Faculty Development in Family Medicine

A reassessment

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SUMMARY

The 16 Canadian departments of family medicine were surveyed to ascertain the availability and content of faculty development activities. The results suggest numerous changes since 1985 and a strong commitment to faculty development. With the consolidation of many faculty development activities to date, departments should now consider other methods of faculty development, broaden their activities beyond the current emphasis on "teaching skills," examine the possibility of integrating faculty development with faculty evaluation, and conduct more systematic program evaluations.

RÉSUMÉ

Les seize facultés canadiennes de médecine familiale ont fait l'objet d'une étude dans le but de vérifier l'existence et le contenu d'activités reliées au développement professoral. Les résultats obtenus tendraient à indiquer que de nombreux changements sont survenus depuis 1985 et que les facultés de médecine sont résolument engagées sur la voie du développement. Un grand nombre de leurs activités étant déjà bien implantées, les facultés de médecine devraient maintenant explorer d'autres méthodes de développement professoral, élargir leurs activités au-delà des "habiletés d'enseignement" sur lesquelles ont met actuellement l'accent, examiner la possibilité d'intégrer développement professoral et évaluation des professeurs, et procéder à l'évaluation des programmes de façon plus systématique.

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IN THE LAST DECADE FACULTY development has become an important component of academic family medicine.[1,2] Departments of family medicine have tried to balance the needs of their teachers with institutional imperatives, and a variety of programs have been designed to assist medical faculty in their teaching roles.[3-7]

In 1985 we surveyed the status of faculty development programs and activities in Canada.[8] At that time, we found that, although most programs sponsored faculty development activities for their faculty, they were limited by financial constraints, a lack of available manpower, and time restrictions. Few departments had a specified plan for faculty development, and most activities were planned ad hoc. In addition, no comprehensive orientation activities were available for new faculty and little attention was paid to established part-time faculty. Teaching workshops were the most common activity.

Since 1985, several significant events have influenced Canadian departments of family medicine. Elimination of the rotating internship, and the subsequent expansion of family medicine training programs[9,10] has increased the demand for new family medicine teachers and has highlighted the need to prepare new teachers for their teaching roles. At the same time, faculty development activities have gained a higher national profile, and many new programs have been developed. What differences do we see? What changes have been made?

This study aimed to examine the growth and development of faculty development programs and activities in Canadian departments of family medicine in light of the many changes that have taken place since 1985. Potentially the results will provide a more accurate profile of Canadian faculty development activities and will facilitate the further exchange of information, resources, and expertise.

METHOD

In the spring of 1991, a four-page survey questionnaire, promising anonymity and confidentiality, was sent to all Canadian departments of family medicine. This questionnaire, based on the survey questionnaire used in 1985,[8] was completed by 13 individuals responsible for faculty

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development and by three departmental chairmen.

Respondents were asked to answer a series of questions concerning their departmental structure and plan for faculty development, the content and methods of ongoing activities, strategies for implementing faculty development, and available resources, both human and financial. They were also asked to comment on faculty participation, the formal evaluation of faculty development activities, and the most common problems encountered. Some questions required a simple yes or no answer; some allowed participants to check off as many responses as were pertinent to them; other questions requested open-ended descriptions of individual program details. Following one reminder, all 16 departments responded.

Table 1. **Most frequently reported strategies for faculty development**

TEACHING METHODS	NO. DEPARTMENTS*
Half-day workshops or seminars	12
2-day workshops	9
Noon-hour or early morning conferences	5
Individual training using senior preceptors	4
Ongoing part-time courses	4
12-month to 24-month fellowships	2
Week-long courses	1
4-month or 6-month fellowships	1

**Total is greater than 16 because departments chose as many methods as were applicable.*

RESULTS

Departmental structure and plan

Of the 16 departments surveyed, six had a faculty development committee. Fourteen (88%) had designated someone to be responsible for faculty development, eight of whom were paid specifically for this activity. The time spent on faculty development by these individuals ranged from 2% to 20%; 10% was the most commonly cited percentage. Remuneration for this activity varied significantly, from "sort of" to "yes: part of my salary."

Of the 14 individuals responsible for faculty development, all but one were physicians; the one exception was a non-physician PhD. However, six of the 13 physicians had an additional degree, such as an MEd or an MClSc.

Half of the respondents indicated that they had a policy or plan for faculty development. This plan varied from a description of available activities to an educational mission statement. Five (31%) of the departments surveyed required faculty to participate in faculty development activities. One required this for all faculty, two for full-time faculty, and two for "expansion" faculty only.

Participation in faculty development was a criterion for promotion in two departments. Faculty evaluation was a key component of faculty development in another.

