for clinical faculty is widely under attack. At some institutions, such as Dalhousie, tenure is not available for new clinical faculty appointments. At others, fewer clinical

faculty are being appointed to tenured or tenure-track positions. Providing the security of tenure for clinical faculty clearly presents special challenges.

University-affiliated health care institutions, more so than any other part of the university, have adopted management practices, including hierarchical organizational structures and limited term contracts, that bear little resemblance to traditional forms of collegial governance and tenured appointment. Moreover, these centres rely less and less on traditional sources of funding, such as tuition and block government transfers, and increasingly on contract research, special grants and income earned from the provision of clinical services. As a result, an expectation has been created for many clinical faculty that they will fund their own salaries and expenses through these new means. Finally, in contrast to that of non-clinical academic staff, the ability of clinical faculty members to do their work depends on the maintenance of not only university appointments, but also appointments/privileges at affiliated hospitals or health care institutions.

For clinical faculty, employment security must exist not only in relation to universities, but also in respect to their appointments and privileges at health care institutions and to funding mechanisms from which they derive all or a large part of their income.

Providing security of position and income with respect to universities is relatively straightforward. The institution of tenure provides a complete and readily available mechanism to protect the university appointments and income of clinical faculty. No clinical faculty should be excluded from eligibility for tenure in respect to university appointments and university income. Unfortunately, in many university medical faculties, university-derived income is small, having been integrated into alternative funding plans or other arrangements. The best protection is that negotiated by associations of clinical faculty so that they receive a salary based on rank—as do all other faculty in the university.[15]

Security in respect to relationships with health care institutions and funding mechanisms is more complex. To provide such security there must be established rules; the appointment/privileges must be of renewable limited term and only terminable for cause—through fair and transparent procedures characterized by natural justice and procedural fairness. The rules should specifically include protection for academic freedom such that the exercise of academic freedom cannot be a justification for non-renewal, variance, or termination.

Clinical faculty are in the same situation today in respect of their appointments at health care institutions as university faculty were in the 1940s and 1950s in respect of their university appointments. Health care institutional appointment procedures, terms and conditions of work, and disciplinary procedures are all determined by institutional policies and statutory rules.

Real security of employment and income can only be achieved when clinical faculty, acting through associations, negotiate collective agreements with the administrations of health care institutions, recognizing limits set by legislation and regulation. Such clinical faculty

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15 See for example the collective agreement between the Université de Montréal and the Association des Médecins Cliniciens Enseignants de Montréal. Retrieved July 15, 2004, from http://www.fqppu.qc.cq -- see: Conventions collectives, AMCEM.

associations, like their earliest university association counterparts, may be voluntary associations that negotiate outside the ambit of provincial labour relations acts, or they may become certified associations with full protections under labour relations acts (except in Ontario and Nova Scotia where this is prohibited by labour legislation). In most instances, physicians are the only group in hospitals that are not unionized.

To protect clinical income, allocations from the funding mechanisms must be made according to clear procedures and protected against arbitrary or capricious reduction or withdrawals. Any disputes over the allocation of clinical income must be subject to formal processes involving natural justice and procedural fairness.

Section Four - Natural Justice for Clinical Faculty

4.0 Context

Security of appointment and strongly stated academic freedom rights are necessary, but not sufficient, to fully protect clinical faculty. The best guarantees on paper are of limited value in the absence of effective university, health care institution, and funding mechanism dispute resolution systems through which clinical faculty rights can be enforced.

4.1 Conflict

The assessment of the quality of a clinical faculty member's medical practice, research, or teaching, as well as workload, remuneration, or ability to work productively with other employees and supervisors can all be sources of disagreement. Disputes over these issues can arise from valid administrative or policy decisions or from simple misunderstandings. They can also arise from the exercise of a clinical faculty member's academic freedom.

Determining if academic freedom issues are involved is not always easy, for colleagues and supervisors do not announce their intention to limit the academic freedom of others. Moreover, academic freedom matters are frequently overlain with personality disputes and harassment. A further complicating factor is the diversity of mechanisms, both formal and informal, in which such disputes are carried forward. Aspects of a particular academic freedom case may be played out before adjudicative bodies at universities, health care institutions, and funding authorities.

4.2 Natural Justice and Procedural Fairness

A great deal of thought has been devoted to finding fair and effective ways to solve disputes. With respect to conflict involving the rights of individuals, this endeavour has borne fruit in a set of rules known as natural justice and procedural fairness. These rules allow parties to a conflict the opportunity for a fair adjudication of their concerns. The rules include the right to be informed of the allegations against one, the right to a timely hearing, the right to disclosure of evidence, the right to legal representation, the right to present evidence and to challenge the

evidence presented by others, the right to be provided reasons for the decision rendered and perhaps most important of all—the right to an independent, unbiased judge or arbitrator.

The application of natural justice and procedural fairness varies according to the seriousness of the dispute. At one end of the spectrum, such as a criminal trial where liberty can be at stake, the degree of protection is very strong and includes the rigid application of rules of evidence and adherence to strict courtroom procedure. Disputes at the other end of the spectrum, for example minor administrative matters such as the renewal of a parking pass, receive lesser safeguards. Academic freedom conflicts are held to warrant a high degree of protection, because there are important career, economic, and societal interests at stake.

