Ethnicity, with its related ideologies related to race, colonialism, nationality and immigration, becomes a confounding variable, its impacts othered and then obscured

Ultimately, as a heuristic, intersectionality asks researchers to appreciate the complexity of experience, and to analyse the enmeshed nature of ideologies and oppressions that construct difference to structure the social world. At a conference organised in 2009 to celebrate twenty years of 'intersectionality', Crenshaw entreated her listeners to remember the context in which she originated the term—as a 'metaphor to capture both the structural and dynamic aspects … of discrimination' that converged to shape the experiences of Black women in the American legal system.[15,16] Extrapolated to institutions that are responsible for medical education, researchers and policymakers can—and indeed must—use their understanding of intersectionality to interrogate, and then address, the ideologically shaped practices that structure who is represented in the ranks of full professors.

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Transforming existing norms for payment and legitimacy of 'teaching work' in medical education

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[Correction added on 13 February 2020 after first publication. The name of the author Hugh Alberti has been corrected in this version]

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What counts as work and the rewards attributed by society for that work are complex. Norms are often well-established within societies and organisations. These norms produce particular power relations and, when not democratically distributed, related inequalities. What we value as work and how this is measured and rewarded are crucial questions for medical education. At the heart of medical education is a tension between curricula ambitions and immersion in the complex, patient-driven world of clinical healthcare. Work as a clinical teacher crosses these two worlds of university-based academia and healthcare service. Each has deeply embedded hierarchical cultures which value certain work and rewards as legitimate; and particular modes of outcome measurement as more or less valuable and reliable.

While service-teaching tensions exist in the clinical workplace, tensions exist within academic settings between the relative historical and cultural value attributed to research and teaching activities.[1] In the UK, a range of recent initiatives have emerged to address this, such as the Teaching Excellence Framework, Higher Education Academy accreditation programmes and related significant shifts in promotion criteria for staff across teaching, research, citizenship and engagement activities. Despite the concept of 'doctor as teacher' being core to clinical professional identity, teaching in clinical settings ranges from the peripheral and piecemeal efforts of individuals, through to coordinated and embedded apprenticeships within committed organisations.[2] Recent attempts to encourage or facilitate greater teaching commitment have included incorporation in performance management processes such as appraisal; consideration of teaching activity for inclusion in the primary care Quality Outcomes Framework (QOF); and attempts by Health Education England to make more explicit and transparent the allocation of funds within primary and secondary care.[3]

> *What counts as work and the rewards attributed by society for that work are complex*

Martinez et al [4] invite us to consider important questions about the provision of medical education. They problematise the delivery of clinical teaching as undervalued work. They highlight the competing demands of clinical service and related inattention and attributed rewards for teaching. Martinez et al go on to propose individual, monetary rewards as a potential solution to this problem and explore participants' responses to this initiative.

Financial reward for activity is a familiar, but controversial approach within Western society, resulting in a range of unintended consequences and behaviours. The attribution of monetary value to particular activities is complex and can be counter-productive. A UK study, when 25% of GPs' income was derived from QOF financial incentives, demonstrated a number of unintended consequences including a perceived reduction in the importance of 'unrewarded activities' and of the patient agenda.[5] Incentive scheme ambitions can become reduced into easy-to-measure markers of 'quality' and 'success', often used to compare and rank activity.[6] Health economics lecturers will remind medical students of the *relational* or *comparative* nature of calculations. What, for example, is teaching work compared to in order to gauge its worth? This can be problematic, with for example, marked income inequalities emerging in some academic institutions between scientist and clinical colleagues where well-intentioned efforts have been made to encourage clinicians into academia with parity of clinical pay. Disparities can also emerge within teaching types, such as between under and postgraduate, or medical and allied healthcare professional learner groups.

> *Financial reward for activity is a familiar, but controversial approach within Western society, resulting in a range of unintended consequences and behaviours*

Inevitably, financial incentives raise questions about how to determine the nature of work and related rewards. Some worry that financial rewards for teaching work might undermine the quality and commitment of teachers to engage in medical education. These arguments tend to position teaching as morally important, but focus on physicians' personal motivations to 'give something back' or 'support students', rather than the financial worth of this work. Feminist critiques have identified similar phenomena in particular forms of work such as 'caring', which are not highly valued by society as worthy of financial reward.[7]

> *Incentive scheme ambitions can become reduced into easy-to-measure markers of 'quality' and 'success', often used to compare and rank activity*

Most medical education aspires to tutor payment which is equivalent and reasonable, while continuing to engage commitment from teachers if recruitment, quality assurance and professional development measures are robust. But how do we do this? One solution offered by Martinez et al[4] is individual financial reward for teaching. There are challenges to both individual and organisational approaches. Barber et al identified an increasing cohort of independent clinicians teaching 'in their own time', peripheral to the core clinical organisation of general practice.[2] We know from organisational literature about delegation of work, that positioning staff and workload 'outside' of core organisational structures can be problematic and challenges ways to foster regular feedback communications; staff support and belonging; career development and more.[8] Conversely, paying organisations, specifically large teaching hospitals, substantial sums to teach has often provoked concerns about the transparency and accountability for funds in relation to teaching organisation and delivery.

This is a critical time for us to question how we should frame and position teaching payment as 'a problem', in order to explore and establish feasible 'solutions'

This is a critical time for us to question how we should frame and position teaching payment as 'a problem', in order to explore and establish feasible 'solutions'. Medical education lies at the intersection between several well-established cultures, challenging how and with what teaching work should be compared, to establish its relative financial worth. Any exploration of possible solutions, needs to consider both the situated and contextual nature of these challenges, in addition to the clinical education community developing broad principles applicable across organisational settings. Is, for example, rewarding an individual for teaching work as a separate activity productive in the longer term, for the integration and legitimacy of teaching in the wider professional context? Can explicit inclusion of teaching in job plans support protected time for teaching as an accountable and legitimate element of work? There is no doubt that hierarchies exist in both academic and clinical settings, which currently disadvantage teaching activity as legitimate and valuable. Understandings of these sociocultural elements of clinical education need to be integrated into discussions about financial reward, and how these rewards operate within and support organisational structures and cultures. No option is perfect, but we need to acknowledge, openly challenge and ultimately transform the wider professional cultures in which teaching is situated, to ensure future, sustainable delivery of high quality workplace-based learning.

No option is perfect, but we need to acknowledge, openly challenge, and ultimately, transform the wider professional cultures in which teaching is situated, to ensure future, sustainable delivery of high quality workplace-based learning

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