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SUSTAINING CAREERS: FACTORS IMPACTING THE VITALITY OF NON-PHYSICIAN EDUCATORS IN MEDICAL FACULTY DEVELOPMENT

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Maureen A. Shannon

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Ann E. Austin

Major Professor's Signature

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SUSTAINING CAREERS:

FACTORS IMPACTING THE VITALITY OF NON-PHYSICIAN EDUCATORS IN MEDICAL FACULTY DEVELOPMENT

By

Maureen A. Shannon

A DISSERTATION

Submitted to
Michigan State University
in partial fulfillment of the requirements
for the degree of

DOCTOR OF PHILOSOPHY

Department of Educational Administration

2003

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ABSTRACT

SUSTAINING CAREERS: FACTORS IMPACTING THE VITALITY OF NON-PHYSICIAN EDUCATORS IN MEDICAL FACULTY DEVELOPMENT

By

Maureen A. Shannon

About twenty-five years ago, medical colleges were provided federal incentives through Title VII to increase the number of trained faculty in family medicine. Many non-physician educators found positions within the medical faculty development programs that grew out of this federal legislation. However, over the years, the federal funds that originally brought many of these educators into medicine have decreased or were targeted to achieve other goals such as care for underserved patients. Despite declining federals funds, many of these educators have continued working in medical education. This study explored factors that impacted the vitality of these medical faculty developers to examine how they sustained their careers through changing times.

This was a descriptive study that utilized two sources of data collection: 1) a survey of 606 non-physician members of the Society of Teachers of Family Medicine, and 2) telephone interviews with twelve senior faculty developers working in medical education. The interview participants spent at least 20% of their time on faculty development and worked in medical faculty development for ten or more years. Two bodies of literature primarily informed the theoretical framework of this study: 1) the literature on productive faculty and institutional vitality, and 2) the literature on socialization.

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Findings include the demographics of vital non-physician faculty developers in medical education. This study also describes how the faculty developers were socialized to the medical culture and their work. Although their socialization is somewhat explained by previous socialization theories, there are unique qualities to medical faculty development. There is no defined entrance point for a career in medical faculty development and no specific training that is universally required. There are no formal opportunities for early anticipatory socialization. Findings showed that a thorough, formalized socialization to medical education is lacking for faculty developers, and most of the faculty developers learned the specific knowledge and competencies of medical faculty development on the job through observation and trial and error as well as through continuing education. Mentors also played a significant role in recruiting new faculty developers. Mentoring was a way that educators learned the competencies needed for working in medicine. Three faculty development roles were defined and explored: 1) Facilitator of Individual Development, 2) Generalist, and 3) Educational Leader. This study also identified cultural/organizational factors and individual factors that positively or negatively impacted the career vitality of medical faculty developers.

Recommendations were made for professional organizations, medical institutions and individuals that might sustain educators' careers in medical education and increase vitality. Twenty-five years of federal funding started careers in medical faculty development for many educators although much of the funding has disappeared. Years later, many of these educators are still working in medical faculty development. This study examines the factors of vitality of the educators who have sustained their careers despite changes in the medical education climate.

Dedicated to my wonderful family who provided

their support, love and encouragement:

Doug, Shannon, Benjamin, and my parents.

Words cannot express my gratitude.

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ACKNOWLEDGMENTS

I am grateful to the many people who helped me along the way to the completion of this degree. I am unable to name all of you here, but your support was important for every step of this long journey.

I especially want to thank the members of the Society of Teachers of Family Medicine who participated in this study through the survey and interviews. You opened up your professional lives to me and provided the heart and soul that humanized the theories and ideas in this dissertation.

I want to thank my dissertation committee at Michigan State University for their ideas and support: Dr. Doug Campell, Dr. John Dirkx, and Dr. Rebecca Henry. With special thanks to Dr. Ann Austin, Committee Chair and Dissertation Director who has been with me for most of this doctoral journey as well as my journey through life – you have seen me through a wedding, a home purchase and the birth of my two children. I am grateful for the personal insights you've shared with me and well as all the academic guidance. I am also grateful to Dr. Linda Roth of Wayne State University. You have been the professional sounding board and friend that has encouraged me every step of the way through this dissertation.

Most of all I want to thank my family: to Doug, for your love, support and time away from the house with the kids. To Shannon and Benjamin for understanding that "Mommy has to work right now." I love you very much. To my parents, Bob and Marge, for watching Shannon and Benjamin and providing your never-ending belief that I could do this.

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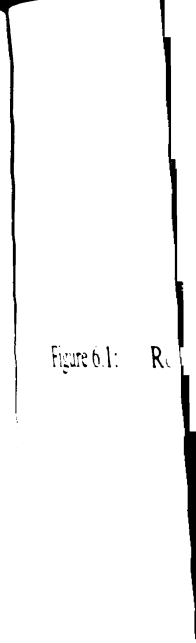

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Chapter 1

INTRODUCTION TO THE STUDY

The purpose of this study was to explore factors that impact the vitality of non-physician faculty developers in family medicine. A large number of non-physician educators were hired in the 1970's and 1980's to work in medical colleges to train faculty in the newly created discipline of family medicine. When first introduced, the Title VII funds focused on increasing the number of trained faculty in the then-new specialty of family medicine. Today, the funding incentives to train family medicine physician faculty are being diverted to achieve other goals in medicine or disappearing entirely as there is now a larger number of trained physician faculty in family medicine. However, a number of the original educators brought in as faculty developers still remain in medical education. For a variety of reasons, Wittenberg (2003) emphasized "Title VII funding is at risk as never before." This study examined factors affecting the vitality of these remaining educators in order to explore how they sustained their careers in medical faculty development. The research methods included a brief survey and semi-structured interviews with faculty developers who worked in medical education for at least ten years. Some of the elements addressed in this study included their socialization to medical education, their faculty development roles, and factors that positively or negatively affected their careers in medical faculty development.

Within the past forty years an interest in faculty development for family medicine physician educators emerged and grew. This growth occurred, in part, because of federal funding incentives offered to medical colleges through the (then-titled) Bureau of

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Manpower's Public Health Service Act known as Title VII. These funds were introduced in the late 1970's to increase the number of trained physician faculty in the new specialty of family medicine. Through Title VII, money was made available to medical colleges to establish departments of family medicine, to develop pre-doctoral and residency training programs in family medicine, and to train faculty. Many non-physician educators were hired by medical colleges to train the new family medicine faculty and to run the newly formed faculty development programs.

Additionally, family medicine (also called family practice) has an important relationship with faculty development because faculty development played an integral role in the growth of family medicine as an established specialty. Family medicine is one branch of primary care medicine, which also includes internal medicine and general pediatric medicine. It has a relatively short history as it was established as an academic discipline in 1967. However, family medicine's relationship with faculty development is well documented. This study looked specifically at non-physician faculty developers who held membership during the fall of 2001 in the Society of Teachers of Family Medicine (STFM), an organization within the discipline of family medicine. The non-physician educators working in medical faculty development who entered family medicine in the late 1970's and early 1980's during this time of growth were the focus of this study.

Throughout this study, I focused on the overall question of what impacted the vitality of senior faculty developers in medical education. Vitality is often discussed in relation to the mission of individual institutions; however, my focus was only on the vitality of the individual senior faculty developers in the field of medical faculty development

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because this was not an institutional/organizational study. The vitality of these medical faculty developers was examined using the definition documented by Woods, Reid, Arndt, Curtis and Stritter (1997), which included four dimensions: 1) retention in the field, 2) job satisfaction, 3) range of activities including teaching, research and administration, and 4) contributions to the discipline. Connections were also drawn to Bland's (2001) and Bland and Bergquist's (1997) work on the productive academic faculty member.

Understanding the vitality of non-physician educators in medical faculty development may be important because the funding that originally started these faculty development positions is diminishing. Individuals, institutions and professional organizations can also benefit through the documentation of the work and roles of educators working in academic medicine. The family medicine physician faculty provide the leadership and create solutions to counter many of the educational challenges that occur but it is faculty development that provides "the tools to enhance [the physician] faculty's knowledge and skills (C. Bland, D. Simpson, F. Hekelman, & F. Stritter, 1997, p. 231). By focusing on the socialization, roles, and work challenges or successes of these educators, conclusions can be drawn regarding how vital faculty developers sustain their careers despite changes in the culture in which they work.

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Definition of Terms

Below I have defined terms used in my research. The reader may find these definitions helpful for understanding the discussions found in this writing.

Culture: Climate and practices that develop or the espoused values and philosophy of an organization or profession (adapted from Schein, 1992); also socially-established structures of meaning, embodied in symbols, language and actions.

Educator: Professional who was trained in any of the various education fields and whose specialty is to train others in education theory and related topics. I use this term to discuss the broader group of non-physicians working in medical education.

Faculty developer: One who works with academic faculty to support and improve teaching, professional academic development, evaluation, research, curriculum efforts and other areas of the "metaprofession of the professoriate" (see definition below). For this study, faculty developers are either self-identified or determined by title and work analysis.

Generalist: One whose skills, interests or habits are varied or unspecialized (Merriam-Webster); in this study, participants used this word to mean that they had knowledge and skills in a wide range of areas such as teaching, curriculum development, assessment and evaluation, medical student education, adult education, research, and psychology.

Medical Education: Educational programs focusing on the teaching and learning of medical students, interns, resident physicians or attending physicians and faculty.

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Metaprofession of the Professoriate: Skills and knowledge associated with a faculty position that are not usually a part of a professional's base training in his or her field of expertise (Arreola, Theall, Aleamoni, 2003). Some of the knowledge and skills included in the metaprofession of the professoriate are: learning theory, human development, group process, technical writing, research and statistics techniques, information technology, communication styles, public speaking and personnel management. Faculty developers are usually involved in helping faculty master the metaprofession of the professoriate.

Non-physicians: Those trained in a professional or career field other than medicine; allied health professionals are included as non-physicians.

Primary Care: Medical practice in one of three areas: a) family medicine, b) general internal medicine, or c) general pediatric medicine.

Vitality: Condition defined by the following dimensions: retention in medical faculty development, job satisfaction, scholarly activity and contributions to the field of medical education (Woods et al., 1997).

Statement of the Problem

There is very little published in the literature about educators' careers in medical education or their contributions to medical faculty development. While the literature on faculty development in post-secondary education could provide some insights, it does not address the many issues unique to working in the medical culture. The literature addressing faculty development in primary care medical education focused mostly on the outcomes of specific interventions or on teaching strategies and techniques but did not

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discuss the attributes or careers of the people doing the faculty development. With the exception of a recently published study on professional educators who are Exemplars in Academic Medicine (Hitchcock, 2002), the personal stories of professional educators working with medical faculty have been missing from the literature. This study attempted to fill this gap in the literature.

Arndt (1999) asserts that for some non-physician educators, faculty development is a primary career emphasis. These individuals are typically located in resource-rich university centers that serve a wide audience. Anecdotal evidence suggests diverse backgrounds of non-physician faculty developers, a lack of anticipatory socialization opportunities to help orient non-physicians to the culture of medicine and their faculty development role, and a lack of a formal entrance point into medical faculty development. Given this unstructured beginning, what factors help faculty developers sustain their interest in their professional work and remain vital to the field of medical faculty development?

As previously mentioned, the amount of federal monies designated to support many faculty development programs in medical education has been steadily declining and as a result there may now be fewer faculty developers within a department than a decade ago. In addition, it seems that managed care and other cost containment strategies in health care delivery have significantly altered the clinical work of many physicians as well as the teaching that occurs (Ludmerer, 1999). Thus, medical faculty developers need to be effective in a shorter amount of time with many constituents (physician faculty, residents, medical students, other health care professionals and staff) who now teach and learn in more complex environments such as clinics and hospital. Because of these conditions, it

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is critical to explore how professional educators sustain their careers during these challenges.

Given the gap in the literature and the anecdotal evidence noted, there appeared to be an opportunity for research. Therefore, I proposed a study exploring what factors support and sustain professional educators in medical faculty development. The exploration of the elements of vitality included discussions about their socialization, professional roles and work within medical faculty development. The literatures on socialization to work and faculty vitality provided the framework for this study.

Defining Faculty Development

The term "faculty development" first appeared in the higher education literature in the 1970's. It was used to refer to an array of services that focus on *purposefully* developing faculty members' teaching performance and attitude in ways that could ultimately improve student learning (Eble & McKeachie, 1985). Bergquist and Phillips (1975) presented a model of faculty development that included instructional development, organizational development and personal development. Diamond (1988) further expanded the definition of faculty development as primarily focusing on "improving the teaching skills of the individual faculty member – common activities include classroom visits by professional staff, personal counseling, and the use of video to analyze teaching styles and techniques" (p. 10). He went on to note that the major outcomes for faculty development included: 1) demonstrating the institution's concern for the individual, 2) improving the productivity of individual faculty, 3) facilitating role change, 4) developing better teaching skills, and 5) improving faculty attitudes toward teaching.

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The development of formal programs for faculty also began in the 1970's. A 1976 study by John Centra reported that formal programs had been established by 60 percent of American colleges and universities (Albright, 1988). Another study in 1985 by G.R. Erickson found that nearly half of all four-year colleges and universities in the U.S. maintained these improvement programs (Albright, 1988).

For the purpose of this study, faculty development encompassed: (a) teaching skills support and improvement, usually done through workshops, observation of teaching and/or one-on-one consultation, (b) professional/academic career development of faculty (promotion-and tenure-related activities of faculty clients, such as research and publication, grant-writing and portfolio assistance), (c) curriculum and instructional development, (d) program evaluation, and (e) organizational and staff development. Essentially, faculty development is responsible for guiding faculty through the "metaprofession of the professoriate." The concept of the metaprofession was recently expanded by Arreola, Theall and Aleamoni (2003). They noted that a number of the responsibilities of a faculty member extend beyond the faculty member's area of scholarly expertise. They detailed responsibilities that are necessary for faculty and categorized them into four dimensions: 1) base profession skills and knowledge, 2) instructional design skills, 3) instructional delivery skills, and 4) instructional assessment skills. Arreola, Theall and Aleamoni believe that their metaprofession model promotes "a better understanding of the full complexity and variety of faculty work" (p. 1). Medical faculty developers work with physician faculty to guide them through this metaprofession of the professoriate.

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Faculty Development and Family Medicine

Historical Perspective

Faculty development programs specifically for faculty within the health professions began to grow steadily in the 1970's as well although a few programs were documented earlier in the 1950's and even in the 1920's (Hitchcock, 2002). When introducing his study on exemplar professional educators, Hitchcock (2002) noted: "no other profession in the United States has collaborated with professional educators on the scale that medicine has" (p. 212). As a result, about half of all U.S. medical colleges and schools currently have offices of medicine education (M. Albanese, S. Dottl & G. Nowacek, 2002) of which most utilize non-physician educators to support their faculty and programs.

The establishment of the Health Resources and Services Administration - Bureau of Health Professions through the Public Health Service Act, known as Title VII, led to the creation of most of the first faculty development initiatives. Family medicine, which first appeared as an academic discipline in 1967 and received board examination specialty status in 1969 (Holloway, Wilkerson, & Hejduk, 1997), was on the leading edge of faculty development and medical education. There was an urgent need for family medicine teachers, but their new faculty were being drawn from clinical practice and had little or no teaching experience (Holloway, Wilkerson & Hejduk, 1997). Faculty development programs, mostly funded through Title VII, were seen as the vehicle to train teachers for this new specialty. Faculty development efforts initially focused on the medical school faculty at the medical college or university, but over time, and through the

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work of family medicine departments, faculty development was expanded to include clinical faculty based in the community. Thus faculty development efforts for these new clinical faculty were then developed as well.

The Society of Teachers of Family Medicine (STFM) was founded in 1967 to respond to the needs of family medicine educators. Holloway et al. (1997) documented the development of workshops in the 1970's that focused on faculty, curriculum, and professional development to enhance physicians' academic careers. While faculty development fellowships began to appear as the main training vehicle for the new physician faculty, other models also existed.

STFM's Group on Faculty Development grew out of work that began in 1977 when Ed Shahady, MD, received a federal grant to study the effectiveness of faculty development workshops. A planning committee was formed and out of this effort grew workshops on faculty development organized by STFM's Education Committee. In 1983, the Taskforce on Faculty Development was founded to address the on-going faculty development needs of its members. The Taskforce then became the Group on Faculty Development, chaired initially by Carole Bland, Ph.D. This group continues today and its mission is to promote the career-long development of family medicine faculty, foster scholarship on faculty development, and advocate for resources to sustain appropriate levels of faculty development in the discipline of family medicine. In addition, the Group on Faculty Development seeks to develop the leadership and scholarship abilities of faculty development professionals while fostering the socialization of its members (Morzinski & Baxley, 1998).

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Medical Faculty Development Today

In addition to patient care, today's physician faculty are often responsible for teaching, administration and research. In particular, teaching can be especially difficult for physicians, but there is evidence that they can benefit from faculty development programs (Skeff et al., 1997a, Skeff et al., 1997b). Multiple demands on primary care faculty have increased the need for faculty developers who can assist these physician educators with their multiple roles and develop the good teachers and good researchers needed to advance primary care medical education for the next generation of learners. Therefore, the focus of most faculty development programs is to improve the teaching, research and leadership skills of medical faculty--both those on-site in university medical departments and those based in community health settings such as hospitals and clinics.

Faculty development in primary care medical education has been a consistent recipient of federal funding. For example, the Bureau of Health Professions (BHPr) estimates that there will be $2.8 million available to support 18 awards to family medicine faculty development training programs and $2 million to support 13 awards to internal medicine and general pediatrics faculty development training programs during the 2003 grant application year (www.bhpr.hrsa.gov/grants/). According to the BHPr, these grants assist accredited schools of medicine (allopathic and osteopathic) and public or private nonprofit hospitals to develop and operate training programs for physicians who plan to teach in primary care medicine. Articles by Skeff et al. (1997a, 1997b) summarize faculty development programs by various types: national fellowship programs; national courses and workshops; national train-the-trainer programs; regional programs; and local programs. The BHPr funding helped establish most of these successful programs for

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faculty development in primary care medical education. Although this federal funding has been decreasing over the years, it has still been a source of steady support for faculty development and training programs in medicine. However, by the end of 2003 experts predict future funding to shrink 14 – 93% depending on decisions still to be made by the House of Representatives and the Senate (Wittenberg, 2003).

More recently, there has been a shift to defining competencies used to evaluate physicians' professional skills (C. Carraccio, S. Wolfsthal, R. Englander, K. Ferentz & C. Martin, 2002). The Accreditation Council for Graduate Medical Education (ACGME) is one of the leading forces behind establishing competency-based training programs for physicians. The ACGME identified six domains in which physicians must demonstrate competence. Educators and faculty developers are being called upon to assist hospitals, residency programs, and medical colleges in developing curricula and evaluation plans to address these competency domains. Educators and faculty developers are also developing the physician faculty's' teaching strategies as they implement the new curriculum guidelines in order to help their learners gain competence.