The main fora available to clinical faculty to resolve workplace disputes are:

- grievance arbitration panels created by collective agreements with universities
- dispute resolution panels created under health care institution disciplinary bylaws and regulations
- dispute resolution panels contained within clinical funding mechanisms

4.3 Dispute Resolution for Clinical Faculty

Disputes involving clinical faculty often cross institutional boundaries and are played out simultaneously in different settings. As was clearly illustrated in her case, Dr. Olivieri encountered difficulties with the hospital, the university, and the practice plan (the funding mechanism for clinical faculty) as a part of her academic freedom dispute.

Such triple jeopardy is hardly surprising because of the intermingling of personnel among university faculties of medicine, affiliated health care institutions, and formal clinical funding mechanisms. The head of a university department of medicine is often the chief of the affiliated hospital's department of medicine and may also be the head of the clinical income mechanism. Despite the overlap in personnel, the formal institutional separation and different statutory and regulatory rules[16] for universities, hospitals, and clinical funding programs mean that clinical faculty must have access to separate but appropriate dispute resolution mechanisms tailored to the specifics of *each* institutional setting. They must also have organizational support for the exercise of their rights in *each* institutional setting.

Clinical faculty rights are best protected when there is access to independent grievance arbitration. Grievance arbitration is a method of dispute resolution used primarily in unionized workplaces, where a grievance is a formal allegation that there has been a violation of the legal terms and conditions of employment, as set out in a collective agreement. Arbitration, by an independent third party panel, is the process by which the grievance is adjudicated. Grievance

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16 For example, resolution of disputes regarding threatened loss of hospital privileges is governed by provincially mandated procedures in each jurisdiction and cannot be superseded by locally negotiated alternative dispute resolution mechanisms, unlike disputes about maintenance of university posts.

arbitration panels were developed as an alternative to the civil courts, which were considered to be too slow, costly, and lacking in expertise and remedial power to resolve employment-related disputes.

Although short of the level offered by the civil courts, grievance arbitration provides an extremely high standard of procedural protection, including the right to a hearing in a timely manner, the right to legal representation, the right to present evidence and to challenge the evidence presented by others, the right to be provided reasons for the decision rendered, and the right to an external, unbiased adjudicator. The rules of the grievance arbitration process are set down in collective agreements and augmented by statutory provisions in provincial labour legislation. Participation by the employer in the process is mandatory and the decision rendered by the adjudicator is binding on all parties and is legally enforceable. As a system for resolving employment-related disputes it is superb, having near judicial level procedural safeguards without the rigidity and cost of the civil courts. At institutions where clinical faculty enjoy access to the same grievance arbitration systems as every other faculty member, this option works very well for resolution of disputes involving clinical faculty.

4.3 (a) Protecting Clinical Faculty Rights in Universities

Unfortunately, as noted previously, most clinical faculty do not currently have access to independent grievance arbitration in *any* institutional setting. In universities, this can be changed by bringing clinical faculty into academic staff association bargaining units, thereby allowing the application of collective agreements and their grievance arbitration systems.[17] There is *no* legal barrier in *any* province to university administrations voluntarily recognizing all clinical faculty as academic staff association bargaining unit members covered by academic staff association collective agreements. Voluntary recognition would give clinical faculty access to the academic freedom rights contained in university collective agreements, as well as to grievance arbitration if those rights are violated.

An alternative for clinical faculty, if university administrations refuse voluntary recognition, is to establish or strengthen existing clinical faculty associations. These associations would then negotiate with the university agreements on behalf of clinical faculty covering the terms and conditions of employment, faculty rights, and grievance arbitration procedures consistent with provincial labour laws. These associations can be voluntary groupings that negotiate independently of the protection of provincial labour laws or (except in Nova Scotia and Ontario) they can become certified bargaining units composed of clinical faculty – as clinical faculty associations have done at Laval, Sherbrooke and Montréal.

Establishing relationships with universities through collective agreements that provide independent grievance arbitration secures optimum rights and protections for clinical faculty in relation to their university work. Similar rights and protections are necessary with respect to their work at affiliated health care institutions.

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17 This has been done at Saskatchewan. At both Alberta and Calgary, the “full-time” clinical faculty are members of the general academic staff associations. The same is true for most “full-time” clinical faculty at the University of British Columbia.

4.3(b) Protecting Clinical Faculty in Health Care Institutions

4.3 (b)(i) Panels under Disciplinary Bylaws and Regulations

For most clinical faculty, maintenance of hospital privileges is essential to employment security and, by extension, to academic freedom. While the quality of procedural protection provided for dispute resolution constituted under health care institution bylaws varies considerably, the individual clinical faculty member is usually denied access to natural justice and procedural fairness in the initial stages and often in subsequent stages of the mandated processes.

In contrast to third party adjudicators under collective agreement grievance arbitration, members of dispute resolution panels constituted at health care institutions are often peers with little knowledge or experience in dispute resolution and often there is no appeal to external adjudicative bodies. In some instances, representatives of the administration sit in an adjudicative position over clinical faculty members. This is an unacceptable arrangement. The shortcomings of institutional dispute resolution mechanisms are one of the most critical academic freedom issues facing clinical faculty. This problem underlines the need for strong representative organizations that can negotiate proper dispute resolution procedures for clinical faculty. Such organizations would also assist members facing dispute resolution hearings, negotiate supplementary policies and rights in agreements with hospital administrations, and lobby governments to introduce fairer statutory and regulatory procedures.

