

9. Faculty Development Re-Imagined

A White Paper Prepared for the Royal College of Physicians and Surgeons of Canada, Future of Medical Education in Canada

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Summary of Key Points

- Classically, 'faculty' development models focused almost exclusively upon the faculty member's role as a teacher
- Given the complexity of PGME which now occurs via traditional (e.g., tertiary hospital-based) and newer (e.g. distributed sites) models this paper supports a much broader conceptualization of faculty development (re-named Professional Development) that includes other elements of professional competence
- This broader view allows us to move away from a traditional view of 'teacher training' for academic faculty at higher education institutions, and moves towards making professional development relevant to all physicians in all areas of practice leading to an expanded impact on patient care, personal practice management, interprofessional healthcare education and traditional clinical medical education
- The challenge of making professional development appealing and accessible to all physicians may prove to be a significant barrier in the widespread implementation of educational innovations in general, and the recommendations below, in particular

Summary of Recommendations

1. The Royal College should consider alternative terminology, such as professional development as the term describing the maintenance and continued improvement of professional competence by physicians in-practice, replacing the current term Faculty Development
2. The Royal College should adopt an expanded definition of professional development that includes competencies from all of the CanMEDS / CanMEDS-FM Roles
3. Professional development in multiple CanMEDS domains should be a mandatory component of maintenance of certification for all physicians in-practice

4. The Royal College should amend the general standards of accreditation to require all residency training programs to demonstrate that residents actively engage in the process of professional development
5. The Royal College should adopt general standards of accreditation requiring residency training programs to ensure professional development targets - specific to medical education - are achieved for all physicians in contact with residents
6. The Royal College should facilitate a commitment from all Canadian Deans of Medicine requiring mandatory professional development -specific to medical education - for all faculty members
7. The Royal College should lead a national network that connects professional development programs that are currently disjointed and duplicative
8. The Royal College should offer strategic professional development programs specific to PGME educational needs, where there are no available programs
9. The Royal College should lead the development of a cadre of clinician educators

9. Le perfectionnement des corps professoraux

Livre blanc préparé pour le Collège royal des médecins et chirurgiens du Canada:
L'avenir de l'éducation médicale au Canada

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Sommaire des principaux enjeux

- Traditionnellement, les modèles de perfectionnement des corps professoraux mettaient l'accent uniquement sur le rôle d'enseignant du membre du corps professoral.
- Étant donné la complexité de la formation médicale postdoctorale (FMPD) dispensée selon des modèles conventionnels (p. ex., soins tertiaires en milieu hospitalier) et des nouveaux modèles (p. ex., les lieux de formation régionalisée), le présent livre blanc appuie une conceptualisation plus élargie du perfectionnement des corps professoraux (maintenant désigné par l'expression *développement professionnel*) qui englobe d'autres éléments de compétence professionnelle.
- Cette vision plus globale nous permet de nous éloigner de la perception classique de la « formation de l'enseignant » des institutions d'enseignement supérieur et de rendre le développement professionnel pertinent pour tous les médecins de tous les milieux de pratique, menant à des effets plus élargis sur les soins aux patients, sur la gestion de la pratique personnelle, sur l'éducation interprofessionnelle en santé et sur la formation clinique médicale traditionnelle.
- Le défi de rendre le développement professionnel attrayant et accessible à tous les médecins peut s'avérer un obstacle important dans la mise en œuvre à grande échelle des innovations générales en éducation, et des recommandations ci-dessous en particulier.

Sommaire des recommandations

1. Le Collège royal devrait prendre en considération une terminologie de remplacement, comme *développement professionnel*, pour décrire le maintien et l'amélioration

continue des compétences professionnelles par des médecins en exercice, pour remplacer le terme actuel de perfectionnement des corps professoraux.