This brief review of the history of faculty development and of family medicine demonstrates that there has been an increasing interest in and demand for faculty development efforts. Today this interest remains, and federal dollars continue to provide some of the monetary resources needed to support faculty development for family medicine faculty. The need for faculty developers continues, although current federal budgetary constraints may lead to program budgets that are smaller. As a result, it is possible that faculty development programs may disappear from some institutions as the funding continues to decrease.

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Educators Working within the Medical Culture: Bridging the Gap

Faculty development in medicine involves the co-mingling of two distinct disciplines, medicine and education. Each of these disciplines has its own culture which is defined as the climate and practices that develop or the espoused values and philosophy of an organization or profession (adapted from Schein, 1992). Non-physician faculty developers must be able to successfully navigate and find a place within the culture of medicine, which relies on hierarchies and has a language of its own.

The field of medicine is hierarchical and structural. There is a progression of training from medical student to intern to resident prior to becoming an attending physician, with each level carrying more importance or influence, as well as more responsibility. Within medicine there are specialties that are considered more prestigious than others. And within the hospital or clinic setting, there is an institutional hierarchy and often a clear division of labor that separates the physicians from their allied health associates (e.g. physician assistants, nurses, technicians) and support staff. Anecdotal evidence suggests that status and hierarchy issues create barriers for some non-physician faculty developers that add to the difficulty of negotiating the culture of medicine and success in their work.

Federal monies have traditionally been available for the creation of faculty development programs and positions. However, faculty developers are often the only full-time professionals working in faculty development within a department or an institution, so they often work in isolation. In addition, this profession often experiences a turnover of personnel because of the tenuous nature of soft money or grants that generally fund these positions.

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Unlike many other careers (e.g. physician, lawyer, elementary-school teacher, accountant) that have an explicit entry into the profession with prescribed credentials (training and experience), there is not a defined entrance point for a career in faculty development in medical education. In fact, anecdotal evidence suggests that faculty development in medical education appears to be a position that most professionals are recruited to, "fall into," or discover later in their career after their formal education has been completed.

The literature (Baldwin, Levine, McCormick, 1995; Bland, 1980; Evans, 1995; Hitchcock, Stritter and Bland, 1993; Jarvis, 1992) documents the vast array of areas in which faculty developers are often expected to have an impact (e.g. education, administration, research, written communications, professional academic skills and organizational development); but there are no studies about *how* non-physician faculty developers learn their professional roles and make effective connections with their physician learners in order to affect these vast areas. Non-physician faculty developers receive their formal training in various disciplines such as education, the behavioral sciences or allied health, so there is great diversity among the knowledge, skills and work of faculty developers in medical education. However, the reality of the federal funding available for faculty development programs increases the interest within institutions to select professionals who can function in their roles in a timely and efficient manner, who can support physicians, and who can be retained in order to see a project through to implementation and/or completion.

Given the paucity of studies regarding those doing faculty development work in medical education, the anecdotal evidence about the diverse backgrounds of these non-

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physician faculty developers, the lack of anticipatory socialization opportunities to help orient non-physicians to the culture of medicine and their faculty development role, the lack of a formal entrance point into the profession, as well as the loss of Title VII dollars, I proposed a descriptive study to explore factors affecting the vitality of non-physician educators in medical faculty development.

Need and Significance of this Study

The results of this study can be useful in several ways. On an individual level, faculty developers and their physician colleagues may learn more about the medical education context in which they all work. Novice faculty developers in particular may benefit from an organized report of factors that impact vitality. All educators working in medical faculty development may benefit from reading the personal stories of senior faculty developers. These stories may provide insight into the strategies successful faculty developers have used to negotiate the medical culture and sustain their careers in medical education.

On an organizational level, this study may shed light on how employers can socialize new faculty developers. Institutions may use this study to learn more about what cultural and organizational factors support and challenge medical faculty developers and may implement any organizational changes if needed. Some institutions may benefit from the data on socialization presented in this study. Medical departments or colleges may create job descriptions or competencies that can be used for orienting educators to medical faculty development. Institutions may also focus on the personal factors that impact the

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The Society of Teachers of Family Medicine (STFM) and its members may receive additional benefit from a current description of the faculty developers within the organization and their work. This study can potentially serve as a needs assessment of members that could lead to professional development interventions by STFM. In addition, STFM's Group on Faculty Development conveyed a number of challenges for the future. Noted among the challenges was the "reduced time to mentor and guide junior faculty development colleagues. Senior colleagues must help plan faculty development's destiny" (Morzinski & Freeman, 1998, p. 5). This study provided an opportunity for some of those senior faculty developers to record their experiences of establishing their faculty development roles and developing their vitality in medical education.

Research Questions

The primary purpose of this study was to explore how non-physician faculty developers remain vital and sustain their careers in medical education. This study was guided by the following primary research question and three subordinate questions:

What factors impact the vitality of non-physician educators in medical faculty development?

- How were they socialized to medical faculty development?
- How do they describe their work?
- What are the factors that positively or negatively impact their vitality?

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Chapter Summary

This study was designed to explore the factors impacting the vitality of senior educators in medical faculty development. Although faculty development has existed in medicine since the 1970's and was intertwined with the growth of Family Medicine as a medical specialty, there are almost no detailed studies about the medical faculty developers. A study about faculty developers' socialization to medical education and the factors that impact their careers could provide important information for professionals involved in this field during this critical time of potential funding loss.

My interest in this study stems from my own work as a non-physician educator in medical faculty development. Through conversations with other non-physician faculty developers, I am aware of how difficult it can be to bridge the culture gap and work successfully in medical education. Because of the lack of a defined entrance point to this career, as well as the diversity of backgrounds of the non-physician faculty developers that I've met, I was curious to explore the factors that help them become successful in their work, sustain their careers, and promote their vitality in the profession.

I believe that the information on the socialization and vitality of faculty developers provided in this study is useful to future and current educators, institutions, and other researchers interested in medical faculty development, faculty careers, faculty vitality, and socialization theory.

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Chapter 2

REVIEW OF RELATED LITERATURE

Two major concepts from the literature are the focus of this review: faculty vitality and socialization to work. I begin by discussing the literature on vitality that guided this study. This is followed by a brief review of the literature on professional identity and then a detailed review of the literature on socialization that also informed this study.

Faculty Productivity and Vitality

As previously noted, the literature pertaining directly to vital medical faculty developers and their socialization is basically non-existent. However, there is literature on the vitality and socialization of other professionals such as traditional academic faculty and professors. Quite often faculty developers have faculty status and thus would be concerned with the same issues discussed in the literature about the professoriate. Others may have received their advanced degrees at institutions that encouraged graduates' socialization to their discipline and an academic life. The writings on the professoriate and academic faculty socialization can be related to the socialization of medical faculty developers. In particular, the work on vitality and faculty productivity by Bland, Schmitz, Stritter, Henry & Aluise (1990), Bland (2001), and Woods et al. (1997) were relevant as I explored the factors that might impact the vitality of non-physician educators in medical faculty development.

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Defining Vitality

Vitality is a concept that "is widely used but infrequently defined" (Clark & Lewis, 1985). In their work, Clark and Lewis defined vitality as the "essential, yet intangible, positive qualities of individuals and institutions that enable purposeful production" (p. 3) Faculty vitality is not a static concept because it is most often based on the mission of the institution and department in which a faculty member works; therefore, what makes a faculty member vital is linked to what the institution values. For example, at one institution a vital faculty member may be someone who is an excellent teacher and advisor, whereas another institution might say a vital faculty member is someone who obtains grant dollars for the institution. The literature revealed many definitions of vitality and some of the institutional factors related to vital faculty members (Bland & Schmitz, 1986). However, since this study is not an organizational study, the vitality of senior medical faculty developers will only be discussed in relation to the field of medical faculty development. Institutional issues that impact the medical faculty developers' vitality will only be touched upon if individual participants brought them up on their survey or in the interview.

My discussion about the vitality of faculty developers is based on the definition from Woods et al. (1997) which defined vitality by four dimensions: 1) retention in medical education and faculty development, 2) career satisfaction, 3) a range of administrative, teaching and research activities, and 4) contributions to the medical faculty development profession. This definition of vitality provided the base for this study. In Chapter 7, I use these four dimensions to discuss the vitality of the twelve faculty developers who participated in the interviews.

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I used Bland and Bergquist's (1997) definition of a senior faculty member as a general guideline for selecting my interview candidates. They wrote that senior faculty members are "1) full time, 2) tenured, 3) working in a collegiate institution for many years (usually at least 15), and 4) more than 45 years of age " (p. 3). In Chapter 4, I present the demographics and backgrounds of the medical faculty developers interviewed for this study. Chapter 8 compares Bland and Bergquist's definition of senior faculty members to the faculty developers who participated in this study.

Austin and Gamson (1983) stated, "The 'productive' academic faculty member ... holds a doctorate, places a strong value on research, and started publishing early. He or she spends more time in research than teaching and stays in close contact with colleagues and developments in the discipline" (p. 38). This definition perhaps fits the "ideal" faculty developer but does not accurately describe the majority of vital medical faculty developers. They are frequently isolated from colleagues in their discipline and spend less time involved in research and publishing and are more involved in teaching and consulting. It is still, however, important to know how a productive faculty member is defined and to further explore how medical faculty developers match this description.

Carole Bland also studied faculty productivity and vitality (Bland and Schmitz, 1986; Bland et al., 1990; Bland and Schmitz, 1990; Bland and Bergquist, 1997; Bland, 2001). Her 2001 work further delineated productivity by identifying thirteen characteristics of a productive or vital academic faculty member.

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The following is a summary of the list of qualities that Bland (2001) indicated vital faculty members are perceived to possess:

1. Personal motivation
2. In-depth knowledge of their area
3. Basic teaching and research skills as well as advanced skills applicable to their area
4. High morale (sense of shared purpose, stimulating colleagues, peer support, trust of administration and not feeling "stuck")
5. Scholarly work habits
6. Contact with a network of colleagues both within and outside the institution
7. Sufficient work time for scholarly activities
8. Commitment to both internal and external professional activities

Bland also stated that productive faculty members:

9. Received a thorough socialization
10. Benefited from an advisor/mentor
11. Engage in multiple, simultaneous projects
12. Have academic freedom and autonomy and are valued as important contributors to the organization
13. Work in a supportive environment that provides the necessary resources

I speculated that productive, vital medical faculty developers would exhibit many of these same characteristics. Therefore, during my interviews with non-physician educators in medical faculty development, I explored how these qualities of productive

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Work Stress

Work stress was another area connected to the vitality of non-physicians in medical faculty development that I explored. The literature on new and junior faculty indicated factors that are stressful for academic faculty. This study tried to draw some connections between stress points for faculty developers in medical education to those that affect academic faculty as noted in the literature. Like other academic faculty, faculty developers in medical education are responsible for teaching, research, service, grant writing, and administration, at institutions that highly value research and obtaining grant funding. Medical faculty developers received little formal training in all the role dimensions for which they are responsible, and so they may negotiate the balance of their role functions based on external demands or their own strengths and weaknesses. Anecdotally, I know that faculty developers have many roles to fulfill and encounter conflicts from pressures to be involved in teaching, research, grant acquisition, service, and administrative tasks. In addition, they are pulled in at least three directions as members of an organization, the field of academic medicine, and the discipline in which they were trained.

Austin and Gamson (1983) and Secord and Backman (1974) reported that faculty members often face role conflict and role strain regarding the multiple demands of research and teaching, and between their profession and their organization. Their literature review noted that excessive demands to perform too many discrete tasks cause

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role strain for faculty: "while variety is important for meaningful, satisfying work in less skilled jobs, too many different responsibilities may threaten those in highly skilled jobs" (p. 19).

Sorcinelli (1992) further expanded upon this concept of the stress of faculty work in her discussion of five stress points for new and junior academic faculty. The factors that Sorcinelli identified were: 1) not enough time to get everything done, 2) inadequate feedback and recognition, 3) unrealistic expectations of what they can achieve during their first years, 4) lack of collegiality, and 5) balancing work and life outside of work. Although her study focused on faculty during their first years in academia, I looked to see if there were any connections to the stress factors of the experienced medical faculty developers in my study. A discussion about some of the stress factors that impact the vitality of the senior medical faculty developers can by found in Chapter 7.

Professional Identity

The term "professional identity" is used here to encompass a variety of definitions. On one level, it closely resembles role identity, which is described as the character and the role that one devises for oneself as an actor in a specific role, that is to say, the way one likes to think of oneself in one's professional role (Secord & Backman, 1974). Role is defined as the norms and behaviors for a particular position (Organ and Bateman, 1991). Though role identity can sometimes be an idealized notion of performance, these thoughts and anticipations are sources for plans of action. In particular, role identity can be used to evaluate how one enacts one's role by identifying mistakes and replaying events. Role identity is encompassed within the broader notion of self-concept, which is

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"an interlocking set of views that an individual holds about himself as a person [that] serves as a core from which role identities are formulated in connection with [the role one] occupies (Secord & Backman, p. 414). Freidson (1994) further broadened the understanding of professional identity through his model of professionalism. The model revolved around the concept that the people within a profession define the goals, conditions of work, and evaluation criteria of the profession.

The literature on professional identity is briefly mentioned here because in the process of exploring what medical faculty developers do, I asked them to define their work roles. The professional identity of faculty developers in medical education, therefore, encompasses the work tasks, roles, and self-concepts that define for them what it means to be non-physician educators in medical education.

Socialization to Work – definitions and key concepts

Socialization is generally defined as the process through which individuals acquire the attitudes, values and skills needed in a particular group or society. Socialization is a continuous process that occurs many times during an individual's lifetime. Bragg (1976) succinctly reported that young children learn how to behave in a family and then later in school. As an adult, individuals are socialized to work roles, spouse or parent roles, and then for some, roles as a retired person or widow(er). For the purposes of this study, however, I will be focusing only on the adult's socialization to work. Many theorists have documented the importance of the socialization process for learning the culture of a profession or organization (Bland et al., 1990; Clark & Corcoran, 1986; Clark, Corcoran & Lewis, 1986; Merton, 1957a; Merton et al., 1957b; Lortie, 1975; Secord and Backman,

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1974; Schein, 1968; Tierney & Rhoads, 1993; Van Maanen, 1976; Van Maanen, 1978; Van Maanen & Schein, 1979).

Merton (1957a) stated that the socialization process often begins at the stage of anticipatory socialization, during which one explores a profession and begins adopting its values before one even belongs to that profession or group. Because a faculty development career in medical education is rarely planned, there is little opportunity for individuals to engage in anticipatory socialization prior to assuming their faculty development role.

Socialization has also been attributed to developing a commitment to work, stimulating motivation and "internalizing occupationally relevant attitudes and behavior that sustain productivity and continued achievement throughout the career" (Clark and Corcoran 1986, p. 23). I suspect that non-physician faculty developers receive little formal orientation or mentoring to the faculty development role and the culture of medicine, so that there is little opportunity for values and attitudes of the field of academic medicine to be introduced at the beginning of one's career.

Many researchers have used the terms "organizational," "occupational," or "professional" socialization, but all of these terms focused on the manner in which the socialization of adults to work occurs. In general, it is the process by which a new member learns and internalizes what is important in an organization, including the norms, values, and behaviors expected of members. Socialization has been characterized as learning how to behave and view the world in a manner similar manner to others in the same role. It includes acquiring and understanding attitudes, learning certain skills and techniques associated with a role (Secord & Backman, 1974), and it is a method of

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learning how to function and behave according to cultural expectations of those in similar professional roles. "From the perspective of the group, socialization is a mechanism through which new members learn the values, norms, knowledge, beliefs, and the interpersonal and other skills that facilitate role performance and further group goals" (Mortimer & Simmons, 1978. p. 422).

Anticipatory Socialization and Entry

Socialization has been discussed in three phases: 1) anticipatory socialization, 2) entry, and 3) role continuance (Clark & Corcoran, 1986). Anticipatory socialization refers to the learning that individuals engage in prior to assuming a role that helps them prepare for their roles. Socialization to work occurs primarily in adulthood, but some anticipatory socialization can even begin in childhood. Merton (1957a) noted that anticipatory socialization is the process of adopting the values of a group to which one aspires to belong but to which one does not currently belong. This process can aid one's rise into a group and also fosters an easy adjustment after becoming a part of a group. In many professions, anticipatory socialization takes place during graduate studies, apprenticeships or internships. Faculty development in medical education does not require a specific degree or training program so there is not a formal, universal mechanism through which the anticipatory socialization stage can occur. It appears to be an unstaged career.

The next stage of socialization that occurs is occupational entry. For some professions, this stage overlaps with the prior stage as when formal training for the occupation is required that includes extensive practical experience while the novice is

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already a member of the profession (e.g. residency level for physicians or student teaching for elementary school teachers). For other professions, this stage includes orientation training, mediated entry, or learning while doing (Clark and Corcoran, 1986).

A study by Ostroff and Kozlowski (1992) reviewed previous work role and socialization literature and further explored the experiences of newcomers into a new organizational setting. They noted that there are four content domains that successful employees master over time: 1) job-related tasks, 2) work roles, 3) group processes, and 4) organizational attributes. In addition, Ostroff and Kozlowski also delineated three interpersonal and three non-interpersonal sources of information for learning about the content domains. "Supervisors, coworkers and mentors have been shown to play an important role in the learning process . . . three non-interpersonal sources [that] are most often mentioned in discussion of socialization [are] official organizational literature, experimenting with new behaviors, and observation" (p. 851). Boice (1992) specifically noted that in regard to university faculty, "mentoring was associated with more rapid socialization to campus and with improved student ratings of teaching compared to non-mentored peers" (p. 52). Ostroff and Kozlowski's study further revealed that knowledge of the group process was greatest initially but that job task knowledge increased over time while knowledge of the organizational attributes remained low during their short-term study of recent college graduates. It is my intent both to collect data that adds to this work on socialization and specifically to explore task domains for faculty developers and the interpersonal and non-interpersonal sources that inform these professionals.

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The period of initial entry, as described above, ends either with role failure or role continuance. Van Maanen (1976) believed that in role continuance, individuals move along within the structure of the career to later stages involving increased leadership, sponsorship, and generative activities. Individuals engage in further learning about their role, the organization, and the stakeholders throughout their time at an organization. During this on-going stage, the new professional has internalized role specifications and has a high degree of role satisfaction, job involvement and commitment (Clark & Corcoran, 1986).