4.3 (b)(ii) Appointment Disputes

The ability of clinical faculty to perform their work is conditional on continuation of their health care institutional appointments. When an individual is appointed to a post in a health care institution, separate from having been granted privileges, it is usually through a contract between the individual clinical faculty member and the health care institution. Any violation of this contract (such as the one discussed at 2.2(c)) is rarely judicable through a dispute resolution system that is governed by natural justice and procedural fairness, other than the civil courts, a costly and problematic solution.

As has been achieved by non-clinical faculty at universities, the goal for clinical faculty in relation to health care institutions is to collectively negotiate appointment procedures and other terms and conditions of work plus independent grievance/arbitration procedures to resolve disputes that are not governed by provincially mandated procedures. It is noteworthy that in many health care institutions, physicians are the only group of staff without collective agreement protections and rights.

4.3(c) Dispute Resolution and Clinical Funding Mechanisms

As noted earlier, there are myriad issues over which academic freedom disputes can occur. One such is the level of compensation clinical faculty members receive for duties performed. Such disputes are often treated as mere administrative matters, and mechanisms developed to resolve

them do not necessarily contain procedural safeguards necessary to adjudicate cases involving issues of academic freedom. Internal dispute resolution mechanisms often lack basic procedural protections, including rights to have an oral hearing before an independent adjudicator, to compel production of documents, to adduce and cross-examine evidence. This may be less a problem for resolving disputes over minor clerical errors or administrative oversights. But such shortcomings can be very serious when clinicians allege that their level of pay has been restrained as retribution for the exercise of academic freedom or other rights.

As in dealings with universities and health care institutions, clinical faculty require both procedurally fair and independent dispute resolution processes with respect to their clinical income, and organizational support in exercising their rights.

Section Five - Strengthening Clinical Faculty Representation

5.0 Dispute Resolution and Representation

Disputes within universities or health care institutions pit individuals against institution—the latter having substantial resources, expertise, and power. For this reason, neither excellent academic freedom and employment security language nor effective mechanisms to adjudicate academic freedom disputes are sufficient to protect clinical faculty. Unless clinical faculty members have meaningful representation in relation to such matters, workplace disputes are overwhelmingly one-sided, and rights on paper are difficult, if not impossible, to enforce. The legal costs of routine employment litigation, for example, can run into the tens of thousands of dollars. Complex matters, such as the Olivieri case at the University of Toronto, generate legal bills into the hundreds of thousands of dollars. Without strong support of representative organizations, the odds against individual faculty members are overwhelming.

5.1 Policy Representation

In addition to providing litigation support, representative organizations also act as voices for faculty in the policy and financial debates that occur within an institution and in the broader public arena. The existing weakness of academic freedom and employment security rights for many clinical faculty, and the urgent need to address this problem, makes this advocacy role all the more important.

5.2 Available Structures

To protect academic freedom, clinical faculty must have effective representation with respect to universities, health care institutions, and clinical funding mechanisms.

Currently, there are three types of organizations that provide specific representation for clinical faculty. These are:

- certified general academic staff associations (unions)
- uncertified general academic staff associations
- clinical faculty associations

Three additional organizations provide representation for all medical professionals, including clinical faculty. These are:

- institutional-based medical staff associations
- the Canadian Medical Protective Association
- provincial medical associations

Because of the complexities engendered by cross-appointments to both universities and health care institutions, no organization can provide complete representation to clinical faculty. It is not surprising, therefore, that clinical faculty representation across Canada is a patchwork, with faculty at different institutions and even within the same institution having representative support from a number of different organizations. The picture is complicated further because a significant number of clinical faculty have no access to specific clinical faculty representative organizations (academic staff associations or clinical faculty associations).

5.3 Representation and Universities

In assessing what forms of organization are best suited to clinical faculty *vis-à-vis* their relationships with universities, an appropriate starting point is to review the characteristics necessary for effective representation. These are

- democratic structure
- financial viability and independence through a mandatory funding mechanism
- legally enforceable collective bargaining relationship with employer
- the exclusion of managerial personnel
- inclusion within the broader academic staff community
- membership in provincial and national organizations
- intimate familiarity with academic freedom issues

The unionized academic staff association is the structure that meets all these criteria. However, with some significant exceptions, most clinical faculty do not currently belong to such organizations. Two factors, statutory prohibitions and tradition, have kept clinical faculty from this form of representation.