2. Le Collège royal devrait adopter une définition élargie du développement professionnel qui comprendrait les compétences de tous les rôles CanMEDS et CanMEDS-MF
3. Le développement professionnel dans les multiples domaines CanMEDS devrait être une composante obligatoire du programme de Maintien du certificat pour tous les médecins en exercice.
4. Le Collège royal devrait modifier les normes générales d'agrément pour exiger que tous les programmes de formation des résidents démontrent que ceux-ci participent activement au processus de développement professionnel.
5. Le Collège royal devrait adopter des normes générales d'agrément exigeant que les programmes de formation des résidents donnent la possibilité à tous les médecins qui sont en contact avec les résidents d'atteindre les cibles de développement professionnel particulières à l'éducation médicale.
6. Le Collège royal devrait encourager un engagement de la part de tous les doyens des facultés de médecine canadiennes pour qu'ils rendent obligatoire le développement professionnel — particulier à l'éducation médicale — pour tous les membres des corps professoraux.
7. Le Collège royal devrait diriger un réseau national qui relie les programmes de développement professionnel actuellement distincts et se chevauchant.
8. Le Collège royal devrait offrir des programmes de développement professionnel stratégiques et adaptés aux besoins de la FMPD, là où il n'existe pas de programmes accessibles.
9. Le Collège royal devrait diriger l'élaboration d'un cadre pour les formateurs cliniques.

Faculty Development Re-Imagined

Introduction

The Royal College of Physicians and Surgeons of Canada is a leader in change initiatives regarding the delivery of postgraduate medical education (PGME) in Canada. The implementation of a competency framework (CanMEDS/CanMEDS –FM) is having a ripple effect across the continuum of medical education¹. The social contract between the profession of medicine and society at-large exchanges professional autonomy for the guarantee of competent physicians, serving the public good.

With the introduction of CanMEDS/CanMEDS-FM, articulation of physician competency has become more explicit. There is now an expectation that all physicians in Canada demonstrate competency in all seven of the Roles: Medical Expert, Communicator, Collaborator, Manager, Health Advocate, Scholar and Professional. This is a tall order, particularly for physicians who may have limited access to resources to help them maintain or expand these competencies. The CanMEDS/CanMEDS-FM framework is also a means of articulating the educational goals of PGME, while the educational process (including the roles of front-line teachers, educators, program directors etc.) is the ongoing challenge facing medical schools.

The PGME system has changed considerably over the past 20 years. Traditionally, residency training was centralized at distinct academic centres. Today, residents may receive a portion of their training outside of tertiary-care teaching hospitals. This trend toward a distributed model of training means that there is an expanded pool of physicians responsible for PGME. We anticipate this trend to continue and even accelerate in the future.

The delivery of quality PGME necessitates supporting and equipping a broader group of physicians with a constellation of competencies. Classically, 'faculty' development models have focused almost exclusively upon the faculty member's role as a teacher. However, given the complexity of PGME which now occurs via both traditional (e.g. tertiary hospital-based) and newer (e.g. distributed sites) models, it is timely that we consider broadening the lens through which we view the essential elements of faculty development. Whether in a rural setting with a medical resident or in a community hospital with an allied health colleague, all physicians in-practice serve as teacher, at least some of the time. Moreover,

physicians must maintain and enhance the other Roles (e.g. Communicator, Collaborator, Manager, Professional etc.) that are integral to the educational process.

The mandate of this White Paper series is to address the future needs of PGME. The intent of this particular White Paper is to expand the focus and adjust the process of faculty development to accommodate the realities of a changing PGME system. While the recommendations may appear to step beyond the mandate, they should be viewed as the essential structures to support PGME.

We propose a broad re-conceptualization of faculty development. The key elements of this conceptualization are:

- The term faculty development should be replaced by professional development;
- Professional development to be defined using the CanMEDS/CanMEDS-FM framework and include all of the Roles, capturing traditional and important faculty development initiatives, yet expanding the scope to include complimentary competencies;
- All physicians in-practice should be required via Maintenance of Certification programs to participate in professional development initiatives across all of the CanMEDS Roles.