Seven of the 16 departments had conducted a systematic assessment of faculty needs during the last 5 years. The key categories included in this assessment were teaching, research, and administration.

Faculty development activities

Orientation activities. An orientation program was available in eight departments. Most of these programs were informal, varying from the distribution of printed material to social dinners. However, one program developed an orientation workshop for new faculty, in response to the influx of new teachers following the Quebec expansion, and two programs developed mentorship programs, for new faculty. Other departments used their ongoing faculty development activities for their new teachers, but had not designed specific programs for them.

In-house activities. Thirteen (81%) departments offered in-house faculty development activities. All provided training in teaching skills, seven in research, and two in administration. Although the content and methods of these activities varied widely, the main emphasis lay on clinical supervision, evaluation, and principles of teaching and learning. Teaching the principles of family medicine was not prominent, although working with "problem" residents was. Research and administrative skills were also not emphasized.

The most common strategies used for faculty development are summarized in *Table 1*. Half-day workshops and seminars were the most commonly reported activity.

Respondents were also asked to describe their most "successful" activity to date. This included weekly teacher training sessions; a workshop on hospital rounds; the development of a series of teaching videotapes for community-based practitioners; an orientation workshop for new faculty; a seminar on the patient-centred clinical method; and a series of workshops on effective writing.

The most innovative activities cited were faculty development by distance education, faculty mentorships for rural teachers, "booster" sessions designed to reinforce previously acquired skills, ongoing site visits to community practices, pedagogical consultations, and the development of an index of faculty development resources.

Departments were also asked to describe how their faculty development activities had changed in 6 years. Respondents noted that their activities are now "more structured," "more interactive," and "more community based." One program reported that the focus of activities has moved from research to teaching, whereas another noted that faculty development is now a priority.

Respondents were also asked to indicate the rate of participation among faculty members. Responses ranged from 5% to 100%. The most common response was 50%. Of the participants, 40% were considered "new" faculty; 33% were considered "mid-level" faculty; and 35% were considered "experienced" faculty. Most program directors reported that they were satisfied with the participation of their faculty.

However, the evaluation of faculty development activities appeared difficult. Although 50% of the programs did evaluate their activities, the data collected were mostly "happiness data," designed to assess participant satisfaction immediately after the workshop or seminar.

Outside access. All but one department had access to faculty development activities elsewhere in the university (eg, the Dean's office; the Office of Instructional Development; the Faculty of Medicine). Of these, all but one availed themselves of this facility. Sixty percent of the departments encouraged their teachers to attend faculty development programs in other institutions. The most commonly cited programs included the Section of Teachers (of the College of Family Physicians of Canada) workshops, the McGill Department of Family Medicine Workshops, and the University of Western Ontario fellowship program.

Resources and support

Eleven (69%) departments provided support for travel. Release time for faculty to pursue their own interests was offered in six centres; study leaves were available in nine. No department facilitated a faculty exchange program.

To encourage participation in faculty development, the following tactics were used most frequently: assisting financially whenever possible; arranging appropriate time off; and circulating available information. Support from the chairperson and combining social and scientific activities were not frequently cited.

Respondents were also asked to indicate their most commonly encountered problems in planning and implementing faculty development activities (*Table 2*). A lack of time, and the busy schedules of physicians, were the most frequently cited problems. As one respondent claimed, "our biggest problem is time, time, and time!" Concern regarding faculty participation was best expressed in the lament that "the people who need it the most attend the least."

Overcoming these problems was also mentioned as the most pressing need for faculty development. Other needs included the necessity to train new teachers, the improvement of clinical teaching in general, faculty evaluation, and the integration of problem-based learning into residency programs.

DISCUSSION

Despite considerable variability in faculty development activities across the country, the results of this survey suggest a strong

Table 2. **Most Commonly Cited Problems**

- Time
- Faculty participation
- Facilitator availability and enthusiasm
- Faculty members' multiple commitments

commitment to faculty development in most departments of family medicine. Most programs have designated someone to be responsible for faculty development, sponsor some faculty development activities in-house, and employ diverse strategies to encourage teachers to participate in their own professional development.

Changes since 1985

Several important gains have been made since 1985. Now 88% of the departments have someone responsible for faculty development, eight of whom are paid for this activity. This practice is in sharp contrast to our earlier survey,[8] in which 56% of the departments had someone responsible, only one of whom was remunerated for this activity. Holmes[11] has discussed the need for organizational support for faculty development activities. The results of this survey suggest that Canadian departments, by designating someone to be responsible for faculty development and by allocating monies for this purpose, are beginning to address this need.