5.4 Statutory Framework

Eligibility for union membership is set out in labour relations legislation. This legislation typically excludes certain classes of employees from unionization, including managerial personnel and those with access to confidential labour relations information. In some instances this exclusion extends to persons engaged in professional practice, for example:

Ontario *Labour Relations Act*, 1995

Definitions

1. (3) Subject to section 97, for the purposes of this Act, no person shall be deemed to be an employee,

(a) who is a member of the architectural, dental, land surveying, legal or medical profession entitled to practise in Ontario and employed in a professional capacity; or

(b) who, in the opinion of the Board, exercises managerial functions or is employed in a confidential capacity in matters relating to labour relations. 1995, c. 1, Sched. A, s. 1 (3).[18]

Legislative prohibitions of this nature might seem a complete explanation for the absence of clinical faculty from their university's unionized association. In fact, statutory language such as this is the exception rather than the rule. More typical is that found in the *British Columbia Labour Relations Code*:

1 (1) In this Code:

"employee" means a person employed by an employer, and includes a dependent contractor, but does not include a person who, in the board's opinion,

(a) performs the functions of a manager or superintendent, or

(b) is employed in a confidential capacity in matters relating to labour relations or personnel;[19]

In the jurisdictions where there are universities with faculties of medicine, only Nova Scotia and Ontario have outright exclusions on professional membership. But even then, the "ban" is not what it appears. The ban has no impact in the two instances where academic staff associations are not certified (Toronto and McMaster). In the other four universities with faculties of medicine where the academic staff associations are unionized (Dalhousie, Ottawa, Queen's and Western Ontario), the legislation does not prevent an employer (the university) from voluntarily extending recognition to clinical faculty as members of the unionized bargaining unit and thereby being covered by the provisions of the collective agreement and its dispute resolution mechanisms.

In British Columbia, Manitoba, and Newfoundland medical professionals may unionize, with the proviso that they must belong to a separate bargaining unit unless a majority of the members of that unit choose to join the main unit in a workplace. At the University of Manitoba and at

18 *Labour Relations Act*, S.O. 1995, c.1, Sch. A.

19 *Labour Relations Code*, R.S.B.C. 1996, c. 244

Memorial University, clinical faculty do not have their own associations nor are they covered by the academic staff association collective agreements, although they could be. At UBC, some full-time medical faculty are covered by the UBC Faculty Association collective agreement. The rest are eligible to be members of the University Clinical Faculty Association, which has negotiated, and is seeking to enforce, individual contracts of employment.

Quebec and Saskatchewan place no restrictions on the right of medical professionals to unionize. Only in these two provinces are clinical faculty currently covered by unionized collective agreements. Clinical faculty are in the faculty bargaining unit at the University of Saskatchewan and covered by the collective agreement. Clinical faculty at Montréal, Laval, and Sherbrooke are unionized in their own clinical faculty unions and have negotiated collective agreements with their respective universities. At McGill, the general faculty are not unionized, and there is no clinical faculty association. In Alberta, academic medical professionals belong to academic staff association bargaining units under the *Post-Secondary Learning Act*, and are covered by the collective agreements at the University of Alberta and the University of Calgary.

Unlike in the United States,[20] nowhere in Canada have clinical faculty formed clinical faculty associations that have negotiated collective agreements (whether under labour law or not) to protect their rights in relation to hospitals or other health care institutions, despite a long history of such collective agreements being negotiated with hospitals for other professional groups such as nurses.

5.5 Tradition

Given the statutory framework, the absence of most clinical faculty from coverage by academic staff association collective agreements cannot be satisfactorily explained by legal prohibitions. A more complete explanation can be found in the traditions and culture of academic and professional employment, specifically in the broader reluctance of these groups to participate in organizational models (unions) associated with industrial workplaces. This reluctance delayed non-medical faculty members from broadly embracing unionization until the 1970s and 1980s and continues to persist in rapidly diminishing segments of the academic population to this day. Among clinical faculty, this pattern has been sustained over time by the differences that have developed between them and non-clinical academic staff. Separate systems of remuneration and employment status for many clinical faculty have set them apart on university campuses, hindering their identification with the larger body of academics and their organizations. While there are examples of heroic voluntary efforts being made by academic staff associations for clinical faculty (*e.g.*, the Olivieri case) there is not usually a close relationship.

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20 In June 1999, the American Medical Association voted in favour of the unionization of physicians. One of the motivating concerns was the need to protect the academic freedom of clinical faculty, whose clinical independence was being impaired by the financial considerations of the insurance industry. It is estimated that about 35,000 physicians are currently unionized in the United States.

Recent developments, however, suggest that academic staff associations and clinical faculty can break with tradition and form closer bonds. In the last several years, academic staff associations have become much more inclusive organizations, opening membership to part-time and contract academic staff. Academic staff associations and the CAUT have also become key players in a number of academic freedom cases at university-affiliated health care institutions, and have thereby established new links with clinical faculty.

On the clinical faculty side, the same forces—diminished academic freedom and economic rights—that drove academic staff to develop stronger representative organizations, including unionized associations, are now occurring with increasing frequency at university-affiliated health care institutions. Historically, efforts by staff to organize are invariably a response to such events. Conditions may now be appropriate for clinical faculty to establish stronger representative organizations, as has happened in the 1970s with the creation of the three unionized clinical faculty associations at Montréal, Sherbrooke, and Laval, and as happened in 2001 at Saskatchewan when clinical faculty became members of the general academic staff bargaining unit.

While it might be disconcerting to some, the involvement of medical doctors in collective bargaining relationships is not as challenging a notion as it might be perceived. In addition to the positive experiences of clinical faculty in Alberta, British Columbia, Quebec and Saskatchewan, there are other examples in the medical world to draw upon. For example, residents (doctors in specialty training) in British Columbia are unionized. Many of the provincial medical associations in Canada function *de facto* as unions by engaging in collective bargaining with provincial ministries of health. The barriers to unionization are not insurmountable.

