

---

## An Integrated Local Approach to Faculty Development

*Deborah E. Simpson, Ph.D.*

*Transcript from session.*

As people were commenting about the slides being out of focus during the previous presentation, I saw that the people who were complaining didn't wear glasses. Those of us who did, kept taking them on and off and squinting. It made me notice the different attributions of those of us who are participating in this conference.

Each of us is different, and, in faculty development programs we must understand that. Faculty development is a continuous process. I am going to describe for you a program that approaches faculty development throughout the faculty's career. We must pay attention to mid-career issues, as well as initial training.

I can tell you what I use as the single best question to ascertain where people are in their careers. I ask them if they know how much is in their retirement accounts! Those of you who know are in a very different place from those who ask why that question is important!

Today, I am the spokesperson for faculty development programs that are nested within departments of a single medical school. I would like to argue that, using the hierarchy of Maslow's needs that Dr. Skeff discussed, local programs can meet some of these needs in a manner that national programs cannot.

I would like to acknowledge the support that our programs have received from the Health Services Resource Administration. Many of our programs have been partially supported by two faculty development grants, one in a combined General Internal Medicine and Pediatric grant, and one in Family Medicine.

In introducing our program, I would like to quote Margaret Mead, who said, "Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed it is the only thing that ever has." If we look at the group of faculty that is out there today and if you are passionate and committed to faculty development, you and we can make a difference. This is our motto locally, because in these times of increasing stress, we need our faculties to make a difference. Who is going to teach? How are we going to accomplish our educational mission?

One of the central issues for faculty development is that the program must help faculty meet the goals of the institution. If you don't, you won't have funding, resources, or the faculty. In considering how to start your faculty development programs, you must begin with small steps. In Table 1 I use the same definition that Carole Bland used earlier, because it is so central to what we do. It is the heart of a local faculty development program because we explicitly attend to institutional goals and priorities. Those who attend our programs feed into the institutional mission in very direct ways. Today, I am going to talk about how essential it is to tailor your faculty development program to meet the goals of your institution.

### **Table 1. DEFINITION:**

Faculty development refers to those activities and programs that are intended to facilitate faculty members' commitment to and ability to achieve both their own career goals and their institution's goals.

*Bland and Simpson, 1997*

The mission statement of the Medical College of Wisconsin does not look much different than anybody else's. It states: The Medical College of Wisconsin is a private, academic institution dedi-

---

cated to leadership and excellence in: Education, Research, Patient Care, and Community Service. We did fight to assure that education was listed first. We are very old, with what we term a rather rigid structure. That is a generous way of saying there is no flexibility. In order for a local faculty development program to be effectively implemented within such a structure, the leaders of the departments and of the school must be supportive and involved.

We have been able to involve our institutional leaders in faculty development. For our program in Family Medicine, two of the four Vice-Chairs in the Department of Family and Community Medicine are responsible for major segments of our program. Within that department we have three full professors, 2 Associate Deans, an Education Coordinator and Fellowship Director who participate. The Chair and senior faculty of the department are mentors who provide guidance to junior faculty. There are not many people that we don't touch. We deliberately go after the senior leaders because they set the standards and also know where the institution is going. They also have a vision of where we should move faculty development.

The same is true for the programs in General Internal Medicine and General Pediatrics. The Division Chief for General Internal Medicine and the Vice Chair for Education in the Department of Pediatrics serve as program staff for the faculty development program. Other senior leaders who participate include 3 Associate Deans, seven full professors, and the Chairs.

We are committed to the institutional structure. We direct our faculties' personal goals in a manner that is consistent and with where the institution is going. Yet, we attend to the individual, starting with individual needs assessment. We must pay attention to people's passions. I am fearful that with the chaos that surrounds us and the fact that our faculty is over-burdened, they may forget why they

are in academic medicine. So what our program strives to do is reunite faculty with their passions. We ask, "Have you really thought about why you are here? What is your passion? Do you get to do your passion in your daily work? Table 2 summarizes this concept that faculty development stimulates professional vitality.