Socialization greatly affects the transition, stress-level and job satisfaction of new employees (Whitt, 1991; Van Maanen, 1976; Sorcinelli, 1992). In particular, Whitt (1991) studied the experiences of new faculty in a school of education at one research institution. In addition to interviews with the new faculty, she also met with school administrators (i.e., deans, chairs) to compare their perceptions to those of the experiences reported by the new faculty. She found the following:

1. New faculty were expected to "hit the ground running"; administrators expected them to bring much of what they needed to know about being faculty members to their new position; and they were expected to have prior socialization to research and teaching and appropriate work habits.
2. Being a new faculty member can be a stressful and negative experience because of conflicting demands and little assistance.
3. "Very new" faculty were the most uncertain about their roles and felt most isolated.

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4. New faculty and department chairs perceived the experiences of new faculty very differently.

Unlike academic faculty in Whitt's study, however, there is little opportunity for faculty developers in medical education to formulate values and expectations about their professional role in graduate school, because there is no formal graduate program for this position. Nor is there a standard set of titles, responsibilities or requirements for those doing faculty development, as evidenced in a study by Monteiro, Whiting and Tysinger (2000) that looked specifically at positions in family medicine for trained educators (including faculty developers). In their study, Monteiro et al. (2000) reviewed positions posted for education professionals from five sources over a two-year period. They found that there were over 90 education-related positions posted. Within the 90 postings that were the focus of their inquiry, they identified 304 qualifications, 305 responsibilities and 103 competencies listed in these posting of positions for education professionals. Only 27% of the positions reviewed included a faculty appointment. This study by Monteiro, et al. demonstrated that there is a range of education positions in family medicine but not a standard job description as evidenced by the large number of qualifications, responsibilities and competencies mentioned in the position postings.

Assumptions about Socialization

The first assumption is that beginning a new role in an organization can be anxiety-producing. Thus, novices are motivated to reduce this anxiety by learning the knowledge and skills of their new role as quickly as possible (VanMaanen & Schien, 1979). There may be many different sources of tension and anxiety for new faculty developers.

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Though not its primary focus, this study may also uncover some of the stressors that may be common to faculty developers in primary care medical education.

A second assumption is that socialization and its associated learning does not occur in a vacuum. Colleagues, superiors, physician clients, and staff provide clues and direct guidance to new faculty developers about how best to proceed in their new role. These co-workers ultimately provide an individual with a sense of accomplishment and competence, or failure and incompetence (Van Maanen & Schien, 1979; Ostroff & Kozlowski, 1992). Van Maanen (1976) cited a number of theorists who look specifically at the organization's role in the socialization process and who have developed organization classifications. Although their findings bear some relevance here, the nature of faculty development in medical education decreases its helpfulness. For example, in most medical colleges, faculty development is not in a separate department and there is no one place where the faculty developer is housed. Often only one person is hired with faculty development expertise, and sometimes other faculty and administrators within the college do not even know there is a faculty developer, let alone know how to define the faculty developer's role.

Third, individuals' ability to adapt and carry out their new responsibilities can greatly affect the stability and productivity of the organization. Therefore, a smooth transition for new employees is in the best interest of the organization and will help ensure the continuity of its mission. Some roles may require even longer processes of socialization that consist of both formal opportunities and informal learning. Auster (1996) pointed out that, although individuals may learn about their professional role through formal orientation and training programs, other aspects of learning that role could be more

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Socialization can be further characterized by the tactics used by the individual or offered by the institution (Van Maanen & Schein, 1979; Bland et al. 1990). Typical tactics are found on the following continua:

1) Collective vs. individual (group orientation vs. singular)
2) Formal vs. informal (structured program vs. trial and error)
3) Sequential vs. random (ordered steps vs. unclear and ambiguous)
4) Fixed vs. variable (specific timetable vs. no timetable)
5) Serial vs. disjunctive (lead by roles models vs. no role models)
6) Investiture vs. divestiture (affirming of individual characteristics vs. transforming individual characteristics)
(Tierney and Rhodes, 1993, p. 31)

Going into this study, I suspected that non-physician faculty developers are most often socialized using individual, informal, random, variable and disjunctive tactics that seek neither investiture nor divestiture. If this is true, there are implications for the profession and its members in that novices must force others in their setting and profession to teach them and mistakes made by novices are regarded as costly and serious (Van Maanen & Schein, 1979). However, the informal and variable nature of the socialization process would also be in line with other complex roles that require creativity and role innovation.

This section summarized the relevant literature on socialization that has guided this study. Although socialization has been studied in great detail, it has not been directly related to faculty developers in medical education. Virtually all studies on socialization show that it is a critical component in learning one's professional role and in gaining a general appreciation of work culture. Appropriate socialization leads to effective performance in an organization and success in one's chosen profession. This study on the factors impacting the vitality of non-physician faculty developers in medical

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Chapter Summary

The literature revealed many interesting studies on vitality, role development, and socialization. However, none of these previous writings applied to medical faculty developers. I used this established literature to provide the framework to explore these topics in a new area of faculty development in medical education. In particular, I used this literature to explore how faculty developers defined their role in the medical culture, how they were socialized to medical education, and how they remain vital to this relatively new professional area.

Although all of the literature cited in this chapter was useful in developing my conceptual framework, five of the studies strongly guided my exploration. Woods et al. (1997), Bland's (2001) and Bland and Bergquist's (1997) work on productive academic faculty provided the framework for exploration of the vitality of medical faculty developers. The work of Ostroff and Kozlowski (1992) was useful in exploring the content domains and sources of information (interpersonal and non-interpersonal) used by the medical faculty developers as they entered their new careers. The socialization tactics that were originally highlighted by Van Maanen and Schein (1979) were also useful in developing my interview questions. The literature on role development, socialization, vitality, and faculty productivity reviewed in this chapter guided my preliminary survey questions and interview protocol. In subsequent chapters, I will present the data regarding factors that impact the vitality of medical faculty developers.

Chapter 3

RESEARCH METHODOLOGY

Introduction

This study was guided by one major research question:

> What factors impact the vitality of non-physician educators in medical faculty development?

I set out to examine 1) how the educators began their medical faculty development careers; 2) who they are and what they do; and 3) how they sustained their careers in medical education. To explore these questions, I primarily relied on semi-structured telephone interviews with senior medical faculty developers. Selecting the interview participants, however, proved to be a complicated endeavor, so a brief survey was used as the initial step to locate interview participants.

The survey primarily focused on data about the subjects' backgrounds and medical education work gathered through multiple choice questions and open-ended response questions. The survey's main purpose was to gather preliminary work data on non-physicians in medical education and to locate a pool of non-physician educators doing faculty development from which to select the interview candidates. The data from the survey were used to select candidates who represented the general population of faculty developers in primary care medicine. Some of the open-ended survey responses are also used in the discussions of faculty development work.

The semi-structured interviews with non-physician faculty developers in primary care medical education with ten or more years of experience explored factors that impacted

their vitality, such as their socialization to medical faculty development, their work, and their career productivity. Together, the survey and the interviews provided data regarding the vitality of faculty developers in primary care medical education.

Study Design

Rationale

As stated previously, faculty development in medical education is still an emerging profession and as a result there is no one organization providing membership and resources for all the professionals working in this field. The Society of Teachers of Family Medicine (STFM) is one of the organizations to which medical faculty developers may belong if they work in primary care. STFM was chosen as the source for locating working faculty developers because it has the longest history of involvement with the faculty development movement that began in the late 1970's. STFM is considered a leader in current faculty development efforts. This organization actively encourages faculty development as a part of its mission and its support has furthered the growth of faculty development in medical education. I have been a member of this organization for about four years and through my membership I was able to purchase the mailing list information needed to locate my sample population.

STFM supports physician and non-physician faculty developers and academic faculty teaching in family medicine, as well as family medicine physicians who do not teach but only work in their clinical practice. Physicians and physician faculty developers were excluded from this study because "most physician faculty continue to identify themselves primarily as clinicians and, secondarily, as academicians" (Holloway et al, 1997). They

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also experience different socialization issues and do not have to negotiate the culture of medicine in their faculty development role because they already belong to that culture. Numerous studies have already documented the socialization process medical students and residents experience (Becker, H., Geer, B., Hughes, E., & Strauss, A. 1961; Merton et al., 1957b) in preparation for their physician role. Other studies (Blackburn and Fox, 1976; Bogdewic, 1986; Dill, 1986; Knopke and Anderson, 1981) have documented the socialization and work setting for physicians as academicians and researchers. Though physician faculty developers may need to become oriented to the educational theories of teaching for their faculty development roles, they automatically begin their new role already on the level with their colleagues and adept in the cultural nuances of medicine. In addition, for most physicians, faculty development is only a part of their many other responsibilities including patient-care, administration, teaching, and research.

Much of the research on socialization involves newcomers and those in the first three years of their new role. However, it was not feasible to select a similar group for this study because many of the positions in primary care medical education are grant funded. Funding typically is awarded to support a two- or three-year faculty development endeavor. After that, institutions that do not receive further funding may not be able to continue supporting the faculty development positions. Thus, it appears that turnover in the early years of a medical faculty development career is quite high, and these professionals often move in and out of medical education in grant-funded positions until they secure a more permanent position--possibly after they have completed at least five years of faculty development work but often over a longer period of time. Therefore, faculty developers with ten or more years of experience provided a more stable group

from which to collect data. In addition, this length of service provided an opportunity to examine the issue of scholarly productivity and vitality.

Design Process

This study employed three processes of data collection: a brief survey, semi-structured interviews and interview follow-up e-mail questions. The survey was a vehicle to locate the sample I wanted to study within the larger population of non-physician members of The Society of Teachers of Family Medicine and the qualitative interviews were used as the primary source of data. Interview methodology was chosen because this method can capture data about beliefs, values, feelings and motivations that underlie behaviors (Berkwits and Inui, 1998). As the design unfolded, additional steps needed to be employed to work with some of the limitations that arose.

The survey instrument, interview protocol and interview follow-up e-mail questions were pilot-tested and changes were made as needed. A description of this study and the data collection instruments were presented to the University Committee on Research Involving Human Subjects (UCRIHS) for review and approval prior to data collection. I will now continue discussing the design process in the chronological order in which it unfolded.

Step One – Survey

During my initial inquiries to STFM, I discovered that this organization does not categorize their membership by job title or area of focus. Therefore the smallest group of names I could elicit from STFM included non-physicians who worked in a broad array of

education areas. So the first step in locating experienced medical faculty developers was to survey 831 non-physician members of STFM. The sixteen-question survey was primarily used to gather demographic data on these members and was sent to these 831 STFM members in October 2001. Because the survey was sent to this large non-physician group, the mailing referred more broadly to "non-physicians in medical education" rather than to "faculty developers." A reminder to complete the survey was sent out over STFM's Group on Faculty Development electronic listserv a week after the first mailing went out, and then a second reminder was sent via the listserv a week prior to the second mailing. The second mailing, which included the survey accompanied by a new cover letter, was sent in November 2001 to 320 non-respondents (Appendix B).

The mailing for this study consisted of: 1) a survey booklet which included a description of the study and outlined participation guidelines per UCRIHS (see Appendix A) and 2) a postage-paid return envelope. The survey contained 13 multiple choice or short-answer questions and three open-ended questions. The questions were designed to gather demographic and work information about the participants. The majority of questions utilized check boxes indicating a response or range. Race and ethnicity questions were purposely omitted from the survey because common categories were not inclusive enough and survey recipients might be offended by the question. I also believed that the interview participants would independently bring up any issues of race or ethnicity if they felt it had impacted their career and vitality. The three open-ended survey questions asked about what the respondents like best and least about their work in medical education and also what significant factors contribute to the success of non-physicians in medical education.

Step Two –Selection of Sample Population

By January 2002, 606 usable surveys and nine incomplete surveys were returned via U.S. mail or e-mail attachment. The survey had an overall response rate of 74%. I had anticipated a response rate of only 40% so I was very pleased with this response rate.

TABLE 3.1

Survey Response Rate

Potential subjects	Completed surveys returned	Returned not completed due to: a) not in sample population; or b) chose not to answer questions	Return Rate
831	606	9	74%

This response rate not only provided more data to work with and assured that I had probably elicited responses from most of the faculty developers in the target population, but it also provided the opportunity to generalize. In general, the higher the response rate, the more likely it is that the characteristics of respondents are similar to those of non-respondents (Passmore, Dobbie, A., Parchman, M., & Tysinger, J., 2002). Passmore et al. (2002) reported that "many investigators consider a response rate of 70% adequate for generalization to the population studied" (p. 281-282).

The high response rate to my survey allowed me to keep my proposed sample population for the interviews without any revisions. Briefly, I will restate the interview criteria and rationale for the sample. The sample population had to spend at least twenty percent of their time in faculty development because this amount seems to indicate a commitment on the part of the individual or his/her institution to faculty development but allowed for the multitude of ways that faculty development is performed at various

institutions. Fifteen years is typically the starting point for discussions on "senior faculty" (Bland & Bergquist, 1997); however, if I applied this same cut-off to my population, it would have narrowed the pool of potential interview candidates to fewer than 35 candidates. Remembering that faculty development has a relatively short history and is still an emerging professional area, ten years in medical education was chosen instead. In general, ten years of experience indicates a commitment to a career in medical education and allows enough time for the individual to have attained role continuance.

Of the 606 respondents who completed the survey, 377 indicated that at least some percentage of their time was spent on faculty development activities, and 91 indicated at least 20% or more of their time was spent in faculty development (Table 3.2). Of the 91 survey respondents with 20% or more time in faculty development, 58 survey participants indicated that they had ten or more years working in medical education (Table 3.2). These 58 participants formed the sample population from which I selected interview candidates because they met the criteria of 20% or more time spent in faculty development and had been in medical education for ten or more years.

TABLE 3.2

Percentage of Time in Faculty Development (n = 377)

Percentage of Time in Faculty Development	Number of survey respondents
5% or less	158
6-19%	128
20% or more and 1-9 years in medical education	33
20% or more and 10+ years in medical education	58

Once I had my sample population of 58 candidates, I wanted to select interview candidates who matched the demographics of this population of senior medical educators. In order to do this, I divided the 58 subjects by the number of years in medical education. The years were broken down into four ranges and I then randomly selected a percentage of interview candidates within each age range that matched the larger population (Table 3.3).

TABLE 3.3

Number of Initial Interview Candidates Selected Based on Years in Medical Education

Years in Medical Education	Percentage of Survey Respondents (n=58)	Number of Candidates to be Interviewed (n=20)
10-14.5	41%	8
15-20	34%	7
21-25	16%	3
26 or more	9%	2

Twenty interview candidates were randomly selected, as were several alternate interview candidates. An adjustment was made after the selected subjects' names and address were revealed because I had three employees from the same faculty development center initially selected for interviews. One additional adjustment was made after contacting original candidates and then alternate candidates. In the end, 26 candidates were contacted to participate: 20 participated in the interview, two did not respond at all, one declined, one changed jobs and was out of medical education, and two initially wanted to participate but emergencies arose with their schedules and we were unable to find a mutually agreeable time to speak during the interview month, so alternates were used. This resulted in the actual interview subject numbers being seven from the 10-14.5 years category and four from the 21-25 years category. The number of candidates interviewed from the other two categories remained the same.

Step Three - Interviews

Twenty interview candidates were selected from the sample population of 58 for audiotaped telephone interviews to better understand the factors that shape their vitality in medical faculty development. The interviews were conducted over the telephone. I audiotaped these interviews to assure that data were collected accurately. Berkwits and Inui (1998) noted that audiotaping interviews "helps guarantee that expressive data are captured accurately and completely as they emerge" (p. 196). They also documented that taping permits the researcher to carry the data to more controlled settings, where they can be transcribed, coded, analyzed for important themes and meanings, and verified.

An e-mail invitation letter (Appendix C) was sent to the initial 20 candidates (one received a letter in place of an e-mail). A few weeks later, reminder phone calls were placed to the five candidates who had not responded. Additional e-mail or letter reminders were used and then alternates were also contacted.

Next, interview times were selected through either verbal or e-mail communication with each candidate. A letter (Appendix D), consent form (Appendix E), and basic interview protocol were sent to the interview participants confirming the interview time and describing the study. Nineteen of the twenty participants requested that the materials be sent as an e-mail attachment. No interview was conducted without a signed consent form on file.

During the initial contacts with potential interview participants, concerns were raised by some about the length of time requested for the phone interview (one hour). In addition, one subject who agreed to participate in the interview inquired about receiving the interview questions ahead of time to prepare for the interview. Upon consideration, I decided that providing the basic interview questions ahead of time would not hinder the integrity of the study and, in fact, might help alleviate some of the subjects' concerns about the time frame (since they could prepare a few responses ahead of time and also monitor the interview's progress). Seeing the interview questions ahead of time helped to solidify some of the candidates' involvement in the interview process because they saw I was taking my work seriously, had prepared straightforward and focused questions, had "laid my cards on the table," so to speak, and did not have a hidden agenda. I received some informal comments to this effect. At the start of each phone interview, I made reference to the interview questions participants had received and stated that I would not

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be following those questions word-for-word but rather, would allow the conversation to evolve within those areas. In some cases, the participants shared that they had the questions in front of them and had written a few notes down. In other cases, the participants stated that they had not had a chance to look at them. In only one case, I felt that the participant had prepared answers ahead of time and that the protocol interfered with the flow of the conversation. Overall, I believe that providing the interview questions ahead of time was helpful to the participants and also provided benefits to me as the researcher.

A request was also made for the curriculum vitae (CV) of each interview participant prior to his or her interview. The CVs provided insight for interview questions and were used to identify themes in the participant group's training, experiences, and professional productivity. The CVs proved to be very valuable in preparing for each interview and also served to keep the interviews within the time limit. Prior to the interview, I was able to review the career of the participant and was sometimes able to pinpoint areas about which to ask further questions during the interview. In most cases, I was able to follow along with the CV to track the faculty developer's career moves and other successes as they were mentioned during the interview. The CV's had some limitations when I began quantifying the participants' experiences, however, because everyone used a different format and chose to reveal different information. For example, even though the interview revealed a faculty developer spent a considerable amount of work time writing grants, if s/he did not include this category on her/his CV, I was unable to quantify and compare productivity in this area. Similar situations occurred when reviewing professional memberships, committee involvement and other service activities. Curriculum vitas

proved to be very helpful for the interviews but had some limitations when used for comparing participants' productivity.

All interviews were conducted using an interview protocol (Appendix F) as my general guide. After the interviews were completed, I felt that not all interviews covered aspects of work and socialization to the same extent because of the flow of conversation with some of the subjects. I developed interview follow-up e-mail questions (Appendix G) that were approved by UCRIHS and sent to the twenty subjects. This e-mail only involved the ranking or numbering of statements, but these numerical data provided a more thorough look at participants' faculty development activities and the interpersonal and non-interpersonal factors that affect socialization, feedback and longevity. I received completed follow-up e-mail responses back from all the interview participants who were the final focus of this study.