5.6 The Best Possible Models

In order for clinical faculty to establish and enforce academic freedom rights, they need strong representation of no less a standard than that enjoyed by all other academic staff. The indices of good representation—democratic structure, financial independence, collective bargaining, exclusion of managerial personnel, inclusion within the academic staff community, membership in provincial and national organizations, and intimate familiarity with academic freedom issues—are most strongly present in unionized academic staff associations. The question is not whether this is the best model available for clinical faculty, but whether it is a realistic one. From a legal standpoint in most Canadian jurisdictions, it is. In Ontario and Nova Scotia, where it is only possible with the approval of the university administration, the challenge is to find the best alternative if the administration refuses voluntary recognition. In theory, the most obvious candidate is a clinical faculty association. As representative organizations, these associations should be well positioned to understand the specific interests of, and to speak for, clinical faculty in relation to the university. However, with a few notable exceptions, such organizations are non-existent or rudimentary, do not possess adequate funding mechanisms, include senior administrators as members, and do not have a tradition or capacity to represent members before administrative tribunals. Nor have they been able to negotiate agreements with provisions and dispute resolution mechanisms that protect clinical faculty members' rights in the university.

As a result, with some exceptions, they are not currently able to effectively defend the interests of clinical faculty. Because of the legitimacy they have as authentic representatives of clinical faculty, in the absence of certification rights, enhancing these associations could be an important part of securing academic freedom protection for their membership. In this regard, certain of the existing uncertified general academic staff associations can serve as a model. For example, the Faculty Association of the University of Waterloo, although not a certified union, collectively bargains on behalf of its members, enjoys an automatic dues check-off and has negotiated a grievance arbitration mechanism with natural justice protections, including access to independent third party adjudication. There is no legal reason why similar representational structures could not be put in place for clinical faculty in jurisdictions where they are barred by statute from certification and where the university administration refuses to voluntarily include them in the certified academic staff association bargaining unit.

5.7 Representation and the Health Care Institution

5.7(a) Privileges

The Canadian Medical Protective Association (CMPA) represents physicians, including clinical faculty, in matters related to the modification or withdrawal of hospital privileges.

The CMPA is a mutual defence organization for physicians who practise in Canada. It is funded and operated on a not-for-profit basis for and by physicians and has a membership of more than 62,000, comprising about 95 percent of the doctors licensed to practise in Canada. Its *raison d'être* is to protect physicians by providing legal defence and other services regarding:

- civil legal actions alleging malpractice or negligence
- criminal proceedings arising from medical care
- complaints and disciplinary proceedings related to a licensing body
- human rights complaints arising from medical care
- coroners' or other fatality inquiries
- inquiries about doctors' work or conduct in hospital
- provincial or territorial billing agency inquiries

The strengths of the CMPA are its expertise and deep financial resources. However, it does not purport to fulfill a role beyond the one it has narrowly defined for itself. In particular it does not provide a broader bargaining or political advocacy function or possess any special academic freedom expertise.[21]

5.7 (b) Other issues

In areas outside CMPA jurisdiction, clinical faculty representation is limited. Institutional medical staff associations currently are one source of representation.

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21 For a discussion of both the importance of the CMPA and the limitations in what it can address, see Thompson, Baird and Downie, *The Olivieri Report*, pp. 421-431.

Medical staff associations differ considerably from academic staff associations and clinical faculty associations. Membership is broader than just clinical faculty, typically comprised of all categories of medical staff at health care institutions. Membership is often mandatory and can therefore include persons who occupy managerial positions.

The roles of such organizations are, in part, cooperative—to facilitate and encourage the fulfillment and discharge of the collective responsibilities of the medical staff—rather than purely representative. Sometimes an advocacy role is explicitly recognized. For example:

> Calgary Regional Medical Staff Association
>
> Mandate: The Calgary Regional Medical Staff Association (CRMSA) is an independent voice representing the physicians of the Calgary region (including Cochrane and Airdrie).
>
> Process of Advocacy for Physicians
>
> A member can appeal to CRMSA President or Site Representatives re:
>
> unsatisfactory performance review*
> unrequested change in privileges
> termination of privileges
> suspension of privileges
> unsatisfactory working conditions*
> refusal of LOA**
> refusal of appointment to Regional Health Authority Department
> any other significant issue regarding physician rights. Currently we have no process in place to decide what is a "significant issue".*
>
> *signifies no Bylaws or Rules and Regulations to cover
> **Rules and Regulations apply; no Bylaws.[22]

In summary, medical staff associations share with clinical faculty associations the strength of excellent knowledge of particular institutions and in addition usually feature mandatory membership. However, unlike both clinical faculty and academic staff associations, they have no specified connection to universities or expertise in academic matters. The inclusion of managerial personnel in the membership and the absence of funding structures lessens their independence. As clinical faculty seek to enforce their academic freedom protection, medical staff associations represent a potential source of support but do not appear to be viable “stand alone” representative organizations.

As such, representation with respect to hospital issues is best filled by empowered clinical faculty associations that undertake to negotiate collective agreements with hospital administrations, as have organizations representing virtually all other categories of hospital staff.