**Table 2. Faculty Development = Professional Vitality**

*(Reminder: Faculty development...facilitates faculty members' commitment to and ability to achieve own career goals)*

**Faculty Development Programs & Activities**

- Re-Ignite faculty passion(s)
- Fan the flames
- Channel that energy into meeting own and institution's goals

Our program forces the faculty to look at their passions. We then provide them with the skills and competencies to fan the flames and enable them to use their passions in ways that are productive and that channels into the organization's goals. Early on in our advanced programs, we ask our fellows to write a professional mission statement. We only allow them ten minutes to do this. The statement is to be one short sentence, to speak to the person's values, beliefs, and passions. We then make them public by sharing the personal mission statements with the group. In our schedule of faculty development, we said that we would talk about this for thirty minutes. We spent an hour and a half on this topic, which illustrates the need for flexibility in adapting. People need to talk about why they are here and what they care about.

In Table 3, I wanted to give you some examples to illustrate this process, so I asked some colleagues if I could use their mission statements. These are unedited and were completed in the allotted ten minutes.

---

**Table 3. Professional Mission Statements**

**Rebekah Wang-Chang, M.D.:** To role model and inspire learners to be compassionate MD's of integrity who pursue life-long learning

**Patricia Lye, M.D.:** *Education:* To be a life influencing teacher for medical students; *Patient Care:* To care for acutely ill disadvantaged kids in a compassionate manner; *Research:* To write one significant research article/book

**David Schiedermayer, M.D.:** To write about the heart and soul (and mind) of medicine

**Charlotte Heidenreich, M.D.:** To mentor learners by humane example and by involvement in the process of their development into mature clinicians, while being my kids' mom

These are passionate people who are busy with clinical demands, whose lives are hectic. How do you capture these passions in thinking about a faculty development program? I am going to focus on those programs that have worked.

We have two parallel programs, one in Family Medicine and one in General Internal Medicine and General Pediatrics. Table 4 describes the local, departmentally based primary care faculty development programs that we now have at the Medical College of Wisconsin.

**Table 4. Primary Care Faculty Development Programs At the Medical College of Wisconsin:**

**Family Medicine:**

- 1991 HRSA Funding
- Comprehensive Program
- Advanced Programs in Education, Clinical Research and Administration

**General Internal Medicine/General Pediatrics:** < 1996 HRSA Funding

- Comprehensive Program
- Advanced Education Program
- Proposed: Career Planning with modular responsiveness to changing faculty roles

We have had funding for Family Medicine since 1991 from HRSA. We have what we call our "Comprehensive Program" that I will describe later.

We have three advanced programs for people to pursue those passions in focal areas of education, advanced research and administration. The Family Medicine Comprehensive Program has been quite successful. We have had less success in General Medicine and General Pediatrics in the Comprehensive Program. We tried to simply take the model from the Family Medicine Program and transfer it to General Medicine and General Pediatrics, and it didn't work as well.

What we have proposed to remedy this is to change to a very strong career planning program in which we will meet with departmental leaders and identify with them the roles of our participants within the Divisions of General Internal Medicine and General Pediatrics. We will ask about the faculties' career needs and then have a set of modules that will help them fulfill their roles within the department and still meet their passions.

In the Comprehensive program, our goal is very explicit. The faculty and the departmental leaders must both be involved. If the faculty members we train are going to make influential changes within their departments, they have to be on key committees and they have to be associate or full professors. We focus on competencies, including those described in Dr. Carole Bland's book, with the added competencies of technology, and computer-based instruction. Our instruction is based on projects. Over two years, participants must complete projects in three areas: research, education, and administrative process. How we teach is designed to help them get their projects done. When we first started in the Family Medicine Program in 1991, we had one and one half days a month to work together. Now, with the clinical demands, we are down to a half-day. We could not just talk faster, so we have had to restructure our program.

---

We met every month on the same Monday afternoon for two years. The groups become quite cohesive. People become true colleagues. That affiliation that we have talked about is very high. To evaluate the effectiveness of this program, we have looked at competencies in research, education, technology, writing, and professional academic skills. This we have done through self-assessment.