More departments have also conducted a systematic needs assessment of their faculty. In 1985, we wondered how faculty development programs and activities were developed. This seems to be clearer now. The assessment of departmental needs has seen a threefold increase since 1985.

Structured programs that are part of a comprehensive plan or that occur regularly are also more common. For example, some departments sponsor a series of three or four faculty development workshops annually; two departments have developed and implemented academic fellowship programs, one with the possibility of pursuing a Masters degree; and many programs hold regular retreats or group discussions on faculty development topics.

The described programs also focus more on the needs of community teachers and rural preceptors. This focus is evidenced by the development of faculty mentorships for rural teachers, the implementation of faculty development by distance educational programs, and increased site visits to community practices. It is interesting to note that addressing the needs of rural and community preceptors in this way is also congruent with some of the new priorities in family medicine education.[12]

Several authors have recommended a systematic, centralized approach to faculty development that is comprehensive and not episodic.[13,14] The results of this survey demonstrate that Canadian departments of family medicine are pursuing this direction. It appears that most activities are no longer planned on an ad hoc basis, and they more frequently form part of an overall plan.

The results of this study also suggest that departments of family medicine are making better use of Canadian resources. Local programs are shared more effectively than before, and the beginnings of a faculty development network are evident.[15,16] In 1985 we highlighted the need for greater coordination and dissemination of information among Canadian programs.[8] Initiatives taken by the Section of Teachers have helped to achieve this goal.

Some of the problems noted in 1985 have been dealt with remarkably well. However, certain expected changes did not take place.

Areas for further development

To our surprise, there has not been a notable increase in the development of orientation activities for new faculty, despite the expansion of residency programs and the need to prepare new teachers for their teaching roles. New teachers have many concerns about their careers, including a fear of failure, anxiety about not having enough to teach, worries about maintaining their clinical competence, and uncertainties about developing appropriate teaching skills.[17,18] It will be interesting to see how the continuing expansion of family medicine programs will influence the development of orientation programs across the country, either in each department locally, or in a national effort to train new teachers.

The content and format of available faculty development activities have also not changed significantly in the last 6 years. Of the activities in place, workshops on teaching that emphasize clinical supervision still appear to be the most common. Although this finding is consistent with other survey results,[1] additional areas of faculty development need to be

addressed.[13,19] If we look at faculty development as that "broad range of activities designed to assist faculty in their teaching roles,"[20] or as "personal and professional assistance to faculty members to allow them to function more comfortably and effectively in a university setting,"[21] we need to broaden the focus of our activities. As Holmes[11] has stated, focusing on teaching alone is "off target."

Indeed, the lack of emphasis on research and administration noted in this survey is striking. With an ever-increasing demand for research productivity in family medicine, faculty development should include this area of activity.[22] A focus on administrative skills is also important, especially in light of increased residency positions, the increased need for funding, and the overall complexity of medical education in the current health care system.

The emphasis on workshops and seminars is consistent with other research findings.[2,13] However, as other faculty developers have noted,[2,19] it is time to consider other methods. Training trainers is an additional area for consideration.[23] In many ways, family medicine has gained an expertise in the area of faculty development that could now be "exported" to other medical settings and work environments.

The finding that participation in faculty development is unrelated to promotion is unsurprising. However, in light of the Smith report,[24] and the re-emphasis on teaching in medical education,[25] it is time to examine whether participation in faculty development, and in teaching activities, should be a criterion for promotion. Linking faculty evaluation to faculty development[26,27] might be a way to address this concern.

The evaluation of faculty development activities remains a challenge. Although the survey results are consistent with other findings,[2,19] it is now time to focus our research efforts on the systematic evaluation of these endeavours.

Survey limitations

Our last survey considered the types of faculty development activities that are sponsored by individual departments without examining how faculty members avail themselves of different programs. In this survey, respondents were asked to describe faculty participation in their activities. Although programs did respond, this question is still difficult to answer and might require a different methodology. Departmental activities do not reflect all of the personal faculty development activities of clinical teachers. Other limitations of this study include many of the problems of survey research: the reliance on program developers for a description of what their departments are offering and the inherent subjectivity in evaluating the noted activities. Nonetheless, determining what departments offer is a necessary first step.

Future challenges

Spooner[28] asserts that faculty development is an institutional responsibility and that institutional leaders must budget resources and enable continuing faculty development opportunities. The results of this survey suggest that Canadian departments are accepting this responsibility.

These findings also highlight additional areas for further development. In light of our current growth, family medicine departments should now try to:

- broaden activities beyond the current emphasis on "teaching skills";
- consider other methods of faculty development, and not restrict the notion of faculty development to workshops and seminars;
- examine the possibility of integrating faculty evaluation with faculty development;
- contemplate the training of trainers, so that family medicine can "export" expertise in this area;
- continue to examine different ways of fostering information exchange and resource sharing, so that faculty development expertise can be more easily shared;
- study the effectiveness of faculty development activities; and
- continue to foster "faculty centred" faculty development.