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22 Calgary Regional Medical Staff Association, Process of Advocacy for Physicians. Retrieved May 27, 2004, from http://www.crmsa.org/process.htm.

5.8 Representation and Clinical Faculty Income

Clinical faculty are paid in a variety of ways. Some receive income directly from the university. Associations representing clinical faculty should negotiate methods, amounts, and appeal procedures for any university income directly with university administrations.

In other cases, there is no university income. Typically this is where all clinical faculty income is paid through a comprehensive alternative funding plan that pools all sources of revenue. The plan usually spells out how the funds are to be allocated and any appeal procedure concerning allocation decisions. Associations representing clinical faculty may have to negotiate with governments, health care institutions, and universities to achieve agreements that set out terms for the allocation of such funding and for procedures for dispute resolution.

For others, there may be clinical research income paid by research institutes of health care institutions. Associations representing clinical faculty should negotiate methods, amounts, and appeal procedures for research income directly with health care institutions or their research institutes, if the latter is deemed a separate legal entity.

In yet other cases, clinical income may come on a direct fee-for-service basis in which the fee levels are negotiated by the provincial medical association with the provincial government.

To protect the academic freedom of clinical faculty, it is essential that their income entitlement is governed by a rules-based system *that they negotiate* and for which there are procedures to resolve disputes—procedures governed by natural justice and procedural fairness—including final arbitration before an independent arbitrator or arbitration panel. This means that for any university income, for combined clinical/university income, for institutional research income, or for income through alternative funding plans, clinical faculty should collectively negotiate the allocation procedures, allocation formula, if any, and the procedures for resolution of disputes. This will require an association representing clinical faculty as described above.

5.9 Moving Forward

Effective organizational models are available for clinical faculty. However, the mere existence of such models does not mean that they will gain wider application. Their adoption will require that significant barriers be overcome, including the cultural distance between academic staff and clinical faculty and the reluctance of professionals to unionize.

Strong representative organizations for clinical faculty are not going to appear spontaneously where they are lacking, but nor can they be imposed from the outside. The broader academic staff community has a responsibility to assist clinical faculty in achieving full representation, but this is a responsibility that can only be met if there is no interference with the democratic rights of clinical faculty. Through dialogue and cooperation, academic staff and clinical faculty can ensure that no faculty members fall outside the protection of academic freedom.

Section Six - Conclusions and Recommendations

6.0 Conclusions

Academic staff, clinical and non-clinical, must defend their academic freedom against infringement by outside interest groups, university administrations, and corporate and government funders. For non-clinical academic staff, the dynamics of this task are relatively straightforward. The majority of them have a single employer (the university administration), a single major source of income (university salary), a single dispute resolution system (grievance arbitration under the collective agreement) and a single representative organization (the academic staff association).

The situation for clinical faculty, who face a multiplicity of institutional relationships, is far more complex. Clinical faculty answer to both university and health care administrations; their income derives from a variety of sources and they are represented to varying degrees by several different organizations, including provincial medical associations, the CMPA, medical staff associations, clinical faculty associations, and, in some cases, academic staff associations. The diversity of institutional relationships and income sources creates numerous "choke points" where academic freedom can be infringed, and the corresponding need for multiple dispute resolution mechanisms. The overlapping representation structure has the potential to diffuse the energies of representative organizations.

Prompted by this situation the task force examined the circumstances of clinical faculty across Canada, focussing on the uniqueness of their environment, but mindful that clinical faculty deserve no less academic freedom protection than other academic staff. The task force was able to identify vulnerabilities common to clinical faculty across the country and has formulated six recommendations to ensure that the academic freedom of clinical faculty, at universities and affiliated health care institutions, is protected.

This is a critical moment for clinical faculty. Funding shortfalls have placed great strain on universities and health care institutions. Administrations have responded by building increasingly hierarchical management structures, structures that may produce narrow, immediate efficiencies, but place the future of academic medicine in danger. Pressure to produce clinical income takes time away from teaching and research. Incentives to create commercializable products push economic concerns, rather than scientific and ethical considerations, to the forefront. As room for independent thought, action and critical examination—the very things that advance the quest for greater human knowledge—disappears, universities and affiliated health care institutions are themselves diminished.

The recommendations of this report—that universities and affiliated health care institutions make strong declarations of academic freedom rights, provide security of appointment and security of income, and allow access to dispute resolution systems characterized by natural justice; and clinical faculty themselves form powerful representative organizations—will increase the ability of clinical faculty and the institutions where they work to advance the

boundaries of human knowledge in health sciences and thereby protect the health and well-being of Canadians.

Strengthen Academic Freedom Rules for Clinical Faculty

The rules that govern the working lives of clinical faculty are set out in a variety of written instruments—mission statements, guidelines, policies, affiliation agreements, and employment contracts. A strong commitment to academic freedom in these documents is critically important for clinical faculty, both to establish a legal and policy basis for academic freedom rights and to foster a culture of institutional respect for academic freedom.

1. To ensure that academic freedom is a foundational principle of academic medicine, explicit references to, and protections of, academic freedom must be included in institutional mission statements, institutional policy, university-hospital affiliation agreements, funding plans, collective agreements, and employment contracts.