Scope of this Paper

We recognize that these the recommendations will have an impact across the medical education continuum (from undergraduate to physician in-practice.) Given the recent changes in the context of PGME, this White Paper seeks to address the educational needs and responsibilities of all physicians in-practice, rather than only focusing upon academic physicians in a classical university setting. Finally, this White Paper should be viewed as addressing an enabling theme within the series; meaning that the impact of a re-envisioned professional development program will support (and make possible) the recommendations stemming from other White Papers.

Background

The definition of faculty development varies widely. Typically, faculty development is construed to mean "preparation [of academic faculty] for teaching".² In many institutions, this constitutes a variety of workshops, seminars, and occasionally, longitudinal or certificate programs limited to teaching and learning strategies. However, in a 2006 review

of faculty development initiatives, Steinert et al.² identify that faculty development can be more broadly defined than training in teaching skills. It encompasses other elements of professional competence required for a physician to practice medicine, including teaching, administration, leadership, and scholarship. This paper supports a much broader conceptualization of faculty development (re-named Professional Development) that includes these roles and the other competencies identified in the CanMEDS/CanMEDS-FM framework.

Taking this broader view allows us to move away from a traditional view of 'teacher training' for academic faculty at higher education institutions, and moves towards making professional development relevant to all physicians in all areas of practice. Bringing professional development initiatives to all physicians (and not to a select cohort) leads to an expanded impact upon patient care, personal practice management, interprofessional healthcare education, and traditional clinical medical education. Of course, an emphasis on equipping clinician-teachers for their educational tasks must continue to be emphasized. This is fundamental to the tasks of PGME. However, a broader understanding of professional development will ensure that other domains (e.g. leadership, administration) and contexts (e.g. community-based rotations) are supported and a larger pool of physicians are engaged to address the changing complexity of PGME.

Current Status in Canada

Current Liaison Committee on Medical Education, Royal College, College of Family Physicians of Canada, and College des Medecins du Quebec accreditation guidelines mandate that faculty development programs are available to all faculty members at every medical school in Canada. These general standards of accreditation require that there are adequate resources to ensure appropriate teaching and assessment of learners as defined within the Educational Directives of the LCME and the CanMEDS/CanMEDS-FM frameworks.

Currently, all 17 faculties of medicine have an office or centre for continuing education, while only 13 faculties have a distinct office or centre for faculty development. The 17 offices/centres of continuing education are led by 12 associate deans and 4 assistant deans; while the offices/centres of faculty development are led by 6 associate deans and 3 assistant deans (the other offices/centres had leadership below the deaconal level). Individual faculties of medicine support their faculty through conference travel funding,

lightened teaching loads for junior faculty members, programs to acquaint faculty with institutional goals, and workshops on instructional skills, the CanMEDS/CanMEDS-FM competency framework, management, research, and leadership/administrative skills.³

A survey of Canadian education leaders indicates that work still needs to be done. Techniques used to deliver professional development opportunities vary widely, and don't always utilize best practices for teaching, learning and program evaluation. Assessment of teacher performance is also an area that needs further consolidation across Canadian medical schools.

Data from a Royal College 2008 CanMEDS implementation survey of residency program directors indicated that the following Roles are most difficult to teach and assess in PGME: Health Advocate, Collaborator and Manager.⁴ Barriers to adoption included the following: faculty time and workload, teacher engagement, educational expertise and lack of teaching materials.⁵ Current trends in maintenance of certification activities (using voluntary reporting) suggest that the Roles identified above are either under-represented or incorrectly reported. These data sources may suggest that the educational activities of physicians in-practice are not in alignment with the challenges facing PGME.

Historically, the Royal College has not been a leader in traditional faculty development efforts. However, in the past 5 years increasing emphasis on professional development initiatives have been initiated at the College to meet the needs of postgraduate medical educators. Examples include:

- CanMEDS Train-the-Trainer program - 8 programs, 380 participants
- Exam boards – 35 basic modular workshops over 10 years and numerous ad hoc sessions during exam development meetings
- Annual specialty chairs workshops on core education topics
- International Conference on Residency Education – since 2008, > 4000 total attendees

Beyond faculties of medicine, other key players in educational activities for physicians in-practice include: individual academic departments, the College of Family Physicians of Canada, Association of Faculties of Medicine in Canada, Canadian Medical Protection Association, Canadian Medical Association and national specialty societies.