Step Four – Narrowing of the Interview Data

Creating the initial survey that matched the nature of STFM's entire non-physician population resulted in survey questions that didn't provide enough specifics to accurately establish the desired pool of interview candidates. For example, because my initial population had to be so broadly defined as all the non-physician members of STFM, I had to utilize the broader term of "medical education" instead of the specific term of "faculty development." This wording change ended up being too broad. When I needed to choose my interview candidates, I only knew who had been in medical education for ten or more years but did not know their years in faculty development. As a result, some of the interview participants were not really a part of the group I desired to study; so once

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the interviews were underway, I realized that eight of the twenty participants did not meet the desired sample characteristics. During the CV reviews and interviews I discovered that although these eight had been involved in medical education for 10 or more years as they had indicated on the initial survey, not all ten years had been in faculty development. In fact, some had only a year or two of working in medical faculty development.

After discussions with my dissertation advisor, it was decided to focus on the twelve subjects who met the desired criteria of 20% of their work time spent in faculty development and 10 years of faculty development (not medical education). The data on these eight interview participants who did not have at least ten years of experience in faculty development were not used in the analysis and discussion for this study. However, their data may be useful in future publications.

Limitations of this study

This study was limited to subjects who were members of the Society of Teachers of Family Medicine (STFM) and who identified themselves as non-physicians in medical education. This study was also limited by the nature and size of the sample. The survey was sent only to those non-physician professionals who held a current STFM membership in September 2001 (when the names were requested). The twenty semi-structured interview participants were selected from the STFM members who returned a completed survey by January 2002. Another limitation of this study could be that I may have missed those senior faculty developers who used to work in faculty development but now were promoted to a position that involved the supervision or coordination of faculty development efforts instead of direct contact. The wording I used on the 2001 survey

asked participants to indicate time spent on faculty development (i.e. workshops 1:1 faculty consultations) thus, senior faculty developers who do little actual faculty development work were not in my interview pool. Being aware of this possible problem when I was establishing the parameter for my interview sample, I looked up the percentage of time responses indicated by approximately ten nationally known senior faculty developers who had completed the survey and did find that one of these known senior developers was eliminated from my interview sample.

This study was further limited to the subjects who consented to the interview. I do not know if those who chose not to participate are a substantially different population or not, but some assumptions can be made based on the names and addresses of the 216 non-respondents. It appears that 67% were female and at least 35% of non-respondents work primarily in the allied health area (nursing, pharmacy) or social work. In addition, a review of the addresses also shows that the majority of the non-respondents were based in a clinical practice setting. This leads me to believe that the majority of the non-respondents were not in my target group and therefore they did not complete the survey that focused on medical education and faculty development because they did not work in those areas. All of this indicates that I probably received responses from the majority of my target audience and that non-respondents would not have been included in the interview pool for this study anyway.

The experiences of early career medical faculty developers were not directly captured in this study. Instead, the interview questions asked the faculty developers to think back retrospectively regarding how they initially constructed their roles and were socialized to medical education. It was not a longitudinal study of the subjects' socialization process

nor did it involve first-hand observations by the researcher. Rather, this study focused on the faculty developers' remembered perceptions of how they were socialized to the profession and learned the strategies of practice.

Because I work in the medical faculty development field, I remained alert throughout the study to carefully safeguard the participant's identity and to maintain a professional research approach. Although confidentiality and anonymity in reporting were assured, anonymity to the researcher was not provided. The quality of the data of the initial survey and interviews, therefore, hinge on how honest and forthright participants were in answering the questions. It appears that survey participants felt comfortable with my assurances, although a few did choose to leave a particular question blank. In addition, some of the interview participants wanted to know more about my background and asked this in the context of wanting to know my familiarity with medical education and how much they had to explain what they were saying. I typically provided a brief statement of my previous work in faculty development in medical education but would hold any further questions about myself until the end of the interview. I did not receive any feedback that my comments about my experiences interfered with the interview and I only shared the information if asked by the interviewee.

Chapter Summary

In summary, obtaining the desired interview candidates proved to be somewhat complex. The net was initially cast very wide to locate as many educators involved in medical faculty development as possible. That pool was narrowed to those with 20% of their time in faculty development activities and ten or more years in medical education. Twenty interview participants were then randomly selected. The group of twenty was further narrowed when it was discovered during the interviews that only twelve participants truly met the study criteria. This process yielded a large amount of data, though only some of it is relevant to the research question posed in this study and will be discussed here. The data presented here can be used to further the knowledge on the vitality of senior faculty developers in medical education as well as the literature on socialization and faculty productivity.

Chapter 4

WHO ARE MEDICAL FACULTY DEVELOPERS?

This chapter begins by providing some demographic data on the twelve participants interviewed for this study. I will then provide a brief narrative description of each participant.

Demographics of the Interview Participants

The twelve participants consisted of eight males and four females. The majority (8) was age 55-64 (note: participants were only asked to indicate an age range). Eleven held a doctorate degree and almost all were trained in educational psychology or education areas (higher education, curriculum design, etc.). Ten participants were employed by a university or medical college and two worked at a foundation or corporation. Eleven participants held a faculty development title, with the remaining participant holding a more encompassing title in Faculty Affairs. Seven held a traditional tenured, faculty position (note: many participants held more than one job title). Tables 4.1 and 4.2 provide more detailed information on the participants.

TABLE 4.1

Demographics of Interview Participants – Education (n = 12)

Gender	Age	Highest Degree	Discipline of Highest Degree
Male 8	45-54 yrs 4	MA 1	Educational Psychology 4
Female 4	55-64 yrs 8	EdD 2	Education 3
		PhD 9	Sociology/ Political Science 2
			Curriculum & Instruction 2
			Research & Evaluation 1

TABLE 4.2

Demographics of Interview Participants – Employment (n = 12)

Primary Employer	Funding Source	Areas of Responsibility Note: Total exceeds 12 because some participants had more than one area	Faculty Rank
University or Medical College 10	Institutional Funds 5	Faculty Development 11	Professor 5
• Dept. of Family Medicine 7[a]	Grant Funds 2	Educational Affairs/ Medical Research & Development 2	Associate Professor • tenure 2 • no tenure 1
• Central Office 4[a] (Dean's Office, Education Office)	Combination of Institution and Grant Funds 5	Other Fellowship Programs (non-faculty development) 1	Adjunct Faculty 2
Foundation or Corporation 2		Graduate Education 2	Clinical Faculty 1
		Medical Student Education 2	Non-Faculty Position 1

Note. a = one participant had a dual appointment in FM department and central office

Although these twelve medical faculty developers exhibit many similarities, a great deal of diversity exists among those non-physicians who are responsible for aspects of medical faculty development. The broad responses I received from the entire survey population with any percentage of work time spent in faculty development (n=377) didn't reveal specific patterns when analyzed. A brief exploration of the 58 survey respondents who worked 20% of their time in faculty development and had worked in medical education for ten or more years also yielded some variety (Appendix H). Professionals may be doing faculty development full-time or as a part-time responsibility. Faculty development may be "housed" at the department level of a university, at a central university office, at a residency clinic or at a foundation/corporation. While some professionals are actually given a faculty development title, many others hold titles in other areas of medical education that receive the majority of their attention. Many faculty developers bring their education training to their work roles while others bring training as researchers, psychologists, or allied health professionals. The entire survey population reflects this variety; however, it appears that some factors encourage retention in the field. That is perhaps why the twelve subjects who participated in the interviews are more homogeneous than the survey population.

Interview Participant Descriptions

This section provides a brief narrative description of each of the twelve interview participants. Participants are referred to using pseudonyms, which protects their identity but still allow the reader to keep track of who is being quoted. Other identifying features have also been modified. Additionally, in order to protect the identity of the interview

subjects, the data will also be reported thematically throughout this study rather than as twelve individual case studies.

Barb

Barb has been in medical education for approximately 20 years and in faculty development for about 14 of those years. She holds a bachelor's and a master's degree in sociology and completed additional graduate coursework in public health. She is currently an Associate Director of a faculty development fellowship program. The university classifies her position as a Research Associate; she does not have faculty rank. Although she does do some writing, overall she is much more of a practitioner and administrator than a researcher in her current position.

She defines her faculty development role as "the glue that keeps the program together" by being a generalist and utility person for the department's fellowship programs. She credits her success to her previous training in medical sociology, a supervisor who initially mentored her in medical education, other directors who were willing to give her a chance, and on-going learning on the job. She also believes that she has always been able to look around her department and find a need that she is able to fill, thus ensuring new areas of responsibility for herself.

Fred

Fred has been in medical education and faculty development for most of his professional career. After completing his bachelor's in science education and his master's in counseling, Fred taught in the military and higher education settings. He then

began developing and directing courses in an allied health area and added faculty development work onto that. He went back to school and completed a doctorate in curriculum and instruction and then shifted from the allied health programs to medical education programs. He has continued to work in medical faculty development and medical student education at various institutions.

Today, Fred is an Associate Professor and is the Director of Faculty Development and Education with the Department of Family Medicine at a large university. When discussing his career, Fred highlights the mentoring he received from other educators working in medicine, the first-hand experience he has had as a faculty member, and also the satisfaction that he receives from contributing to the development of students and faculty.

Judith

Judith possesses a bachelors and masters in a liberal arts area and a doctorate in educational research and evaluation. She grew up with a physician-father and worked previously as a social sciences teacher, but her medical education career began toward the end of her graduate training. During the last year of her doctoral program, she took a grant-funded position with an office of medical education. After graduating with her PhD she sought out a professional position in medical education at another institution and has remained in medical education ever since. Her career thus far has primarily occurred at three different institutions and during that time she has established a department of family medicine, developed a standardized patient program, coordinated faculty

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development efforts for primary care physicians, worked in predoctoral education, written numerous grant funding applications and conducted educational research.

Today Judith holds a Professor rank and is a vice chair for educational and faculty affairs within a Department of Family Medicine. Overall she has been very satisfied with her career in medical faculty development, especially because it has consisted of so many opportunities for her to apply her creative talents.

Kathryn

Kathryn's entire professional career has been focused on medical education. After completing a master's degree in educational psychology, she entered medical education as a research assistant and evaluator while continuing her education in a Ph.D. program. She worked in this capacity for a number of years and gained knowledge in grant writing, program evaluation and research design. After graduating with her doctorate, she made a conscious choice to find a permanent position in medical education with faculty development responsibilities. She then worked in various facets of medical education over the years at three different institutions, and has been in her current position directing an educational development office at a medical college since 1991. She also completed an MBA and her rank is Professor.

Kathryn defines her role as being an advocate for education and educational concepts. Her business background lends itself to a focus on quality, and her evaluation background supports her interest in continually evaluating and assessing her programs, learners and faculty. She enjoys working at a smaller school because she is able to have more impact on the faculty and ultimately the students.

Kim

Kim has worked in medical faculty development for over 20 years. After completing bachelor's and master's degrees, she began working in student affairs within higher education. She soon realized she liked working with faculty members but would need a PhD to be successful. She began a PhD program in Educational Psychology and was introduced to medical education and faculty development shortly thereafter when a graduate assistant position arose that involved consulting with medical faculty about their teaching. After completing her doctoral work she became a Director of Faculty Development at a medical college and established a successful career in medical faculty development at this institution and nationally.

Kim currently has Professor rank and works in faculty development, educational evaluation and academic affairs at the medical college. She believes those who started before her have mentored her well in her career and she works hard to build relationships on her campus, within regional organizations and with national colleagues.

Larry

Larry joined the ranks of medical faculty developers after a career in secondary education teaching and administration. He was also a Peace Corps volunteer. After completing a doctorate in educational psychology, he moved into post-secondary education as a director of counseling. Then in his early 40's he was recruited into a medical faculty development position at an institution that focuses on helping community-based, family medicine physicians gain the teaching skills needed for an academic career. Currently he is now in his early 60's and is the Director of Faculty

Development at this same institution. The institution operates independently but Larry does hold adjunct faculty appointments from affiliated medical schools.

Larry defines his faculty development role as a coach and mentor, and uses an individualized approach that draws on his counseling skills. He spends considerable time completing administrative tasks necessary for running the program and writes grants to fund their work. He is active at the national level in organizations, committees and grant-funding agencies. Although he is a well-known presenter, he only publishes about once every year or two partially because it is not required for his current position.

Michael

Michael's career in medical faculty development spans about twenty years and has occurred primarily within one institution. He was trained in the sciences and then received masters' degrees in counseling and educational psychology and a doctorate in educational management. His professional work followed his degrees with his initial work in international education as a science instructor followed by work as a therapist. After one year working in a hospital and directing a faculty development program, he helped co-found a faculty development center and residency program health center for primary care. He has remained at this institution ever since and continues to work on both the faculty development areas and the residency education areas. He has a non-tenured clinical faculty appointment with an area medical school.

His style is entrepreneurial in nature and he easily integrates organizational psychology concepts into all his work. He believes that his background in the sciences has helped him when working with the residents and physicians.

Paul

Paul's entire career has been focused on teaching and learning after receiving his bachelor's in science and his master's and doctorate in education. He initially worked at a university in teacher education but was unable to secure a full-time, tenure track position because of the competitive climate and the abundance of PhD-trained educators at the post-secondary level. A graduate school friend contacted Paul because he was leaving his evaluation and faculty development position at a college in another state and encouraged Paul to apply. Over the next two decades, Paul has worked in various aspects of medical education and faculty development at five different institutions. Currently he is in his mid-50's and is a Director of Faculty Development and Adjunct Associate Professor for the Department of Family Medicine at a medical college. His college does not give faculty rank to PhD educators.

Paul defines his faculty development role as an individualized facilitator of learning. He identifies himself as a practitioner although he would like to try to do more evaluation and publication in the future.

Ray

Ray has worked in medical education for almost 30 years. After completing bachelor's and master's degrees in mathematics, he served abroad in the Peace Corps as an instructor and then taught in a mid-west high school. He entered a doctoral program in educational psychology and was introduced to medical faculty development through a grant-funded position he held while completing his dissertation. He shares that the late 70's were a time of tremendous growth for medical faculty development and that there

were a number of new positions that began then. He believes he was fortunate to have a number of mentors and colleagues to learn from during that time. His initial entry was in research, which segued into educational consulting and faculty development over the years.

Today Ray holds a Professor rank at a large research university where he is also the Director of Faculty Development in the Department of Family Medicine. He views his role as an education generalist and a mentor to the physician faculty. He hopes his involvement encourages the faculty to become more analytical about their teaching and to try new things.

Robert

Robert has a bachelor's, master's and doctorate in political science. He used these degrees to first enter into public health work after his graduate studies and then eventually assumed medical faculty development responsibilities. He also worked in the Peace Corps after graduating with his bachelors. Robert's medical education career started as a research associate with a medical school in the Department of Family Medicine about 30 years ago. He gradually assumed more responsibilities over the years as family medicine evolved and worked with curriculum development, faculty development and medical student education at two different institutions.

Today, Robert is a Professor in a Department of Family Medicine and Director of Faculty Development. He embraces the role of building relationships between his department and its constituency organizations locally and around the state. He is nearing

retirement but continues to take an active role in national organizations and mentoring other educators.

Sam

Sam's career in medical faculty development also grew out of his graduate school experiences approximately 25 years ago. After completing his bachelor's degree, he taught overseas in the Peace Corps. He then returned to complete a masters and doctorate in education. He took a graduate assistant position in an office of medical education that provided his entry into medical faculty development and medical education. After completing his doctorate, Sam stayed on at his institution as an evaluation specialist for the School of Medicine and eventually accepted a faculty development position with another medical college and has remained ever since. Currently, Sam is a Director of Faculty Development and Assistant Director of Education at a medical college within a larger university. He is a non-tenured Assistant Professor.

Sam's focus is to support and service the medical faculty so that they can succeed in academia. He provides significant one-on-one attention and takes advantage of teaching opportunities to share education's body of skills, strategies and information that the physicians can use in their teaching.

Tom

Tom entered medical education a little later than some. After completing a master's degree in library science, Tom worked for almost a decade as a college librarian. During that time his interest in research grew and he took additional research courses and then

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applied to a higher education program. He eventually left his job and became a full-time graduate student in educational psychology and higher education. He took a research assistant position to help fund his graduate studies as an evaluator for a faculty development project. He developed a mentoring relationship with a faculty member already in medical education who asked him to come and work in the Department of Family Medicine as a graduate assistant after his initial research assistant position had ended. Tom's mentor introduced him to medical education work, the professional organizations, and other medical faculty developers and he began to see himself making a career in medical education and faculty development.

After completing his PhD in higher education, Tom was recruited in to a medical education position by another colleague whom he had met as a graduate student. Tom did not recall any difficulties making the transition from his previous career into medical faculty development. Over the years he worked with the physician faculty on grant writing, research and curriculum design. He assisted with predoctoral programs and also managed the computer resources for the Department of Family Medicine. After almost a decade at this institution, he went to another institution as the Director of Faculty Development where he's remained for about eight years. He has the rank of Associate Professor.

Tom is now in his mid-50s and is employed as the sole faculty developer at the medical college. He defines his faculty development role as being a resource person for the faculty but also as the "conscience of faculty development"—trying to advocate for more faculty development throughout the organization.

Chapter Summary

I began this chapter by presenting some of the demographics and general characteristics of the twelve interview participants. Then, using pseudonyms, I provided a narrative description of each interview participant. The upcoming chapters provide the results of this study using data primarily from the interviews but will also intersperse some survey data. Chapter 5 discusses the faculty developers' entry and socialization to medical education. Chapter 6 examines faculty developers' roles and work and Chapter 7 explores factors impacting their vitality.

Chapter 5

SOCIALIZATION OF MEDICAL FACULTY DEVELOPERS

A review of these twelve medical faculty developers' career paths sheds light on many areas of socialization that impacted their entry into the field and ultimately their longevity within medical faculty development. I begin this chapter by sharing some general themes relating to these faculty developers' entry and early socialization into medical faculty development. I then focus on specific socialization factors that appeared frequently during the interviews.

Entry into Medical Faculty Development

This study confirmed my initial thought that medical faculty developers established their careers in many different ways. As a participant named Tom noted, the fact that the people he met at medical faculty development meetings were all coming to this career from a lot of unusual ways, as he did, appealed to him. Tom entered medical faculty development later in life after a decade-long career as a librarian but was introduced to medical education through a research assistant position that he took while pursuing a doctorate degree in higher education. His story, and those of many others I interviewed, showed that about half of the faculty developers came into this field after first working in a different area. Most of their stories revealed that medical faculty development careers develop slowly and that there are few opportunities for anticipatory socialization prior to entering medical faculty development. The stories also showed how graduate school opportunities were particularly influential in establishing a medical faculty development career for these participants.