Protect Security of Appointment and Security of Income for Clinical Faculty

Termination of employment is a means of silencing critical opinion. The academic freedom of clinical faculty therefore depends upon security of position and security of income in respect to both universities and health care institutions.

2. To protect the academic freedom of clinical faculty

- *(i) clinical faculty members must be eligible for tenure in respect of university appointments and university income*
- *(ii) decisions in respect of health care institution appointments and privileges must follow established rules*
- *(iii) health care institution appointments and privileges must be for renewable terms and can only be terminated or not renewed for just cause*
- *(iv) health care institution rules must include protection for academic freedom, such that the exercise of academic freedom cannot be a justification for non-renewal, variance, or termination of appointments and privileges*
- *(v) procedures must be established to ensure that allocations of clinical income are made according to clear procedures and protected against arbitrary or capricious decisions*

Ensure Access to Natural Justice for Clinical Faculty

In the absence of effective dispute resolution systems characterized by natural justice and procedural fairness, written guarantees of academic freedom and appointment and income security are insufficient to protect clinical faculty.

3. Universities, health care institutions, and clinical funding plans must ensure that clinical faculty have access to dispute resolution procedures characterized by natural justice and procedural fairness, including access to independent external arbitration for resolution of matters other than those covered by statutory prescription.

Strengthen Representative Organizations for Clinical Faculty

Disputes between clinical faculty members and their university or health care institutions pit individuals against organizations. Unless clinical faculty have meaningful representation, workplace disputes are one-sided affairs, and academic freedom rights are difficult to enforce.

4. Clinical faculty should create effective representative organizations with respect to universities, health care institutions, and clinical funding plans. These organizations should be characterized by

- *democratic structure*
- *financial viability and independence*
- *a legally enforceable collective bargaining relationship with the institution*
- *the exclusion of persons in managerial positions*
- *participation in the broader academic staff community*
- *intimate knowledge of academic freedom issues*

Where membership in existing certified associations or creation of new certified associations is not possible, clinical faculty should create robust uncertified associations (similar to academic staff associations at non-unionized universities that negotiate collective employment contracts and enjoy access to dues check-off and independent grievance arbitration mechanisms).

Appendix A

The CAUT Task Force on Academic Freedom for Faculty in University-Affiliated Health Care Institutions

Background

Prompted by the absence of effective protection for clinical faculty to conduct research, speak freely and share findings with patients and colleagues without interference, CAUT established a task force to examine academic freedom at university-affiliated health care institutions and to make recommendations as to how academic freedom for clinical faculty could be best enhanced and protected.

Membership

Dr. Philip Welch, chair of the task force, is a medical geneticist and professor of pediatrics at Dalhousie University. He was formerly head of the Medical Genetics unit and also head of Cytogenetics at the IWK Health Centre in Halifax. He is a founding fellow of the Canadian College of Medical Geneticists and a former vice-chair of the Dalhousie University senate, former president of the Dalhousie Faculty Association, and former vice-president of CAUT. Welch is a consultant in medical genetics in Nova Scotia, and to the major hospitals in New Brunswick and Prince Edward Island. He currently chairs the Dalhousie University Pension Advisory Committee.

Dr. Carol E. Cass is professor and chair of oncology and Canada Research Chair of Oncology at the University of Alberta, Director of the Cross Cancer Institute and Vice-President of the Alberta Cancer Board. Cass, a member of the Academy of Sciences of the Royal Society of Canada, was president of the Canadian Society of Cellular & Molecular Biology, a founding member of the executive of the Canadian Society of Biochemistry and Molecular & Cell Biology and an inaugural member of the Institute Advisory Board of the CIHR Institute of Cancer Research. She has served on the Medical Advisory Board of the Gairdner Foundation and is currently a member of the selection committee of the Canadian Medical Hall of Fame.

Dr. Gordon Guyatt is a professor in the departments of clinical epidemiology and biostatistics and medicine at McMaster University. He is a clinical epidemiologist practicing secondary care hospital-based internal medicine. After being appointed director of the McMaster internal medicine residency program, Guyatt initiated a process that lead to adoption of a policy limiting pharmaceutical company access to residents as part of their program. He has been a prolific researcher having published more than 400 papers in peer-reviewed journals.

Dr. Alan C. Jackson is a neurologist and professor of medicine at Queen's University. He is also associate professor in the department of microbiology and immunology, and attending

staff (neurology) at Kingston General Hospital. He is a member of the editorial boards of the Journal of NeuroVirology and the Canadian Journal of Neurological Sciences and a member of the Board of Directors of the International Society for Neurovirology and of the Rabies in America Steering Committee. Jackson is a former member of the executive committee of the Queen's University Faculty Association and of the Clinical Teachers' Association of Queen's University (and treasurer).

Dr. Derryck Smith is head of the division of child and adolescent psychiatry at the University of British Columbia, head of the department of psychiatry at the Children's & Women's Health Centre of British Columbia and the regional clinical psychiatrist, child and youth programs for Vancouver/Richmond Health Board. He is president of the UBC Clinical Faculty Association and past-president of the British Columbia Medical Association.