Current Challenges & Drivers for Change

Current challenges for professional development in Canada include the following:

- *Variable scope, support and philosophy of professional development across institutions, ranging from teaching skills, to full professional development, including research, administration, and leadership skills.*
- *Variable access to professional development opportunities*
 - o Distributed medical education presents challenges to physicians at distributed sites, remote from primary medical schools where professional development is typically centered
 - o Limited availability of mentors and medical educators to foster development across these domains. For senior level physicians requiring advanced development and mentoring the limitation of resources is even more pronounced.
 - o Only some universities have longitudinal certificate programs, graduate programs, etc
- *Incentives are limited for physicians in-practice to actively seek out further professional development*
 - o It costs time and money
 - o It is poorly recognized/rewarded within academic and community institutions
- *Individual faculty members have specific educational needs depending upon their previous experiences and clinical and academic context. This creates challenges in delivering effective (and tailored) professional development initiatives.*
- *Continuing Education (Continuing Medical Education) and Faculty Development offices frequently compete for resources, creating ineffective competition and power differentials*
- *The language of "faculty" development creates a false perception that only physicians with a faculty appointment in a university setting require professional development*
- *There is poor assessment of physician performance in professional development domains, including teaching, leadership, research, mentorship, etc.*
 - o There is an inconsistency across educational settings as to how or if faculty are assessed in their educational roles.
 - o There is an inconsistency within universities regarding mechanisms to identify local observed professional development needs.

- Few universities will protect time for faculty to participate in professional development
- *Few universities mandate professional development – even for teachers with demonstrated need (i.e. remediation)*
- *There is no national-level network for front-line faculty developers*
 - While the Association of Faculties of Medicine of Canada supports a committee of Faculty Development Deans/Directors, many front-line faculty developers remain unconnected. As a result, they continually ‘re-invent the wheel’ locally to address their needs.

The challenge of making professional development appealing and accessible to all physicians may prove to be a significant barrier in the widespread implementation of educational innovations in general, and the recommendations of the White Papers in this series, in particular.

Recommendations

1. **The Royal College should consider alternative terminology such as professional development as the term describing the maintenance and continued improvement of professional competence by physicians in-practice, replacing the current term Faculty Development.**

Adoption of this new nomenclature would ensure alignment of the profession of medicine with other healthcare professions, specifically and other professions, generally.

2. **The Royal College should adopt an expanded definition of professional development that includes competencies from all of the CanMEDS / CanMEDS-FM Roles.**

A proposed model for professional development using the CanMEDS framework is shown in Table 1.

Table 1: Conceptualization of Professional Development Mapped to the CanMEDS/CanMEDS-FM Physician Competency Framework

CanMEDS Role	CFPC Framework	Professional Development Topics for the Physician In-practice
Medical Expert	Principle 2: The Family Physician is a Skilled Clinician	<ul style="list-style-type: none"> • Conventional CME • Lifelong learning with focused clinical “expertise” • Tele-health care
Communicator	Principle 1: The Doctor Patient Relationship is Central to the Role of the Family Physician Principle 2: The Family Physician is a Skilled Clinician	<ul style="list-style-type: none"> • Interpersonal communication training • Complex topics – bad news, consent, disclosure • Crucial conversations
Collaborator	Principle 1: The Doctor Patient Relationship is Central to the Role of the Family Physician Principle 3: Family Medicine is Community-Based Principle 4: The Family Physician is a Resource to a Defined Practice	<ul style="list-style-type: none"> • Conflict management • Crucial conversations • Team dynamics • Intra-disciplinary care • Intra-professional care • Relational-centred practice
Manager	Principle 3: Family Medicine is Community-Based Principle 4: The Family Physician is a Resource to a Defined Practice	<ul style="list-style-type: none"> • Leadership skills • Change Management • Practice assessment • Information Technologies • Practice management
Health Advocate	Principle 3: Family Medicine is Community-Based Principle 4: The Family Physician is a Resource to a Defined Practice	<ul style="list-style-type: none"> • Policy development • Media relations skills • Health Intelligence Units
Scholar	Principle 2: The Family Physician is a Skilled Clinician Principle 4: The Family Physician is a Resource to a Defined Practice	<ul style="list-style-type: none"> • Teaching Skills • Curriculum Development • Assessment • Program Evaluation • Research • Lifelong Learning • Personal Learning Plans • Teaching Dossier
Professional	Principle 1: The Doctor Patient Relationship is Central to the Role of the Family Physician	<ul style="list-style-type: none"> • Ethics • Ongoing service to the profession • Physician Wellness • Mentoring