Career Paths Marked by Serendipity

For most of the twelve participants, the road to their current faculty development position in medical education was indirect and highlighted by happenstance and serendipity. When asked how they made their way into medical faculty development, I heard the following replies: "circuitously and indirectly," "divine intervention," "I truly stumbled into it," "I never made a conscious decision to become a medical education specialist or faculty developer ... it kind of just happened that way ... I got to like it more ... and kind of went on and on," "I lucked into my next job," and "entirely circumstantial." Most of these professionals entered faculty development in medical education quite by accident or by way of serendipity, that is to say "fortunate discoveries accidentally" (Merriam Webster's Dictionary). For example, Tom shared his thoughts on how serendipity affected his faculty development career and provided opportunities for his talents to shine:

> There was a lot of serendipity but within that serendipity – you would do things and if you are good at them you keep doing them...So the things that you are good at, you have an opportunity to get better at and then maybe move to the next level.

Interviews showed that many faculty developers first followed their undergraduate or masters-level training with a few years of employment in elementary and secondary education, counseling or higher education administration. A few worked in the Peace Corps or other international education programs and one spoke of a successful career in the military. None of them had aspirations to work in medical faculty development early on, although two spoke about parents being a physician or nurse and so they possessed a comfort-level with the medical field. Somewhere along the way, however, an

opportunity to work in medical education and medical faculty development presented itself. For about half of the participants, these opportunities came while doing their doctoral coursework or shortly thereafter. For a smaller group, the medical education opportunities came even later in their careers and their involvement in medical faculty development happened gradually.

In this first section, I share some of the early influences on the participants' medical education career. I then look specifically at how graduate school provided opportunities in medical faculty development.

Early Influences

I did not specifically inquire about the early influences in participants' lives that may have affected their career choice, but three participants discussed the impact of their parent's career on their own choices. A participant named Ray reported that his mother's work as a teacher, as well as opportunities in his grade school years for him to tutor younger children, impacted his interest in teaching as a part of his career. Ray has worked in medical education for almost 30 years after a short career teaching in the Peace Corps and at the high school level in the U.S., so it seems his interest in teaching has been a part of his life since a young age.

Two other participants related that their parents' careers in medicine provided them with a comfort level in talking with physicians and an understanding of the medical culture that has been helpful in their own careers. A participant named Judith, who has worked in medical education for over twenty years, discussed growing up with a physician parent:

> I've been in medical education since I was born. My dad's a physician, he was a GP (general practitioner), and so I always was reading and hearing about medicine...so when [the associate dean] asked me in the interview "Would you have difficulty talking to physicians?" I said, "I've been doing it since I arrived on this planet!"

Another participant who has worked in medical education for over twenty years, Kim, also revealed how her parents' careers influenced her understanding of the medical culture:

> I think one of the reasons I'm more comfortable with clinicians is [that] my father was a physician. So at dinner he would come and talk about ... the patient that died. And my mother was a nurse, so ... it just seemed like normal conversation to me. [These experiences growing up] also [helped in my current] understanding [of] the stresses of physicians and their families.

So while having a physician or teacher parent did not appear to specifically influence their career path initially, comments made by Ray, Judith and Kim indicated that a parent's career can provide an understanding of teaching and medicine and a comfort level with teaching and working with physicians that helped these faculty developers in their work.

Graduate Student Opportunities

When participants were asked about how they became faculty developers, over half of them talked about introductions to medical education that occurred while pursuing a doctorate at graduate school. In particular, seven of the twelve faculty developers first entered medical education through a graduate assistantship or other graduate student work position. While most of them had previous experience in elementary or secondary school teaching, international education or higher education, most of these participants

just happened upon a graduate position in a college of medicine. After their graduate work experience, many actively sought a career in medical education and faculty development after graduating. For these faculty developers, their graduate school course work and employment provided some anticipatory socialization in the profession. For a smaller group, graduate school provided an introduction to medical education, but their entry into faculty development came later. Clearly these graduate school experiences provided opportunities to work in medical faculty development that led to career opportunities in this emerging profession. This graduate work also connected them with some of the early pioneers in the field who proved to be mentors and also provided opportunities to develop collegial relationships with classmates and colleagues that helped them later in their careers.

Introduction to Medical Faculty Development

The opportunity to work in medical education as a graduate student was the first experience many of the interview participants had to explore this emerging career field. Many of these participants were in graduate school during the 1970's when the field of family medicine was maturing, interest in faculty development was growing and funding by the Bureau of Health Professions through Title VII of the Public Health Service Act was encouraging medical schools to establish faculty development programs for their faculty and clinicians. Graduate student positions proved to be a low-cost way for departments to hire part-time educators to work in these newly established programs.

Kathryn's entry into medical education and faculty development highlights how graduate student work experience can translate into a career. Kathryn was a graduate

student in Educational Psychology and saw an announcement for an evaluator in a cancer education program. She described having "good leadership [from her department] in that they had a lot of experience with grants." She continued that "program evaluation was sort of like research design and so it fit real nicely with the training I'd had from the school of education." However, after three years, the grant that was funding her position was ending and she knew she needed to find a new position. She also knew from her previous work experiences that she didn't want to work in elementary education, so she made a conscious decision to seek a position in medical education with faculty development responsibilities. Kathryn then worked in various facets of medical education over the years at three different institutions, and has been in her current position directing an educational development office since 1991.

A similar progression of events occurred for three participants I have named Sam, Kim and Tom. Sam's journey to his current position as director of faculty development shows a similar story in which his graduate school experiences led to a lasting career. Sam reported that he initially returned from three years of training elementary school teachers through the Peace Corps and decided that although he wanted to continue in education, he would like to teach adults rather than children. Sam sought out a masters program in curriculum and instruction and then a doctoral program in higher education. He worked in various international education and professional education positions for about seven years while going to graduate school. By this time he was married with young children and needed to earn more money to support his family. Through a graduate school friend, Sam learned that the Office of Medical Education had graduate positions available. He was hired and ended up under the supervision of an assistant director who was doing

faculty development at the university. As Sam explained, the assistant director "was very influential and so that kind of happened." It took Sam a long time to write a strong dissertation proposal and during that time he left the Office of Medical Education to work on an international grant project. After five years, Sam moved back to the Office of Medical Education and decided to focus on medical education work and faculty development from that point on. In fact, he ended up writing his dissertation on a medical education topic. After completing his doctorate degree, he continued at the same institution in various capacities working on medical curricula, faculty development, and evaluation. About a decade later, he moved to a new institution where he was a Director of Evaluation for their rural-based primary care training programs. Sam moved into the Director of Faculty Development position in 1990 and has continued to experience a successful and busy career in medical faculty development.

Kim was also introduced to medical education as a graduate student when she worked as an evaluator for a college-wide, grant-funded faculty development project. She liked the work and also met a valuable mentor who helped her get a positive start in her medical faculty development career, which I will discuss more in the next section on developing mentors. Tom's transition into medical faculty development was similar. He took a research assistant position to help fund his graduate studies as an evaluator for a faculty development project. Tom developed a mentoring relationship with a faculty member already doing medical education who asked him to come and work in the Department of Family Medicine as a graduate assistant after his initial research assistant position had ended. Tom's mentor introduced him to medical education work, the

professional organizations and other medical faculty developers, and he began to see himself pursuing a career in medical education and faculty development.

The stories of Kathryn's, Sam's, Kim's and Tom's entry demonstrate how their graduate student work experiences served as an entry into a long-term career in medical faculty development. Although they entered it not knowing much about medical education initially, they found that it matched their interest in working with adult learners, utilized their teaching skills, and ultimately provided each with a network of colleagues to sustain more than a decade-long career in medical faculty development.

Developing Mentors and Networks

Graduate school not only exposed these participants to a growing career field as discussed in the previous section, but it also introduced them to colleagues and mentors who helped to advance their careers. In fact, many interview participants told stories that relayed the impact from (a) the informal "a graduate school friend called to tell me of a position opening" to (b) the more formal mentorships that occurred under the tutelage of some of the founders of medical faculty development like Carole Bland, Frank Stritter, Dick Holloway and others. These graduate school opportunities for mentoring and establishing collegial networks are discussed here.

At the informal level, many participants described how graduate school connections introduced them to their medical education career. For a participant I've named Paul, this bit of serendipity occurred after graduate school. Paul's initial post-doctorate career plans were to work in a college of education teaching students to be science educators. But as he recounted, when he started applying for jobs back in the late 70's, there was an

abundance of educators looking for work. When he applied for a job in a college of education, he faced fierce competition. He eventually found a position as an adjunct instructor. Then a graduate school friend called to say he was leaving his faculty development and evaluation position and asked if Paul wanted to apply for it. Paul followed-up on this lead from his friend and was hired as a faculty developer. This informal contact with someone who was already in medical education has led to a 24-year career in medical faculty development for Paul.

Another participant, whom I've named Larry, shared a similar story that also illustrated the importance of graduate school colleagues and friends. Larry first worked as a counselor and program director at a community college after completing his doctorate degree. Although Larry did not enter medical faculty development directly out of graduate school, he explained that his entry was "entirely circumstantial." He recounted how a friend from graduate school called him and recruited him to work in medical faculty development about four years after they had graduated from their doctoral program. Larry has since stayed in medical faculty development and recently passed his twentieth year in the profession.

Kim's journey to medical faculty development highlights a formal mentorship that grew out of her graduate student employment. She initially worked on both the student affairs side of higher education and on the faculty side. Kim realized that she preferred instructional design work with the faculty more than student personnel work. She also recognized that she needed a doctorate to excel in a post-secondary education setting so she returned to graduate school for a doctorate degree. While in graduate school, she took a graduate student position recommended by her advisor doing faculty development

in a college of pharmacy. Through this position, Kim established herself as an instructional consultant and built a network of colleagues that in turn led to another graduate student position in the college of medicine where she worked until after graduation. It was through these colleagues that she learned of job posting for a full-time director of faculty development at another medical college. Kim revealed that the network of colleagues and mentors that she established during her graduate work was extremely helpful in acquiring her first full-time position after graduation.

> [My mentor] said "Well, I know somebody who used to work there" ... so she actually called the person ...[who] then talked to me and really told me all the political stuff and ... what kind of candidate they were looking for. [Then my mentor] actually sat me down once I got an offer and said, "Here's what you want to negotiate for... [and] here's the other things that you're going to need." [This kind of help] again, was not real common.

Other participants expressed similar stories about how their graduate school experiences exposed them to the medical education field or introduced them to other professionals who became supervisors, colleagues and mentors. In conclusion, graduate school opportunities served two important functions. They served to 1) introduce these participants to the emerging field of medical faculty development as a career choice, and 2) connect these participants with colleagues whose contacts led to a career in medical education and mentors whose guidance supported their careers in medical faculty development.

Conclusion

In this section I discussed opportunities for anticipatory socialization and initial entry into medical faculty development. Graduate school opportunities had a large impact on

many of these participants' entries into medical faculty development careers and in some ways served as a vehicle for anticipatory socialization. Almost all of these senior faculty developers were either introduced to medical education while in graduate school or developed a collegial relationship while in graduate school that eventually led to a position in medical education. Many of these educators took medical faculty development or other medical education positions right out of graduate school, although a few others cultivated their medical faculty development career slowly. In the next section, I explore factors of their initial socialization that seemed to have impacted their vitality in medical faculty development.

Socialization of Medical Faculty Developers

Socialization is the process of learning the values, knowledge and skills of a career field or professional group. In order to understand the socialization process of medical faculty developers, I asked the interview participants to describe their entry into faculty development (discussed in the previous section) and to share who or what shaped their understanding of their role. The interview summaries only highlighted the socialization factors that the participants mentioned. The interview follow-up e-mail questions inquired about these critical influences more directly by asking participants to check which factors from a list of interpersonal and non-interpersonal influences helped them learn their faculty development role. Results from both data sources are discussed in this section.

Ostroff and Kozlowski (1992) delineated three non-interpersonal sources and three interpersonal sources of information for learning about the content of one's work.

Some of the non-interpersonal sources of information were the official organizational literature, experimentation with new behaviors (i.e. trial and error) and observation. Some of the interpersonal sources of learning were supervisors, coworkers and mentors. I listed these sources in the interview follow-up e-mail question about factors that may have helped developers learn their role. I included additional sources of learning discussed in the literature, such as one's formal education and training and one's previous work experience. I also added two strategies for learning on the job that were taken from the socialization literature: using the published literature and attending continuing education opportunities (conferences, classes, etc.) while already working in medical faculty development. The results from the follow-up e-mail questions are reported in Table 5.1. They are coded using NP= non-interpersonal factors, IP= interpersonal factors, and O= other factors of learning. They are listed within each category in order of most frequently mentioned and are discussed on the following pages.

TABLE 5.1

Socialization Factors and Strategies (n = 12)

Code	Factors	Number of Participants	Percentage
NP	Trial and error	11	92%
NP	Observation	9	75%
NP	Formal orientation to faculty development role	1	8%
NP	Department/institution handbook or job description	1	8%
IP	Co-workers	9	75%
IP	Mentor	8	67%
IP	Supervisor	6	50%
O	Previous work experience in education or medicine	11	92%
O	Published literature	10	83%
O	Continuing education	9	75%
O	Formal education or training	9	75%
O	Previous work experience not in education or medicine	7	58%

Note. Data source was Interview Follow-up E-mail Questions

NP = Non-interpersonal Factors
IP = Interpersonal Factors
O = Other Factors

Non-Interpersonal Strategies of Socialization

The non-interpersonal sources of information identified in the literature that helped employees learn about their roles received mixed reviews regarding importance from participants. The official organizational literature (e.g. job descriptions and handbooks) did not help these faculty developers learn their roles. In this study, only one of the faculty developers indicated that there was a formal orientation to his job and that a written job description helped him learn his faculty development role. Interview conversations revealed that most did not receive a formal orientation to their new roles and for those who did, it had little impact on their role development. Many described a situation where they were expected to "hit the ground running." These faculty developers learned their role primarily through experimenting with new behaviors while on the job. Their interview follow-up e-mail questions revealed that trial and error was overwhelmingly the method most frequently used for learning their faculty development role (92%). Additionally, 75% of the participants indicated observation as a source of learning their faculty development role.

The interviews also provided a number of comments that support the importance of experiential learning. For example, Robert described this process of learning through experience:

> I made a lot of mistakes, learned a lot, grew, came to [the next institution], made a few more mistakes, learned a lot and grew and had lots of opportunities open up for me... so I really learned a lot about medical education by having to do it. Most of my learning [was] on the job training.

Robert later summarized his experiences by saying that his training gave him some general knowledge and prepared him to have an interest in healthcare, but in terms of the

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Larry disclosed how learning about medical education after a career in counseling brought some challenges. He recounted how medicine was a "new culture" to learn and that he also had a new group of learners, the physicians, who were "very direct in their feedback" especially if they didn't think what he was covering was useful to them. He used the physicians' feedback to learn how he could better relate educational principles to his learners. He also stressed that developing collegial relationships with physicians helped him understand the pressures and needs of his physician learners.

For these participants, there were no formal orientations or official job descriptions to socialize them to their new roles as medical educators. Instead, those new to medical faculty development were often expected to "hit the ground running" by relying on their previous experiences and to learn on-the-job by observing colleagues, physicians or other models of success and also by trial and error.

Interpersonal Strategies of Socialization

Auster (1996) pointed out that although individuals may learn about their professional roles through formal orientation and training programs, other aspects of their professional roles could be more elusive. Many of these aspects can be learned best through on-going informal processes such as mentoring relationships or professional memberships. Ostroff and Kozlowski (1992) also highlighted the importance of supervisors, coworkers and mentors in helping novices learn a professional role. In interviews, these senior medical

faculty developers concurred that having these relationships was critical for learning their work and for remaining in this profession.

In the section on entry into medical faculty development, I previously told of Kim's experience with her supervisor acting as a mentor and an advocate for her career in medical faculty development. Her supervisor not only showed her the ropes of medical education but also recommended her for a faculty development position after graduate school and advised Kim on what to negotiate for in her first medical faculty development job. Three other participants that I mentioned in the previous section on graduate school entry, Tom, Kathryn and Sam, were also mentored by some of the successful educators who had been in medical faculty development almost from the beginning. These participants met their mentors while working as graduate student employees at their university and found that the mentors not only taught them practical skills, but also offered advice on career moves and scholarly endeavors.

Other participants also spoke of a mentoring relationship. For example, Barb, who first joined a department of family medicine in a research position, commented that a female faculty member was influential in her career. This faculty member had worked with Barb in another department and, after the faculty member moved into family medicine, she recommended Barb for a position there. Barb described this long-time, female faculty member as "one of the trail blazers [who] felt like she had an obligation to younger women to lay out the ropes ... she was very active for a while in mentoring me." She went on to describe how she's had the good fortune to have worked with several other supervisors over the years who were willing to give her a chance to take on different responsibilities:

> The whole time that I've been in the department, I've been on the lookout for opportunities that seemed like they would be a good fit ... I would make a proposal to whoever the relevant person was ... and say "Here's what I'm doing now; I see this area that people aren't paying enough attention to. I think I've got something to offer in that area."

She explained that these supervisors were different from mentors but were people willing to say, "Okay, you think you can do this; we'll give you a chance."

Fred shared stories that also highlighted the value of a mentor or colleague. After he had been at a particular institution working with students who needed academic assistance, he became involved in a faculty development fellowship in family medicine. Fred recalled how the director of this fellowship was open to Fred's ideas and actively involved him in the fellowship. They developed a collegial relationship and the director then introduced Fred to STFM and many of his national colleagues. Fred was invited to give presentations with his new colleague/mentor and described how people began to associate him with his mentor who happened to be "a strong presenter." Fred's mentor also introduced him to PowerPoint software, which was new at the time, and suggested other strategies to improve Fred's impact at national presentations.

Another participant, Larry, also recognized the importance of supervisors, physician colleagues and national networks. He initially entered medical faculty development because a graduate school friend was working in the field and hired Larry to work at a faculty development center he was directing. As his supervisor, Larry's friend showed him the ropes of medical education and faculty development, encouraged him to join national organizations such at STFM, and involved Larry with his publications and presentations. Through this relationship, Larry learned the knowledge and skills of medical faculty development and received encouragement for scholarly and professional

involvement and developed a national network of colleagues so that Larry easily stepped into the director position when his friend left the institution about eight years later.

The senior medical faculty developers in this study almost all referred to significant personal relationships that positively impacted their careers. For some it was a mentor that they had met while in graduate school. For others it was a supervisor who hired them and showed them the ropes of medical faculty development. And for others, there was support that came from colleagues and networks with other educators.

Other Socialization Factors and Strategies

Previous Work Experience

The results of the interview follow-up e-mail responses (n=12) demonstrated that the faculty developers highly ranked their previous work experiences in education or medicine (92%) as a way that they were socialized to their faculty development roles. Although the interviews did not probe this socialization issue in depth, three participants, Michael, Ray and Sam, referred generally to their experiences in teaching abroad in the Peace Corps or other international programs. Four other participants, Kathryn, Judith, Ray, and Larry, mentioned their experiences administrating, consulting or teaching in elementary or secondary education in the U.S. Larry also added that he felt he was able to bring his experiences as a counselor forward to his faculty development role.