Terms of Reference

The CAUT Task Force on Academic Freedom for Faculty in University-Affiliated Health Care Institutions

Terms of Reference

(a) review the state of academic freedom for faculty* at university-affiliated health care institutions across the country;
(b) review the mechanisms and procedures for dealing with tenure, harassment, and violations of academic freedom at each university-affiliated health care institution;
(c) recommend model policies on academic freedom, including tenure policies, to be adopted by universities and university-affiliated health care institutions;
(d) recommend how CAUT can promote academic freedom at university -affiliated health care institutions;
(e) recommend ways (given the statutory rules in different provinces) that medical and health-related faculty members who work in health care institutions affiliated with universities can be provided with effective grievance and arbitration procedures.

* "Faculty" includes geographic full-time faculty (GTF), part-time clinical faculty, clinical researchers, basic scientists and bioethicists.

The Canadian Association of University Teachers (CAUT)

Founded in 1951, CAUT is the national voice for academic staff. Today, representing 35,000 teachers, librarians, researchers, and other academic professionals, CAUT is an outspoken defender of academic freedom and works actively in the public interest to improve the quality and accessibility of post-secondary education in Canada.

Appendix B

Glossary

Academic Freedom - Academic freedom is the right of academic staff to teach, study, and publish regardless of prevailing opinion, prescribed doctrine, or institutional preferences. It includes the freedom of academic staff to express critical opinion about broad public issues and the institutions at which they work. It also includes the freedom to participate in professional or representative academic bodies and the mechanisms of governance that regulate the core functions of their institutions. It is sustained by security of appointment and security of income.

Academic Staff Association - An organization representing the interests of university faculty, librarians, and researchers, particularly in their relationship with the university administration, but also in respect to wider social, political and economic issues. Academic Staff Association is synonymous with the less inclusive term "Faculty Association."

Affiliation Agreement - An agreement between a university and a health care institution setting out the terms and conditions of their relationship.

Alternative Funding Plan - A method of funding the remuneration of Clinical Faculty whereby a Health Ministry provides money for Clinical Faculty in accordance with a preset agreement.

Appointment - The assignment of a person into a position. Clinical Faculty are expected to hold appointments at both a university and its affiliated Health Care Institution.

Bargaining Unit - Employees who, because of their commonality of interests, are recognized at law as an appropriate group to bargain collectively through a union with ~~an~~ *their* employer.

Certified Association - A representative organization that is recognized under labour legislation as the bargaining agent for members of a bargaining unit.

Clinical Faculty - Health sciences professionals, generally those with an MD and/or PhD degrees, who hold simultaneous appointments at both a university and a teaching hospital or other health care institution. Membership spans the spectrum from full time university professors to physicians in private practice who teach medical students on a part-time or occasional basis.

Clinical Income - The portion of a Clinical Faculty member's remuneration derived from either Clinical Billings, a Practice Plan or other funding arrangement separate from a university salary.

Clinical Billings - Fee per service payments billed by Clinical Faculty to a provincial medicare plan.

Clinical Faculty Association - A Representative Organization whose membership is comprised only of Clinical Faculty. A Clinical Faculty Association can be either certified or uncertified.

Collective Agreement - A contract between a union and an employer setting the terms and conditions of employment for all members of a bargaining unit. A collective agreement can only be negotiated by a Certified (Unionized) Association.

Disciplinary By-laws - Health care institution regulations governing the conduct and discipline of medical staff.

Dispute Resolution Mechanism - A process to resolve conflicts.

Employment Contract - A contract between an individual employee and an employer setting the terms and conditions of employment for the employee.

Grievance - In unionized workplaces, a formal allegation that there has been a violation of the legal terms and conditions of employment.

Grievance Arbitration - A formal process to adjudicate grievances that is characterized by adherence to the rules of natural justice and procedural fairness, including the right to a hearing before an independent arbitrator.

Health Care Institution - A hospital or medical research institute.

Medical Staff Association - An organization whose membership comprises all medical staff at a hospital or health care institutions, including medical staff who occupy managerial positions. Membership is unconnected to university appointment.

Natural Justice and Procedural Fairness - A set of legal rules whose purpose is to allow the parties to a conflict the opportunity for a fair adjudication of their concerns. The rules include the right to be informed of the allegations against one, the right to a hearing in a timely manner, the right to disclosure of evidence, the right to legal representation, the right to present evidence and to challenge the evidence presented by others, the right to be provided reasons for any decision rendered and the right to an independent, unbiased judge or arbitrator.

Practice Plan - A method of remuneration whereby Clinical Billings are pooled and divided up amongst Clinical Faculty according to a preset agreement.

Privileges - The scope of permitted clinical activities that a physician can perform in a Health Care Institution.

Representative Organization - An organization whose purpose is to defend and advance the interests of its members.

Tenure - A system of university appointment whereby the services of an academic staff member can only be terminated for just cause, upon reaching the age of retirement, or because of financial exigency (an imminent financial crisis which threatens the survival of the institution as a whole). Tenure's purpose is to protect academic freedom, and thereby the advancement of knowledge, by preventing faculty from being fired for exploring controversial or unorthodox areas of research or for speaking out on controversial issues.

Unionized Association - An Academic Staff Association that has applied for, and received, certification under labour legislation, or has been voluntarily recognized by the employer as a union, thereby allowing it to be the legally recognized bargaining agent for members of the association.