With the current diversity of faculty experiences and needs, there is no single recipe for successful faculty development. Departments must use their individual strengths and resources, continue

to balance organizational needs with those of the individual teachers, and strive to evaluate the effectiveness of their work in this area. ■

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References

1. Nieman LZ, Sanchez RC. Faculty development for family medicine: a status report. *Fam Pract Res J* 1988;8:42-52.
2. Sheets KJ, Schwenk TL. Faculty development for family medicine educators: an agenda for future activities. *Teaching and Learning in Med* 1990; 2:141-8.
3. Ramsey C, Hitchcock M. A statewide model for faculty development in family medicine. *J Fam Pract* 1980;11:421-6.
4. Hitchcock MA, Ramsey CN, Herring M. A model for developing clinical teaching skills of family practice teachers. *J Fam Pract* 1980;11:923-9.
5. McGaghie WC, Frey JJ, Stritter FT, Shahady E. A multi-component program to increase family physicians' faculty skills. *J Med Educ* 1981;56:803-11.
6. Bland CJ, Froberg DG. A systematic approach to faculty development for family practice faculty. *J Fam Pract* 1982;14:537-43.
7. Bland CJ, Hitchcock M, Anderson WA, Stritter F. Faculty development fellowship programs in family medicine. *J Med Educ* 1987;62:632-41.
8. Steinert Y, Levitt C, Lawn NR. Faculty development in Canada: a national survey of family medicine departments. *Can Fam Physician* 1988;34:2163-6.
9. Yaffe MJ, Steinert Y. The impact of expansion. One family medicine department's experience with mandatory 2-year residency programs. *Can Fam Physician* 1990;36:2053-60,2074.
10. Levitt CA, Klein MC. The demise of the rotating internship and family practice program expansion. View from the trenches. *Can Fam Physician* 1991;37:604-10,742.
11. Holmes B. Faculty development for what and for whom: a question of balance. *CAME Newsletter* 1991;4:1-3.
12. Rosenthal TC, Maudlin RK, Sitorius M, Florence J, Markowski G, Cleveland P, et al. Rural training tracks in four family practice residencies. *Acad Med* 1992;67:685-91.
13. Bland CJ, Schmitz CC, Stritter FT, Henry RC, Aluise JJ. *Successful faculty in academic medicine: essential skills and how to acquire them.* New York: Springer Publishing, 1990.
14. Bland CJ, Stritter FT. Characteristics of effective family medicine faculty development programs. *Fam Med* 1988;20:282-8.
15. Section of Teachers. *Proceedings of the day on faculty development.* Montreal: College of Family Physicians of Canada, 1989.
16. Section of Teachers. *Orienting new teachers to family medicine: proceedings of the day on faculty development.* Calgary: College of Family Physicians of Canada, 1991.
17. Stephens G. On becoming a teacher of family medicine. *J Fam Pract* 1977;4:325-7.
18. Swee DE, Winter RO, Hammonds BL. Testing a model of academic career development. *Fam Med* 1989;21:350-4.
19. Lipetz M, Bussigel M, Foley R. Rethinking faculty development. *Med Teacher* 1986;8:137-44.
20. Konrad AG. Faculty development practices in Canadian universities. *Can J Higher Educ* 1983; 13:13-25.
21. Wergin JF, Mason EJ, Munson PJ. The practice of faculty development. *J Higher Educ* 1976;47:289-308.
22. Bland CJ, Schmitz CC. Characteristics of the successful researcher and implications for faculty development. *J Med Educ* 1986;61:22-31.
23. Skeff KM, Stratos GA, Bergen MR, Albright CL. The Stanford Faculty Development Program: a dissemination approach to faculty development for medical teachers. *Teaching and Learning in Med* 1992;4:180-7.
24. Smith SL. *Commission of Inquiry on Canadian University Education.* Ottawa: AUCC Publications Office, 1991.
25. Hansen PA, Roberts KB. Putting teaching back at the center. *Teaching and Learning in Med* 1992;4:136-9.
26. Stritter FT. Faculty evaluation and development. In: McGuire C, Foley R, Gorr A, Richards RW, editors. *Handbook of health professions education.* San Francisco: Jossey Bass, 1983:294-318.
27. Whitman N, Schwenk T. Faculty evaluation as a means of faculty development. *J Fam Pract* 1982;14:1097-101.
28. Spooner J. Faculty development: an editorial. *CAME Newsletter* 1991;4:4-5.

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