Fred is currently a Director of Faculty Development and also oversees much of the medical student education program at his institution. He first learned about medical education while teaching in several allied health programs while in the military. A few years later, he was given the chance to teach a faculty development course that served as

his first introduction to the field. His next position was in a central office of a medical school where he gained experience evaluating courses and teaching at the medical school. This position also provided opportunities to counsel medical students regarding academic matters. He has continued to have contact with medical students in his subsequent positions and believes that this contact with the learners has been crucial in helping him have success in faculty development with the physician faculty. His initial experiences teaching in allied health programs and working with medical students provided learning experiences that he drew from in his later work in medical faculty development.

Education and Training

Typically one's education provides an opportunity for anticipatory socialization in that the learners begin embracing the values of a particular profession and begin learning more about the specific work. Since there is no set training and career path for medical faculty developers, the participants in this study came from a variety of education backgrounds (Table 5.2) and had no opportunities for what is traditionally considered anticipatory learning. Many faculty developers completed degrees in education-related areas, but degrees in the liberal arts, counseling and business degrees were also represented (Table 5.2). Although there was variation in educational backgrounds, 75% of the interview participants indicated that their formal education and training influenced how they performed their medical faculty development work. I will now share some of the comments from the participants' interviews that indicate a positive connection between their formal education and their medical faculty development work.

TABLE 5.2

Major Discipline of Medical Faculty Developers' Degrees

Bachelor's Degree Major [a]	**Number** [a, b]
Foreign Languages / French	2
Mathematics	1
Political Science/History	5
Psychology	2
Sciences / Science Education	3
Sociology	1
Master's Degree Major [a]	
Counseling/Human Services	2
Curriculum and Instruction	1
English Literature	1
Business Administration	1
Educational Psychology	3
Higher Education	3
Library Sciences	1
Political Science/History	2
Sociology	1
Doctorate's Degree Major [b]	
Curriculum and Instruction	2
Educational Management	1
Educational Psychology	4
Higher Education	2
Political Science	1
Research and Evaluation	1

Note. Data source: Participants' CVs from spring 2002

[a] numbers exceed 12 in Bachelor's and Master's category because some participants held more than one degree

[b] numbers add up to 11 in Doctorate category because one participant did not complete a doctorate degree

Some participants conveyed that their formal training was valuable for learning the specific knowledge and skills needed for their work in medical faculty development. For example, Paul emphasized that his curriculum and instruction background made all the difference when he was asked to implement a new curriculum or measure the impact of educational interventions. Paul also had a background in science education that proved helpful. He stated that his science background was helpful for connecting with physicians. Fred's bachelor's degree in science education and biology helped him with his initial teaching positions in allied health before he eventually went on for degrees in counseling and in curriculum and instruction. In addition to a background in the sciences, another participant, Barb, believed her two degrees in medical sociology were useful in understanding what medical education was all about as well as the structure of the medical culture.

Michael also believed that his undergraduate work in biology and chemistry and his previous experiences teaching the sciences served him well and have been a way to connect with the physicians. He explained that he was able to talk the language of the basic sciences. His knowledge helped him learn clinical medicine to the extent that he could use some of their medical cases and examples in his faculty development work. Michael also spoke about his training in counseling and subsequent work in hospitals that brought him into medicine. He emphasized that his training in psychology and organizational behavior has been useful in medical faculty development. He is often involved in institutional or departmental change and development issues that draw upon his solid base in individual and organizational behavior. Another participant, Kathryn, received formal training in business and organizational development. She recounted that

this knowledge was helpful when facing the bigger issues of programmatic change and organizational development she has been involved in as a director of educational development who oversees predoctoral and residency learning and evaluation.

Independent Learning Opportunities

Over half of the participants indicated on their interview follow-up e-mail responses that independent learning opportunities helped them learn their medical faculty development roles. Eighty-three percent responded that they sought answers and ideas from the published literature and 75% indicated that the continuing education (conferences/classes) they received while in their faculty development positions was also influential in helping them learn to be effective. Judith said that she taught herself how to write journal articles that got published and to write grants that got funded. She explained that she learned by seeking out models of success, such as examining published journal articles to model her work after or reading the grants of other faculty developers that had received funding. She taught herself about these areas by looking for successful models. In addition, she often shared the models she found with her faculty learners so that they could learn from them as well.

The participant interviews yielded few specific comments that the literature and continuing education was helpful, but there were many general comments acknowledging that they read to learn and took courses to update their skills. In addition, during the interviews, most of the participants mentioned the positive influence of professional organizations. For example, Robert provided a clear description of the positive influence received from his involvement in professional organizations. The Society of Teachers of

Family Medicine (STFM) has been "a tremendous national support group for PhDs [in medical education] and it quickly became my national support group and gave me colleagues ... who had the same kinds of problems and issues I had. We talked about them [and] we learned from each other ... it's just a tremendous resource." He mentioned that the Generalists in Medical Education group and the Association of American Medical Colleges (AAMC) also provided some support and contacts but not to the extent of STFM. He also discussed how he got involved in the leadership of these organizations and commented positively that this involvement helped him improve and be "a more effective faculty member in faculty development" since he was more in touch with the broader issues affecting medical education and funding issues at the federal level.

Fred also spoke about the opportunities and improvements that came from his contact with national organizations. He pointed out that networking at the AAMC meeting led to some opportunities to interview for faculty development positions. He selected one of the medical schools and ended up learning a tremendous amount from another educator who had been doing medical faculty development for a while. This experienced medical educator introduced Fred to STFM. His involvement in STFM led to a network of national colleagues from whom to learn and receive support. Larry also discussed this network of support and learning. Larry explained that once he was comfortable in his faculty development position, he spent a lot of time developing relationships with people all over his state and all over the country in order to improve his program.

The senior medical faculty developers in this study indicated some sources of independent learning that proved valuable for them. In their interview follow-up e-mail

responses, they positively acknowledged the impact of learning from the published literature and continuing education opportunities though they offered few specific comments about their impact in the interviews. Instead, the interviews focused more on the opportunities for learning and support that came from involvement in national organizations. A participant named Paul summed up the impact of national organizations by saying,

"You can get whatever you want there, and I've just had incredible luck of being around some of the right people at the right times... when you are connected and feel comfortable asking questions [then] collaborative relationships [develop]."

Chapter Summary

Medical faculty development careers paths were marked by serendipity. Most faculty developers were introduced to medical faculty development through a graduate school contact either during graduate school or later in their career. There were minimal opportunities for traditional anticipatory socialization, however, it can be said that for some faculty developers, graduate school opportunities served to introduce them to medical faculty development as a potential career

The second half of this chapter outlined many of the factors of the participants' socialization to medical faculty development that had a positive influence on their learning. Most notably were: a) the impact of experiential learning; b) their relationships with supervisors, colleagues and mentors; c) their previous work experiences; and d) the support received from national organizations. Some of these factors concurred with what has been written by Ostroff and Kozlowski (1992), Secord and Backman (1974), Whitt (1991), Lortie (1975) and others in the socialization literature about newcomers in other professional groups such as engineering, business and higher education.

Chapter 6

A DESCRIPTION OF MEDICAL FACULTY DEVELOPERS' ROLES

Introduction

This chapter describes how the senior medical faculty developers interviewed for this study defined their roles. A discussion of roles is included because it is important to understand how these senior faculty developers described and enacted their work roles. How they defined their faculty development roles may have been a factor in the success they found in their careers in medicine and, in turn, in their vitality.

How Medical Faculty Developers Defined Their Roles

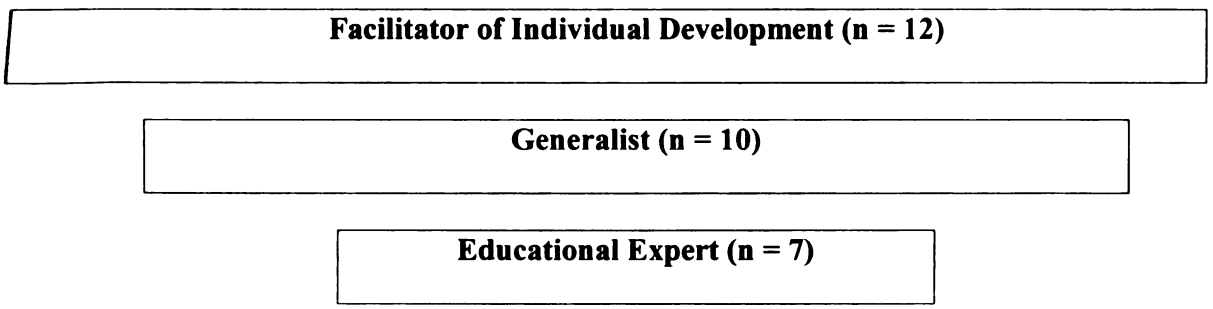
During phone interviews with the senior medical faculty developers, I specifically asked how they defined their roles. I analyzed the faculty developers' statements about how they defined their faculty development roles and three somewhat distinct role descriptions emerged: 1) Facilitator of Individual Development; 2) Generalist; and 3) Educational Expert. I developed the titles of the roles by listing what the interview participants stated and looking for similarities in the meanings of their words. The three categories emerged and the title for each category was selected by using the role stated most often or by the title that seemed broad enough to sum up all the related roles in that category that were described by the subjects.

Most participants mentioned more than one role; so senior medical faculty developers clearly have many areas of responsibility within their organizations and take different approaches to meet their goals. Ray summed up the responsibility of having multiple

roles when he said: "Right now I've probably got like 77 things that I'm supposed to be doing ... life isn't as simple as just being a faculty developer ... nothing breaks down as clean as you think it would." As a result of interviewees having multiple roles and approaches to their work, the roles discussed here are not discrete categories; rather, they must be seen as somewhat fluid. All of the faculty developers mentioned characteristics of the Facilitator of Individual Development role so it will be covered first. A slightly smaller group mentioned their Generalist role and about half spoke of assuming an Educational Expert role. A representation of the roles is shown in Figure 6.1 and a discussion of each role follows.

Figure 6.1

Roles of Senior Medical Faculty Developers (n = 12)



Facilitator of Individual Development

Many of the senior medical faculty developers who participated in the interviews discussed their role in terms of being a Facilitator of Individual Development. This was the primary role that most participants were hired to do; the focus of this role was on their

individual constituents rather than on the organization as a whole. They described this role using words such as "Coach," "Facilitator of Learning," "Trainer," and "Colleague." Kim reflected on her individualized approach to faculty development: "I do think it's about individual development ... my biggest strength is that I'm very good one on one and building relationships with people. That allows me to challenge and support them and help them as educators." The goal of these facilitators is to help faculty master the metaprofession of the professoriate and they often achieved this through one-on-one interventions and workshops.

Within the role of Facilitator of Individual Development, I identified three approaches that were derived from comments made by the senior faculty developers: 1) an Expert Approach, 2) a Service Approach, and 3) a Collegial Approach. This study makes no judgments as to the effectiveness of these approaches but merely states their existence. In addition, the three approaches are not mutually exclusive in that faculty developers may use a combination of the approaches or use different approaches for different learners.

Expert Approach

The most frequently-mentioned characteristic of a faculty developer who uses the expert approach was demonstrating competency in a defined field of expertise. The fields of expertise most frequently mentioned were teaching, education and learning theories, instructional design, learner and program evaluation, and information technology. During the interviews, many of the medical faculty developers who spoke about this approach thought it was essential that they knew education theory, but that it

was also helpful to know about the medical education and healthcare systems. In addition to demonstrating competency in these content areas, one of the skills that senior faculty developers possessed was an understanding of what junior faculty needed. The senior faculty developers believed that this skill was gained over time from work experience in the field.

In addition to competency in education-related fields, senior faculty developers also mentioned the importance of having good interpersonal skills. In particular, the interview participants imparted stories about knowing when to intervene and when to "keep your mouth shut," and looking for opportunities without trying to be overly directive, listening carefully, and knowing the lingo and culture of the medicine in order to participate in the conversation and make suggestions that fit.

Service Approach

Some medical faculty developers who embraced the role of facilitating individuals' development also emphasized the importance of a service approach. At a very basic level, this approach meant being available for whatever was needed. This frequently meant working doctors' hours to be around when the physician faculty were around instead of a traditional eight-hour day. Some senior faculty developers who spoke of this service approach also highlighted the importance of showing humility or possessing a willingness not to take center stage, but rather to delight in assisting others in their success. Judith best articulated the service approach when she clarified that her role is to "assist faculty in becoming all they're capable of doing and to help them overcome the barriers that they have to their own professional development ... I get a lot of joy out of

other people's success. " Other faculty developers who participated in the interviews and on the surveys echoed this notion of gaining energy from others' successes and embracing each development opportunity.

Collegial Approach

While some faculty developers highlighted an expert approach or service approach to faculty development, others mentioned a "collegial approach" to faculty development. The first faculty development approach positioned the faculty developer's role as teacher or expert and the second approach described a position of assistance or resource. The third faculty development approach positioned the faculty developer's role as colleague or fellow learner. Fred detailed why he preferred the colleague approach:

> One [word to define my faculty development role] that I would most prefer is colleague. That's a little bit different than just a facilitator. As a colleague, you know what people are going through and you know their challenges. And given [your] educational background, you can think of interventions that will help them do their job better ... then as a colleague you're not separate, you're one of them. You may not really be from the same discipline but you can see what people do and you can understand what helps them do it better.

Paul described one of the benefits of the collegial approach when he acknowledged, "I almost think that [the] people who are the very best at faculty development are the ones that do it without [their colleagues] even noticing [that a teaching intervention occurred]." Tom echoed this strategy when he discussed looking for teachable moments and shared that he spends a lot of time looking for opportunities to interject "a teaching pearl" without trying to be overly directive.

Other senior faculty developers related the importance of being aware of opportunities for conferences, presentations or grant funding and informing their faculty about and then

helping to facilitate the attendance at a conference, the writing of a grant proposal, or a presentation submission if the faculty member was interested. Judith further expanded on this approach when she spoke of breaking these scholarly tasks down into manageable steps for faculty and then working on a proposal submission together as colleagues.

Conclusion

The senior faculty developers in this study all mentioned the role of Facilitator of Individual Development. I classified the interview responses into three approaches, which are not mutually exclusive. Some senior faculty developers approached their role more as an expert coach or facilitator while others used a colleague approach; and others focused on a more altruistic service approach. Faculty developers in both the interviews and on the surveys echoed this notion of gaining energy from others' successes and embracing each development opportunity.

Generalist

The majority of the faculty developers also referred to the role of being a Generalist or Boundary Spanner. The word Generalist is used to describe those faculty developers who have a wide variety of skills and interests and are called upon to serve in the areas of teaching, psychology, curriculum design, evaluation, and research. Almost all of the participants shared stories that reflected how their faculty development role allowed them to wear many hats, work in many areas and cross over boundaries.

The generalist concept is familiar within the culture of medicine, and many participants drew attention to the similarities between the generalist characteristics of

faculty development and the nature of family medicine. Family medicine physicians are "trained to prevent, diagnose and treat a wide variety of ailments in patients of all ages. They have received a broad range of training" (Thornborough & Schmidt, 1993. p.122). Similarly, medical faculty developers often bring a wide range of training in education, counseling and research, and they are called upon to work on a variety of organizational and faculty issues. Judith demonstrated this connection by sharing a story from when she was interviewing for a medical education position: "I told them that I was a family doc in disguise. I'm a generalist, you know." Another senior educator, Michael, made a similar connection when he summed up why the generalist role is so important for a faculty developer:

> [It] is not unlike the way that medicine sees family physicians. A broad area of knowledge is pretty mandatory [for medical faculty developers] otherwise... they [the physicians] won't call upon you.

Barb used the term "Boundary Spanner" to describe her medical faculty development role and stated, "I've worked with a lot of different people on a lot of different projects ... that's really one of the things that I've found the most enjoyable over the time that I have been [here]." She shared that it is important for an organization to have people who are generalists or boundary spanners and identified her role as "the glue that keeps the program together." She further expanded on what it means to enact this role:

> I think that [being the glue of the program] is not only what I am valued for, but it's what I value myself about what I do. I feel like if I weren't in [this] role, that the [faculty development] fellowship would be in trouble.

Tom, who is the sole faculty developer in his organization, also enjoys being a generalist and stressed the importance of having generalists within organizations because "the needs

out there require more than just the one approach" and also require someone who has a broad enough focus to be able to move across boundaries.

By definition, Generalists are boundary spanners who have interests and skills in a variety of areas. This role provides a constantly-changing work agenda for the faculty developers. Kathryn, whose entire professional career has been in medical education, conveyed that the Generalist role is a balancing act when she said her job involves hard work and long hours at times because she may work on a variety of projects and those projects constantly change so that her job is different each year.

Generalists are usually self-motivated. They work in many different areas related to education, partially because they are constantly looking for needs within the programs. Barb and Judith both articulated the recurring phenomenon of seeking out areas of need within their department and working for improvement, even if it was outside the original scope of their job description. Barb expressed her self-motivation this way:

> The whole time that I've been in the department [of family medicine] I've been kind of on the lookout for opportunities that seemed like they would be a good fit and they would be interesting things to do ... and when I would see something that looked like it might work, I would make a proposal to whoever the relevant person was... and say, "Here's what I'm doing now, I see this area that people aren't paying enough attention to. I think I've got something to offer in that area." And I think that [being proactive] has really been essential ... nobody ever asked me to do a lot of the things that I've seen and volunteered to do.

The faculty developer in the Generalist role is called upon to assist in a variety of education-related areas and uses knowledge gained from a broad background of formal and informal learning experiences. The Generalist role involves coordinating many areas of education including curriculum and evaluation or assisting departments in diverse areas such as technology, tenure review and scholarly work.

Conclusion

Almost all the senior faculty developers in this study alluded to being a Generalist within their institution. The Generalist role involved being able to work in many different areas of medical education. Their diverse training and experiences assisted them in this role and helped Generalists easily cross boundaries to work on a variety of education-related tasks and projects.

Educational Expert

Many of the educators I interviewed also mentioned a leadership role in medical faculty development. Their descriptions of a leadership role took various forms, which I have combined here for the purposes of this discussion. Some faculty developers identified their leadership role as a guidance role and described being the "Voice of Education," or "Conscience of Faculty Development." Others identified their leadership role within the organizational domain and described their role as a "Creator of Coalitions," or a "Program Builder." It was difficult to choose a title to encapsulate this leadership role because it represents examples of both the strong leadership of building programs and the quiet leadership of providing the "Voice of Education". The term Educational Expert, however, seemed to combine all elements because these faculty developers were looked to for advice and leadership in educational areas.