We have also looked at the impact on peer reviewed publications, regional and national presentations, and on leadership both within the medical college and nationally. Participants' self-assessment of competencies have shown significant improvements in the areas in education, research, administration, technology, and specialized academic skills. We have also been able to show a large increase in the number of publications and in the number of leadership positions filled by these faculty. We have had a small group of dedicated people who are making a difference!

I would like to go on to describe our advanced program, which we think is unique. We don't know of anyone else who is using a similar format. We started this program in Family Medicine in 1994 and in General Internal Medicine and General Pediatrics in 1996. Our stated goal is professional vitality.

Many of the people who are participating in this program have gone through national faculty development programs such as Dr. Skeff's at Stanford or the program at Waco, Texas or the Michigan State Program. They return to the institution and ask: "What am I going to do to keep academics and scholarship a viable part of my life?" We identified the needs listed in Table 5 for the advanced education program.

**Table 5. Identified Needs – Vitality**

- Advanced Education Faculty Development in General Internal Medicine and General Pediatrics
- Gain in-depth knowledge in ambulatory education
- Improve skills as clinical teacher
- Remain current in medical education literature
- Produce scholarly products
- Enhance professional academic skills

The focus of the advanced program is on a group project. The reason for this focus is because these individuals do not any longer have enough time to pursue their own research interests. They don't have the skills, or the time to pursue individual research. Through their project, they learn and they teach each other, using qualitative methods. Our first project was a study of the careers of academic physicians as educators. Our question was: Can you have a career as an academic educator? We did a survey, and are now working on the submission of the actual qualitative interviews that each of our participants conducted. They learned how to do qualitative interviews. They also learned how to analyze the content data from protocols. They learned to do systematic qualitative research.

Our Family Medicine advance group is developing Web-based community preceptor modules. There are over a thousand community preceptors that are involved in our medical education programs. We can't possibly go to their offices and teach them all, so they are learning how to do Web-based instruction.

Our participants have recognized the need to be more efficient and more effective with clinical teaching. Our advanced education group in Medicine and Pediatrics is doing a series of studies on the topic. They have conducted a critical review

---

of the literature on ambulatory education. They found there are a lot of new models but very little data about their effectiveness. They have looked at computers in ambulatory education. Each should have authorship of a literature review by the end of the year.

Now we are doing a study based on the teaching methods identified through the literature review. The faculty members in the program are the actual subjects of the study. We created a videotape of each method and had students rate, which they prefer. Now they are testing five clinical teaching methods over 12 months. They use palm pilots that have a pre-formatted questionnaire that they fill out at the end of each half-day.

This is an example of how the group project can meet both the individual needs and the needs of your institution. The chairs are excited, waiting for the results of the study of efficient and effective methods for clinical teaching, so that they can get more clinical productivity from their faculty. The faculty have a project and publications that will help with promotion. There is a sense of collegiality, of group affiliation, and a feeling that they are doing something fun and that it is going to make a difference.

In the program we also spend a lot of time reviewing what people have written. We are brutal critics, but every paper that has gone through our group review has been published. Our data on effectiveness has indicated a real increase in the number of publications, with an average of two for each participant in the last year. I challenge anyone to top that for primary care faculty who are not researchers. These are educators.

These faculty are also now getting grants and contracts and winning teaching awards. Organizationally, they are involved. They are on our Faculty Council, they are assuming positions of leadership in primary care and in education.

We share these data with the Chairs, and it makes a difference. We have learned that working with the same group of faculty over an extended period of time is very valuable, that they hone and refine each other's skills. That doesn't sound like I'm teaching them something. It sounds like they are teaching each other in a very powerful way. Collegial feedback and support is critical. Most important, however, is that the time they take to participate in the faculty development program, they would otherwise simply be on their own. Without such a program, our primary care faculty is getting more and more isolated as they are being more pressured.

In summary, I think the power of an integrated local program is that you can meet institutional needs as you meet the personal needs of faculty.

If we support professional vitality through faculty development that fans their personal passions in a way that matches the institution's mission, we can really make a difference.

**The Power of the Local, Integrated approach to Faculty Development:**

Never doubt that a small group of thoughtful, committed faculty colleagues whose vitality is supported by Faculty Development can change their institution.

Indeed, at the Medical College of Wisconsin, it is the only thing that ever has.