All physicians, regardless of context, should be actively engaged in professional development to maintain and enhance their abilities in all Roles. Effective patient care (the primary goal of medicine) is dependent upon the integration of all of these Roles that support the central Role - Medical Expert. However, it should be stressed that adoption of this new, expanded professional development framework should not detract from the ongoing need to support the educational issues facing PGME. This recommendation does not suggest a simple realignment of faculty development within the broader rubric of continuing education. Rather, the proposed conceptualization of professional development emphasizes that: (1) all physicians play an educational role (with physician peers, allied health peers, patients etc.), in part, that requires ongoing development; and (2) changes to PGME will require the engagement of many more effectively equipped physicians in-practice to educate physicians in-training.

3. Professional development in multiple CanMEDS domains should be a mandatory component of maintenance of certification for all physicians in-practice.

Current models of maintenance of certification emphasize the Medical Expert Role – the typical domain of continuing medical education. This emphasis should be maintained. However, there is no required demonstration of professional development related to the other Roles. All physicians, regardless of their educational (i.e. university-based v. community-based) or clinical context, should be required to demonstrate maintenance of competence across all CanMEDS Roles. (The CanMEDS Framework describes competent practice, hence, the need to demonstrate ongoing maintenance of such competence.) Yet, there is no expectation that all physicians would advance similarly across all of the Roles. Rather, tailoring of professional development activities would be matched to the needs of the individual.

This recommendation will serve a number of issues. First, physicians in-practice will have the opportunity to develop and be recognized for new abilities in their professional practice. Second, the growing demand for professional development offerings will promote increasing collaboration and synergy across the often isolating gaps that exist between various providers (e.g. university-wide education offices, academic departments, national specialty societies etc.). Third, development of education competencies will increase the pool of engaged clinician-teachers. Finally,

focusing resources and attention towards educational competencies will improve the clinical environment (where the predominance of PGME occurs) and ultimately enhance patient care.

To facilitate this expanded model of maintenance of certification, the Royal College should expand its accreditation process to facilitate the credentialing needs that are not currently served by university-based Continuing Education offices or national specialty societies. Effective professional development programs should not be penalized because of challenges (e.g. administrative access, administrative cost etc.) in achieving accreditation.

Performance rather than attendance should be used as the method to assess learning. Rather than simply documenting exposure to concepts, maintenance of certification should emphasize actual application of concepts (e.g. portfolio).

4. The Royal College should amend the general standards of accreditation to require all residency training programs to demonstrate that residents actively engage in the process of professional development.

Too frequently there is a disconnect between the lifelong learning requirements expected of physicians in-training and the educational practice of physicians in-practice. Introducing residents early in their career to the requirement to “maintain and enhance professional activities through ongoing learning” (Scholar key competency) will ensure a more congruent and integrated approach to learning throughout a physician’s professional life.

5. The Royal College should adopt general standards of accreditation requiring residency training programs to ensure professional development targets - specific to medical education - are achieved for all physicians in contact with residents.

Recognizing that effective professional development will be tailored to the needs of an individual and span across the CanMEDS/CanMEDS-FM Roles, physicians with active PGME responsibilities should demonstrate development of their teaching abilities.