Educational Experts acted as leaders in the traditional sense of building programs, forging new directions and creating coalitions between constituencies. But this role also encompassed the quiet leadership of those who interject the perspective of an educator

when needed. Educational Experts focused mostly on the broader educational arena of their institution such as their department or medical college. Robert emphasized that successful faculty developers have to be program builders in the sense of recruiting learners for their services. He felt that faculty developers have to go out and sell ideas to people who may not really know what they need, but helping these learners set goals and giving them the support to achieve them is a key faculty development function. Robert suggested building a program on the successes of individuals. Meanwhile, Kathryn spoke of being the more quiet or subtle guide when she said: "I wave the flag of education ... and [am] an advocate for educational concepts." She saw it as her responsibility to interject an educational point of view if she though it was being forgotten during a particular discussion.

Senior faculty developers in the Educational Expert role used their knowledge of organizational development or instructional design to help guide their organization. Three participants specifically defined their faculty development role as a creator or builder of coalitions within their organization and with the medical community at large. Robert articulated that he saw himself as "building relationships between the department, its constituency organizations and the medical center and around the state." Tom has also taken on a more traditional leadership role by trying to get the organization to reorganize, and to recognize more of a role for faculty development.

Various knowledge, skills and attitudes were identified as being a part of successfully managing the Educational Expert role. Essential knowledge included a solid understanding of curriculum design and evaluation, as well as the basics of medical education beyond the particular program or department where one worked. In addition,

faculty developers in this role highlighted the importance of having knowledge of organizational behavior and business/administrative skills. They often assumed regional or national leadership positions in medical or education organizations and also made themselves visible at their own institution.

Faculty developers who identified with the Educational Expert role had an understanding of organizational behavior that they gained through formal education and/or experience. Some of the talents they mentioned came from experience such as knowing "what a particular organization needs in order to make suggestions that fit," as Larry highlighted. He explained that this comes from having spent time in the field, watching, listening and learning. Tom also talked about "knowing" the organization and his need to be patient and flexible to facilitate change. He elaborated by saying that he has to really know the politics of the institution, take change slowly, and avoid being seen as somebody with an axe to grind or an individual viewpoint to which he's trying to make everybody conform. He continued to elaborate that "even though you know that a person or a program needs to grow in an area, you can't say all you know." He gained this understanding of his organization by getting on committees where he could be both seen and heard; talking with his boss and other people; and also keeping confidential those things that needed to remain so as a way of building trust.

Judith used a different analogy when she explained that she is a catalyst by nature and that she tends to see things holistically or organizationally because, as she states, "I don't think one can pull out [one brick] when there are a whole bunch of bricks and say 'well, we don't need those,' you know. They are just part of the building. That's the way I look at it." She continued to detail her success in her role by explaining that she makes

herself visible, gets involved and that she is not afraid to take risks and occasionally make a mistake.

Another strategy employed by Educational Experts was to assume leadership positions at the national level and within professional organizations (such as STFM). Those who spoke of this strategy highlighted the contacts and networks they made through these endeavors that helped them do their work better. Some invited the national colleagues they met back to their own program to consult with their faculty. Others mentioned the credibility their national involvement afforded them at their home institution, although most of those I interviewed were quick to add that they feared being "nationally known and locally unknown," and worked hard to make sure that wasn't the case.

Senior faculty developers who identified with the Educational Expert role also possessed strong skills in the area of grant writing. As leaders they needed to have strong grant writing skills in order to provide financial support for their programs and other educational programs within the department. In some cases the acquisition of financial support led to more tangible leadership positions for faculty developers as well. In addition to grant writing skills, Educational Experts also spoke about having strong skills in program assessment and evaluation. These skills helped them assess learners and design strong educational programs. These same skills also provided opportunities to turn their data into scholarly publications or presentations. This scholarship helped establish their work locally and nationally, and also aided in their responsibilities of guiding department faculty through the metaprofession of the professoriate. Scholarly opportunities also encouraged faculty developers to stay current with the literature and

expand their vision beyond their immediate scope to see other ideas that might benefit their organization.

Conclusion

The Educational Expert role encapsulated leadership positions (both formal and informal) described by the senior faculty developers. The Educational Expert's role was to provide the voice of education or the faculty development expertise. Many also worked to build their programs by creating partnerships and building networks within the institution and its community. Sometimes the Educational Experts took on more visible leadership positions through regional and national involvement. All Educational Experts stressed the importance of understanding their organization, acquiring grants and effectively administering them, and then disseminating their outcomes in a scholarly manner.

Chapter Summary

This chapter discussed the roles that the senior faculty developers enacted to perform their work tasks. Three role categories were described: Facilitator of Individual Development, Generalist, and Educational Expert. The participants stressed the Facilitator of Individual Development role as their primary role. Although they may approach this role in one of three different ways (Expert, Service or Collegial), they all served as a guide to the metaprofession of the professoriate for the physician faculty. Almost all of the interview participants indicated elements of the Generalist role within their organizations and relied on their diverse backgrounds to find success in this role. Fewer senior faculty developers mentioned the role of being an Educational Expert, but those who did referred either to opportunities for strong leadership, such as directing new programs or serving in leadership positions, or to quieter leadership, such as being the "Voice of Education" or the "Conscience of Faculty Development." The Educational Experts frequently relied on their grant writing skills and knowledge of organizational behavior to enact their role. These three roles were most frequently mentioned during the interviews with the senior faculty developers.

Chapter 7

FACTORS IMPACTING THE VITALTY OF MEDICAL FACULTY DEVELOPERS

This chapter outlines factors that positively or negatively affected the vitality of non-physicians in medical faculty development. It begins with the definition of vitality and an exploration of the vitality of the medical faculty developers in this study. The chapter continues with a discussion of the factors impacting the vitality of these senior medical faculty developers.

Data discussed in this section are from both the interviews as well as from the interview subjects' responses from the 2001 survey. To further support findings from the twelve who were interviewed, at times I also refer to responses from the open-ended responses of the larger 2001 survey population, consisting of the fifty-eight subjects with at least 20% work in faculty development and ten or more years in medical education.

Defining Vitality

The vitality of these medical faculty developers was examined using Woods' et al. (1997) definition of vitality. When related to this study, their definition of vitality included: 1) retention in medical education and faculty development; 2) career satisfaction; 3) a range of professional activities including administration, teaching and research; and 4) contributions to the medical faculty development profession. In general, the twelve medical faculty developers who were studied exhibit the characteristics of vitality described by Woods et al. I will use this definition of vitality in this section to

explore each of the four dimensions in order to further describe the interview participants and their work and to support the case that they are indeed vital in medical faculty development.

Retention

The first dimension of Wood's et al.'s (1997) definition of vitality was retention in the profession. The matter of retention was partially addressed in the selection of the interview participants by targeting those with ten or more years in medical faculty development. Table 7.1 shows each participant's career broken down by years in medical faculty development and by years in medical education using data from the survey and their curriculum vitas.

TABLE 7.1

Participants' Years in Medical Education and Medical Faculty Development

	Years in Medical Faculty Development [a]	Years in Medical Education [b]
Sam	14	19
Barb	14	21
Tom	17	21
Kathryn	17	26
Judith	18	22
Michael	18	18
Larry	19	19
Fred	19	30
Robert	19	30
Kim	22	22
Paul	23	24
Ray	25	29
AVERAGE	**19**	**23**

Note. a = Based on my curriculum vita review as of spring 2002

b = Based on 2001 survey

The participants involved in this study have worked an average of 19 years in medical faculty development (Table 7.1). This length of time signifies a commitment to the profession and a wealth of knowledge and experience within this group of senior faculty developers. In addition, most of the senior faculty developers in this study anticipated remaining in medical education for more than five years (Table 7.2). In fact, 42% of the interview participants intend on staying in medical education for 11-20 years.

TABLE 7.2

Years Senior Faculty Developers Intend to Remain in Medical Education

Anticipated Years Remaining in Medical Education	Number n = 12 [a]	Percentage	Number n = 57 [b,c]	Percentage
Less than 5 years	3	25%	9	16%
6-10 years	3	25%	20	35%
11-20 years	5	42%	21	37%
21-30 years	0	0%	3	5%
Unsure	1	8%	4	7%

Note. Data Source was 2001 Survey

[a] Responses from the twelve interview participants only.

[b] Responses from survey respondents who indicated 20% or more faculty development activities and 10 years or more in medical education.

[c] n = 57 because there was one survey respondent who was already retired.

A summary of the larger population of faculty developers (n=57) who completed the 2001 survey showed that 77% would remain in medical education more than 5 years and 42% of those intend to remain for 11-30 years. This is good news for an emerging profession that may need its senior people to mentor the novices.

Career Satisfaction

The second dimension of vitality according to Woods et al. (1997) is job or career satisfaction. This section also reports on what elements contributed to the career satisfaction of the medical faculty developers in this study.

The medical faculty developers in this study were satisfied with their careers in medical education (Table 7.3). According to the survey responses collected in Fall 2001, nine of the twelve interview participants checked that they were "very satisfied" with their medical faculty development career. Two indicated that they were "satisfied" and one checked "neutral".

TABLE 7.3

Interview Participants' Career Satisfaction from 2001 Survey Data (n = 12)

Survey Response Choices	Number	Percentage
Very Satisfied	9	75%
Satisfied	2	17%
Neutral	1	8%
Unsatisfied	0	0%
Very Unsatisfied	0	0%

Comments from the open-ended questions on the survey and from the interviews also indicated high career satisfaction. Open-ended questions from all twelve participants' surveys and comments made by eight of the twelve participants during the interviews revealed what they liked about working in medical faculty development. These comments mostly focused on four elements (Table 7.4): (a) the people with whom they worked; (b) specific aspects of the work; (c) the ability to contribute; and (d) the support networks in place for educators in family medicine.

TABLE 7.4

Elements of Career Satisfaction for Medical Faculty Developers (n=12)

Elements of Career Satisfaction	Number	Percentage
The People	12	100%
Their Work	8	67%
Making Valuable Contributions	5	42%
Available Support Networks	5	42%
Other Factors	1	8%

Note. Data source was the open-ended questions from the 2001 survey

One faculty developer, Larry, actually mentioned the rewarding elements of his work that fell into many areas discussed in this section:

> I [like] working with the extremely bright people ... and having their respect; [I like] to be engaged in interesting projects – challenging projects and using my background as an educator and psychologist in a creative way with a lot of autonomy to try things and conceive them and implement them.

The four elements of career satisfaction are discussed in the next sections. References back to the data in Table 7.4 are made in those discussions.

The People

According to the 2001 survey, all of the twelve participants noted that the people (learners, students, physician faculty, colleagues, administrators) were one of the things they liked best about their careers in medical education (Table 7.4). Specifically, the faculty developers who credited a part of their career satisfaction to the people they

worked with found their colleagues and the physician faculty at their institution to be intelligent, forthright, and collegial. For example, Kim highly valued the colleagues and physician faculty on her campus who gave her honest insight about a new idea she had. Michael also found the people to be a rewarding facet of his work:

> Smart, highly motivated men and women who want to work in academic medicine ... [who] need to know all this other stuff if one day they want to be a medical director or residency director or chairman of the department ... I think just working with bright motivated people is what has been nice for me.

Others comments from the survey indicated that medical faculty developers often experienced an eagerness from their physician learners and colleagues to grow professionally with the help from a faculty developer. In her interview, Kathryn pointed out that "doctors have a structure for dealing with consultants. They won't believe anything that you say necessarily, but they are willing to give you a chance." The fact that there has been a history of consulting relationships in the medical culture helped encourage these learning relationships to take place.

Their Work

Eight of the twelve interview participants' surveys indicated career satisfaction derived from specific aspects of their work (Table 7.4). Most commonly mentioned was the variety of responsibilities and variety of areas that they got to work in. Many found the work interesting and challenging and mentioned its always-changing nature. Most appreciated the broad range of responsibilities for which they were held accountable. Many faculty developers also liked the flexibility of the work in medicine and that their job changed every year. Tom reflected about the flexibility of his medical faculty

development career that has spanned seventeen years: "The job keeps changing and it stays interesting by changing ... you have opportunities to move into areas that are a better fit and more interesting ... I get to put my fingers wherever I want to." Aside from the general variety of tasks, some medical faculty developers also noted the opportunities that they had to use their creativity. Another participant remarked positively about the challenge of applying principles from a variety of areas such as education, psychology, and evaluation to the complex environment of medical education.

In addition to the task enjoyment mentioned above, most of the faculty developers loved seeing the outcomes of their work. Kim described the best part of her work as:

> Watching the 'ah-ha' phenomenon go on and people feel valued for teaching and education ... and the biggest is to know that we actually do make some progress that makes a difference in terms of our educational programs.

Fred also spoke of the greatest rewards of his work as "developing people and watching that occur." He went on to say:

> I just heard yesterday that four of my colleagues were promoted up to associate professor ... and as I look back on it, I've had at least a part in their development and for a couple of people, a major role. And so when you see people succeed, when you see people get a grant ... that makes you feel good.

Kathryn talked about the outcomes of her work as a motivating factor in her career:

> So it's actually seeing a difference ... seeing a difference in the quality of what we're doing educationally that keeps me plugging away.

And finally, Judith shared her pride in seeing "what's happened to the people with whom I've worked and the positions that they've been able to get; the grants that they've been able to get; I've taken joy out of being a catalyst [of all these good things]."

Many of the senior faculty developers highly valued the work that they did because of the variety of the tasks and changing responsibilities that are a part of their positions in medical education. Seeing the outcomes of their development interventions with their learners and colleagues was also an element of career satisfaction for the medical faculty developers in this study.

Making Valuable Contributions

Another element of career satisfaction for the medical faculty developers was the opportunity to make valuable contributions that impacted society. Just under half (42%) of the interview participants indicated that their careers in medical faculty development provided opportunities to make valuable contributions. Some highlighted the end result of being able to ultimately affect the healthcare system by helping make better doctors through their development of good teachers. In particular, three participants who work in what are considered underserved or rural settings, were optimistic about improving the quality of healthcare in their locations.

Another participant reflected on how gratifying it was to see a program improve because of her influences. Another participant specifically focused on the satisfaction he received when faculty he mentored were promoted or received a grant because he recognized that his work with them made a difference in their career.

The Support Networks

The fourth element of career satisfaction identified by these professionals was the support networks available in medical faculty development, especially for those working

in Family Medicine. Five of the medical faculty developers also indicated specific support networks that have positively impacted their career. In particular, the overall nature of family medicine as a discipline was mentioned as being a warm environment in which to work. The Society of Teachers of Family Medicine was specifically mentioned for providing a support network to these educators, for being an agent for connecting with other non-physician faculty developers nationally, and for providing opportunities for regional and national involvement in their profession.

Overall, the medical faculty developers in this study noted a high satisfaction rate with their career and attributed their satisfaction most often to four elements: (a) the people with whom they work, (b) the responsibilities of their work, (c) the opportunity to make valuable contributions, and (d) the available support networks within family medicine.

A Range of Professional Activities

The third dimension of vitality according to Woods et al. (1997) was substantial work in a range of professional areas including teaching, research and administration. According to the 2001 survey data (Table 7.5), all of the interview participants indicated some percentage of time spent in faculty development activities. The average interview participant spent 34% of his/her time conducting faculty development workshops or in one-on-one faculty development endeavors, with two spending 50% or more time in faculty development activities (overall percentage of time ranged from 20-80%). All of the participants also indicated time spent on administrative tasks and grant writing responsibilities. All but one indicated time spent in research and publications. Curriculum/instructional development also received attention from eleven of the

participants (16% of time on average). Six of the twelve medical faculty developers in this study also indicated a percentage of time in classroom teaching or student advising.

TABLE 7.5

Interview Participants' Work Activities (n = 12)

Work Activity	Number indicating activity	Mean % of time [a]	Mode % of time	Range % of time
Faculty development workshops & consultations	12	34%	30%	20-80%
Administration	12	18%	20%	5-30%
Grant writing	12	9%	5%	2-20%
Curriculum development	11	16%	20%	5-40%
Research and publications	11	11%	10%	5-30%
Classroom teaching and/or student advising	6	5%	5%	2-10%

Note. Data source was the 2001 Survey.

[a] Mean percentages only include those respondents who performed the activity.

Further analysis using data from the interview follow-up e-mails (Table 7.6) revealed that the three *faculty development activities* which they most often performed were: 1) facilitating or organizing faculty development workshops, 2) curriculum development, and 3) professional development consulting with individual faculty regarding their academic career. These three activities were closely followed by writing faculty development or education grants, administering faculty development programs (budget,

personnel, paperwork), and completing their own research and writing. Table 7.6 shows the *faculty development activities* that engaged the twelve participants most often.

TABLE 7.6

Interview Participants' Faculty Development Activities

(n=11 missing data from one participant)

Faculty Development Activity	Number performing activity	Mean % of time [a]	Mode % of time	Range of responses
Facilitating or organizing faculty development workshops	11	17%	10%	5-50%
Curriculum development	10	8%	10%	2-15%
Consulting with faculty about their professional development / academic career	10	6%	5%	2-15%
Working on own research and writing	10	4%	5%	1-10%
Grant Writing	9	8%	7%	5-20%
Administration (grant administration, budget, personnel, paperwork)	9	8%	5%	2.5-20%

Note. Data Source was the Interview Follow-up E-mail Questions.

[a] Mean percentages only include those respondents who performed the activity.

A number of activities make up the faculty development work of medical faculty developers. The data from two different instruments (the survey and the interview follow-up e-mail questions) showed that these senior faculty developers spent considerable time engaged in "traditional" faculty development activities such as faculty development workshops and academic career consultation. For a few faculty developers,

workshop presentation and consultation engaged up to 50% of their work time, but more often these activities engaged about 10% of their time. The majority of participants also used their time and talents in the areas of curriculum development, research, grant writing, and administration. Only a few faculty developers remained active in traditional (for credit) classroom teaching.

This section provided a snapshot of the work-related tasks in which these medical faculty developers engage. This brief overview demonstrated the array of activities that define medical faculty development work and highlighted the percentage of time spent in the range of professional activities. Almost all the participants were engaged in teaching (including faculty development), curriculum development, research and administration; however only six of the faculty developers performed traditional classroom teaching and student advising. The data in this section indicate that the medical faculty developers work in a range of areas including teaching, research and administration. Their involvement in a variety of activities is linked to vitality because it demonstrates their productivity and commitment to the work of their institution.

Contributions to Medical Education

The final dimension of vitality according to Woods et al. (1997) is making contributions to one's profession. This dimension is explored in this section by discussing the medical faculty developers' contributions to various professional organizations and their scholarly work towards advancing the medical education.