- 6. The Royal College should facilitate a commitment from all Canadian Deans of Medicine requiring mandatory professional development -specific to medical education - for all faculty members.**

- 7. The Royal College should lead a national network that connects professional development programs that are currently disjointed and duplicative.**
A national 'clearing-house' of professional development resources and opportunities would be a valuable resource for physicians across Canada. Assuming equitable access to such programs, a national network would both provide access to physicians in under-supported areas, increase the visibility of existing professional development opportunities and leverage resources to develop a greater breadth of resources rather than simply duplicating programs. Additionally, a central resource would promote cross-fertilization of ideas and strengthen existing professional development programs.

- 8. The Royal College should offer strategic professional development programs specific to PGME educational needs, where there are no available programs.**

- 9. The Royal College should lead the development of a cadre of clinician educators.**

Clinician educators are clinicians with formal medical education training, who provide consultative expertise to clinician teachers, curriculum and residency directors and produce scholarship around educational themes. The development of a Royal College diploma in medical education will provide a high-standard, recognizable certification in medical education for interested physicians, and could potentially support a train-the-trainer model of dissemination in medical education. The process used to develop this diploma should not dissuade the development of high-quality programs by other institutions.

All residency training programs should endeavour to have one clinician educator per program. In the interim, faculties of medicine should coordinate the resources of existing clinician educators, such that all programs have access to skilled resources.

Similar diplomas in fields such as health administration, leadership etc. would be complementary to the PGME needs served by a diploma in medical education.

The Royal College should expand the scope, variety and number of education fellowships (i.e. monetary awards) to support physicians engaged in education training. Additionally, such fellowships will strengthen the academic credibility of medical education training within universities.

The Royal College should actively influence the academic medical culture to achieve parity of recognition between medical education and traditional research.

References

1. Frank, JR (Ed). 2005. The CanMEDS 2005 physician competency framework. Better standards. Better Physicians. Better care. Ottawa: The Royal College of Physicians and Surgeons of Canada.
2. Steinert Y, Mann K, Centeno A, Dolmans D, Spencer J, Gelula M, Prideaux D et al. A Systematic Review of Faculty Development Initiatives Designed to Improve Teaching Effectiveness in Medical Education: BEME Guide No. 8. Medical Teacher 2006;28(6):497-526.
3. Mcleod PJ, Steinert Y. The evolution of faculty development in Canada since the 1980s: Coming of age or time for a change? Medical Teacher 2010;32:e31-e35.
4. Chou S, Cole G, McLaughlin K, Lockyer J. CanMEDS evaluation in Canadian postgraduate training programmes: tools used and programme director satisfaction. Med Educ. 2008 Sep;42(9):879-86.
5. Frank, J.R., Abbott, C., Bourgeois, G., Hyde, S., Lee, A.C. Adoption of the CanMEDS competency framework in residency education 2001-2009. Open Medicine 2010; 4(3Suppl):35-36.

Suggested Readings

McLean, M., Cilliers, F., and Van Wyk, J.M. (2008) Faculty development: Yesterday, today and tomorrow. Medical Teacher; 30(6): 555-584

Offer a new definition that aligns with this...personal and professional development of teachers, clinicians, researchers and administrators to meet the goals, vision and mission of the institution in terms of its social and moral responsibility to the community it serves.

Sheets, K.J., and Schwenk, T.L. (1990) Faculty development for family medicine educators: An agenda for future activities. Teaching and Learning in Medicine;2(3):141-148.

Defined faculty development broadly as any activity to improve individuals in areas considered essential to the performance of a faculty member in a department or residency program.

Hatem, C.J., Lown, B.A., and Newman, L.R. Strategies for Creating a Faculty Fellowship in Medical Education: Report of a 10-Year Experience. Acad Med. 2009; 84:1098-1103.

An in-depth look at both the curricular content and process of three well-established, yearlong medical education fellowships, in which single cohorts of medical teaching faculty

participate in extended faculty development activities. Provides a useful starting point for those who develop and conduct educational faculty development activities at medical schools and academic medical centers.