Professional Organizations and Leadership

Most of the curriculum vitas reviewed indicated membership in professional organizations in medical education as well as in higher education and faculty development. Some of the organizations included The Society of Teachers of Family Medicine, The Association of American Medical Colleges, The American Academy of Family Physicians, Generalists in Medical Education, Professional and Organizational Development Network in Higher Education, American Association for Higher Education, and American Educational Research Association. A few interview participants' CVs also indicated membership in organizations in the faculty developers' discipline such as public health associations, international health organizations, various psychology associations, and associations for other counseling specialties. A few faculty developers also held memberships in other areas of medicine (surgery, internal medicine, cancer education) as well as research groups, osteopathic associations, and national fraternities.

Many participants held leadership positions within these medical education organizations and six participants have held at least one leadership position in various STFM committees at some point in their career. These senior faculty developers also contribute to the field of medical faculty development by frequently serving as proposal reviewers for conferences, manuscript reviewers for referred publications, editorial board members for referred publications and reviewers of federally funded grants.

Scholarly Publications and Presentations

Quantifying the medical faculty developers' scholarly productivity presented some challenges. My only source of information for evaluating their productivity was their curriculum vitas, but not all participants included the same information on their CVs. This lack of information was particularly troublesome in the area of grants. Interviews with all of the participants indicated time spent on grant writing, but three participants did not document their grant work on their CV so I had no way to measure the productivity of these three participants in this area. I also did not know the monetary amount of all the grants funded, so I resorted to simply counting the number of funded grants rather than the dollars received.

In addition, since I did not have access to all of their actual publications and hadn't seen most of their presentations, I could only evaluate quantity rather than quality. As noted by Bland and Bergquist (1997), the general criterion of productivity usually concerns the number of publications/presentation/grants rather than the quality or impact on one's discipline and I had no choice but to follow along in this manner. Finally, since there are no universal standards used to assess productivity, I compared these faculty developers with each other. Thus the twelve medical faculty developers were rated using a scale of Low, Medium and High for the number of refereed publications, refereed presentations, and funded grants documented on their curriculum vitas from 1990 through early spring of 2002 (Table 7.7).

TABLE 7.7

Interview Participants' Scholarly Productivity 1990-2002

Name	Faculty Rank	Publications [a]	Presentations [a]	Grants
Kim	Professor	HIGH	HIGH	HIGH
Ray	Professor	HIGH	HIGH	HIGH
Judith	Professor	HIGH	HIGH	MEDIUM
Fred	Associate	HIGH	HIGH	LOW
Robert	Professor	MEDIUM	MEDIUM	HIGH
Larry	Adjunct	MEDIUM	MEDIUM	HIGH
Kathryn	Professor	MEDIUM	MEDIUM	MEDIUM
Tom	Associate	MEDIUM	LOW	MEDIUM
Paul	Adjunct	LOW	MEDIUM	LOW
Sam	Associate- no tenure	LOW	MEDIUM	N.A.
Barb	None	LOW	LOW	N.A.
Michael	Clinical Faculty	LOW	LOW	N.A.
	PARAMETERS	LOW = 0-9 MEDIUM = 10-19 HIGH = 20+	LOW =0-24 MEDIUM = 25-49 HIGH = 50+	LOW = 0-9 MEDIUM = 10-19 HIGH = 20+
	RANGE **MODE**	0-78 13	0-218 43	2-25 no mode

Note. Data source was the Participants' Curriculum Vitas from Spring 2002

[a] = Peer-reviewed/refereed publications and presentations

N.A. = not documented on C.V.

Discussing their accomplishments in the area of scholarly productivity brought about a mix of comments from the faculty developers. A few specifically voiced concerns about working as practitioners in a research setting. They asserted that the scholarly writing they did was really more "the scholarship of application" and was more about describing their programs or their learners rather than new research. So even though I rated some faculty developers as being highly productive in publications or presentations, most of this scholarly work is the work of practitioners rather than the work of researchers. Overall, this practitioner angle taken in the scholarship of these faculty developers is reflective of the work they do and the expectations set for them by their institutions. It is also the nature of an emerging professional field that still relies on its scholars to describe what is currently in place, before launching into new areas of knowledge and research.

So overall, although the rate of scholarly productivity for these twelve medical faculty developers varied, over half were considered productive or highly productive in the number of refereed publications, refereed presentations, and funded grants documented on their curriculum vitas.

Conclusion

In this first half of the chapter, I used the dimensions of vitality defined by Woods' et al. (1997) to characterize these medical faculty developers' characteristics and their contributions. I found that the interview participants have worked in medical faculty development for an average of 19 years, and 92% were satisfied with their medical faculty development career. Some of the elements of career satisfaction were: 1) the people with whom they work, 2) specific aspects of their work, 3) the ability to make

valued contributions, and 4) the support networks in place in their profession. They spent an average of 34% of their work time engaged in faculty development activities. This work was balanced out with administrative duties, grant writing, curriculum development, and research. The faculty developers in this study contributed to medical education by maintaining professional memberships and holding leadership positions within those organizations. About half of the participants were considered productive or highly productive based on the number of funded grants and refereed publications and presentations documented on their curriculum vitas.

The data presented in the first half of this chapter further described the participants and made the case that they possess characteristics of vitality as defined by Woods et al. (1997). In the second half of this chapter I will examine cultural/organizational factors and individual factors affecting this vitality.

Factors Impacting Vitality

This section explores factors that positively or negatively impacted the vitality of faculty developers in medical education. The discussion of vitality uses data from both the interviews and the 2001 survey. The data from the 2001 survey is separated into two categories: 1) responses from the 58 participants who indicated 20% time in faculty development activities and ten or more years in medical education and 2) responses from the twelve faculty developers who participated in the interviews.

On the 2001 Survey, the 58 respondents revealed challenges and supports related to success in medical education when they responded to the open-ended question "What are the significant factors that contribute to the success of non-physicians in medical education?" An analysis of the significant factors affecting vitality pointed to two sets of factors: 1) Cultural/Organizational Factors and 2) Individual Factors. The titles of these two categories of factors emerged from the participants' responses; however, they are similar to the categories used by Bland & Bergquist, 1997 and Bland, 2001. These two sets of factors are discussed in the next section and they are compared to Bland's work in Chapter 8.

Cultural/Organizational Factors Impacting Vitality

A number of cultural/organizational factors that contributed to the success of non-physician faculty developers in medical education were identified in the open-ended responses on the 2001 survey. The responses essentially fell into the broad category of having a "supportive environment" (Table 7.8). The data in Table 7.8 are referred to in the following sections that discuss the factors related to a supportive environment.

TABLE 7.8

Cultural/Organizational Factors Contributing to Success in Medical Education

Factors [a]	Number n = 12	Percentage	Factors [b]	Number n = 51 [c]	Percentage
Supportive Environment	3	25%	**Supportive Environment**	15	29%

Note. [a] Data Source was the open-ended responses from the 2001 survey of the 12 interview participants only. Respondents could indicate multiple factors.

[b] Data Source was the open-ended responses from the 2001 survey of the 58 participants who indicated 20% time in faculty development and 10 + years in medical education. Respondents could indicate multiple factors.

[c] n = 51 because there were 7 with no responses

Responses from both the 2001 survey and interviews indicated specific factors related to a supportive environment included: 1) the value of faculty development, 2) the impact of the dean/department chair, and 3) time and workload issues. A broad discussion of the culture of medicine is followed by a discussion of the specific organizational factors.

A Reminder about the Culture of Medicine

Although this is not an organizational study, it is important to remember the context of medical faculty developers' work before exploring the institutional factors that affect vitality. The culture of medicine is hierarchical and structural. There is a progression of training with each level carrying more importance or influence, as well as more responsibility. Some medical specialties are considered more prestigious than others. Within the hospital or clinic setting, there is an institutional hierarchy and often a clear division of labor that separates the physicians from their allied health associates (e.g. physician assistants, nurses, technicians), professional staff (e.g. faculty developers,

statisticians, administrators) and support staff. Faculty development programs are often viewed as expendable programs. The apparent stability of a position at a hospital/clinic can never be taken for granted. Because faculty developers are usually not generating any income (by seeing patients or providing services for a fee) for the hospital/clinic or medical school, their positions are often looked at as "extras" that could be cut first before any income-generating positions and programs. Many survey respondents mentioned the need to constantly be thinking about ways to "prove their worth" and measure the outcomes of their work in order to combat their second-class status. Additionally, this situation encourages the continual process of searching and applying for funding as a way of bringing dollars into the university or hospital. These are a few of the characteristics of the medical culture that provide the backdrop for this study.

Both the 2001 surveys and the interviews indicated some of the challenges of working in the medical culture. Three interview subjects wrote specific comments about the difficulties they encountered in medicine. Sam wrote on his survey that a significant factor is "recognizing that being a non-physician in a physicians' world has limitations." Kathryn wrote that it is important to "accept, and don't mind, that being a physician is a club, and we are not members, just guests." Barb also noted that "tolerance of the substantial discrepancies in salary and status between physicians and non-physicians" is a significant factor contributing to success.

One survey respondent indicated that a successful non-physician needed to "reconcile [one's] self to second-class status." The second-class status that this survey respondent alluded to is related to the institutional factor of the medical culture. Faculty developers are usually not physicians, but rather specialists in education. Some do not have a PhD;

not having a terminal degree can be an obstacle in a heavily credential profession such as medicine. Many faculty developers are women, which may also prove to be a disadvantage in a traditionally male-dominated field, although only a few non-physicians working in medical education indicated on the survey that sexism was the most difficult part of their work.

Supportive Environment

Having a supportive environment was mentioned by over 25% of the study participants (Table 7.8). Some participants expanded their survey responses to explain some of the elements of a supportive environment; the interviews also shed light on just what factors were part of a supportive environment. The specific factors of a supportive environment that were discussed with frequency in the interviews were: 1) the value of faculty development, 2) the impact of the dean/department chair, and 3) time and workload issues. These specific factors were derived from the qualitative data on the survey and interviews so it was difficult to attach a specific number or value to them to show them in table form. Therefore, specific quotes and general trends from the survey and interview data are interspersed throughout the next section to illuminate factors impacting vitality rather than references to table data.

The Value of Faculty Development

There was a general belief among survey respondents that the more faculty development was valued by their institution and the more that they, as individuals, were seen as valuable, the more successful they would be in medical education. Indications of

the value an institution placed on faculty development can be found in a number of different areas. The faculty developers participating in this study identified some indicators that were indicative of their perceived value. They mentioned having 1) stable funding, 2) tenured faculty rank within the medical college, and 3) opportunities for advancement as indicators of their worth. They believed that the institutions that provided these benefits saw the value of faculty development in general and also the specific value of having non-physician faculty developers involved in the medical education programs.

Funding of Faculty Development

The first indicator of the institutional value placed on faculty development was stable funding for faculty development positions and programs. Funding by the institution ensures continuity of programs and allows faculty developers to spend more of their time on faculty needs rather than securing grant funds to keep their positions. Five of the twelve faculty developers I interviewed were in positions fully funded by their institution. The remaining seven were either on a combination of grant and institutional funding or were solely funded by temporary grant dollars. A glance at the fifty-eight faculty developers who responded to the 2001 survey (n=57 because one respondent was retired) showed that 39% were funded entirely by their institution, 9% were only on grant dollars, and 52% were funded by a combination of institution and grant funds. Tom said that one of the most challenging facets of his faculty development work is "the insecurity of knowing that [faculty development] is something that is seen as peripheral" so "you may

not be getting enough money to do what you really want to do" and that at the next budget cut, "[you might be out] and you've got to find something else to do."

Having faculty development programs that are funded increases the likelihood that the faculty developers will stay in the profession because, if it is a good fit, there is no need to seek out a new position elsewhere. However, the senior faculty developers interviewed for this study universally felt that the funding of faculty development programs was of great concern. Some noted that a large portion of their time was spent on grant writing and that acquiring funding for their programs took precedence over scholarly publications and presentations. In the near future, it appears that most institutions may not have room in their budgets for faculty development programs, and faculty developers may continue to be asked to fund their own positions or programs through external funding sources. When institutions fund their faculty development programs (either entirely or partially,) it is a sign that the development of their faculty is an important part of their mission. In addition, institutions that fund their faculty development programs usually retain the experienced educators who have been working in their programs.

Faculty Rank

Another indicator of the value placed on faculty development is whether faculty rank is provided within the medical college/school to the educators directing the faculty development efforts. Just over half of the faculty developers who participated in the interviews held a tenured faculty position. Of the five interview participants without tenure, two did not feel having a tenured status would significantly change things for

them because they primarily work in the clinical setting and had little contact with the college or university politics. The other three faculty developers felt that having tenured faculty status would positively impact their work. Paul reflected:

> I feel [having faculty status] would have made a big difference because I think faculty development people tend to feel they are on the outside looking in anyways. And I think it says to the faculty that faculty development is important ... and [that the faculty developer] is one of them and engages in some of the same things that they engage in [as tenured faculty].

Barb also ruminated over her "non-physician, non-faculty" status, and while she believed that at one point it would have helped her, after having worked over twenty years in the same department, her value is more dependent on who her department chair is than on her faculty status. But she acknowledges that it has been a major issue in the past.

Fred, a tenured associate professor, stated that he'd been at institutions where he did not have faculty status and at those that he did; he concurred that having a tenured faculty position in the same department/college as the people he worked with made a difference. However, he went on to say that another factor in his success has been his work with students, which provided him more credibility with teaching faculty because he was in "the trenches" as well.

Overall, the 2001 survey comments and the interview comments, especially those from respondents with less than ten years of experience in medical education, indicated that having tenured faculty status was desirable and added credibility to faculty developers' work. In addition, faculty status may provide faculty developers with more protected time for research and scholarly activities via a sabbatical or a similar arrangement.

Opportunities for Advancement

Anecdotally I heard that, in general, there is a lack of upward mobility for non-physician faculty developers because physicians have historically held most of the higher administrative positions such as department chairs and deans within medical colleges. Kathryn, who has full tenure and is a Director of Educational Development, commented that "you have to realize that there are limits and so I'm at the top of what I can get in this [institution] and in this profession." The titles of the interview participants support this trend because only two of the ten faculty developers who work in a university setting hold leadership titles (Associate Dean and Vice Chair). Judith, although she felt she has done well, acknowledged that she was limited but still looked to the positive:

> Look, I'm not going to become a chairman of a department of family practice; I'm not going to. But the program director [who received my faculty development interventions], she'll become a chair. I have no doubt in my mind.

Paul's comments echoed that he felt similar limits were placed on him at his institution because he simply was not eligible for "faculty status or assistant dean status". He went on to note that he could never be president of many professional medical organizations but named STFM as an exception to this limitation.

In addition to limitations on their upward mobility, some interview participants believed that faculty developers have to change institutions in order to move into higher positions even within faculty development or to achieve a higher faculty rank. For example, Judith changed institutions four times before achieving her Vice Chair title.

On the other hand, Kim achieved Associate Dean status working at just one institution (her other institution was related to her graduate school work in faculty development). So the claim that faculty developers had to change institutions in order to move into

higher positions was not conclusively proven through my interviews with these twelve senior faculty developers. Table 7.9 indicates the number of institutions these faculty developers have worked in during their tenure in medical education. I included the participants' graduate schoolwork if applicable.

TABLE 7.9

Number of Medical Institutions at which Faculty Developers Have Been Employed

Faculty Developer	Number of institutions employed in medical education [a]	Years in medical education [a]	Current administrative title [b,c]	Current faculty rank [b]
Barb	1	21	Associate Director	None
Larry	1	20	Director	Adjunct
Kim	2	21	Associate Dean	Professor
Sam	2	19	Director	Associate
Robert	2	29	Director	Professor
Michael	2	18	Vice President	Clinical Faculty
Tom	3	21	Director	Associate
Fred	4	30	Director	Associate
Judith	4	22	Vice Chair	Professor
Ray	4	29	Director	Professor
Paul	5	24	Director	Adjunct
Kathryn	5	27	Director	Professor
AVERAGE	**3**	**23**	**MODE: Director**	**MODE: Professor**

Note. Data Source was the Participants' CVs as of spring 2002

[a] includes graduate school work experience in medical education if applicable

[b] used highest title and faculty rank indicated on CV or stated in interview

[c] used most recent administrative (not faculty) title

Even though these faculty developers have worked an average of 23 years, they have only held an average of three positions. For some faculty developers, a change in institution brought about a change in faculty tenure status or administrative title, but others were able to achieve upward mobility within faculty development by staying at one institution.

The opportunity for upward mobility was a factor impacting vitality mentioned by some of the faculty developers. The majority of the faculty developers had assumed the title of Director although most speculated in their interviews that they would not advance much higher. Ultimately, there was a limit to the status they could achieve because of the precedent of having physicians or basic scientists assume the roles of department chairs or deans. These limits are a part of the general culture of medicine acknowledged earlier although some institutions provided more opportunities for the advancement of faculty developers than others depending on their leadership.

Impact of Dean or Chair

Another critical factor of a supportive environment is the impact of the faculty developers' college deans or department chairs. Having a supportive dean or department chair was mentioned as being a factor of success by 29% of fifty-eight survey respondents who have worked in medical education for ten or more years. This factor was reiterated by over half of the senior faculty developers that were interviewed. A supportive dean or chair could lead to vitality but, conversely, that individual could also be a negative factor that challenged faculty developers.

The senior faculty developers interview comments emphasized that the dean or chair sets the tone for faculty development and so faculty development is often "up in the air" when a college is replacing a dean or chair with a new person. Kathryn noted that at her college, "if we get a new dean, it will be very different next year from what it is now. I don't know whether it will be better or worse, but it will be different." One faculty developer told of a negative experience in which his previous dean didn't believe PhD faculty development people should have faculty status, which he believed made his work with the faculty more difficult.

Fred spoke positively about the impact of his current chair on his work: "I'm really blessed that I have a great chair and he supports me and he encourages people to do grants and to participant in faculty development." Kim also told of a positive experience when she revealed that she was the first educator with faculty status to be promoted within the college, so she was advised that the promotion standards were going to be higher for her than for medical faculty. Before Kim went up for promotion, she met with her chair to discuss naming her as the Principal Investigator (PI) on the grants she was writing and leading. This ran contrary to the typical trend of naming the department chairs as PIs. She found that her chair was willing to let her take the lead and name her as PI and she ultimately received her promotion. Kim felt that her chair supported her in her faculty development efforts:

> That's not true of all department chairs. So again, I've been in an environment where the people that have been my supervisors have been very supportive.

Deans or chairs clearly set the tone for faculty development. As Barb, who has always had to struggle because of her non-physician, non-faculty status, noted:

> Our current department chair ... made absolutely clear from day one that he values people's contributions based on their contribution, not on their title. I have had every opportunity, and then some, to do whatever I feel like I can contribute to the department. And my salary [now reflects] that and I've done some major catching up over the last few years and I am actually no longer several thousand dollars below the lowest paid faculty member.

Overall, despite some negative comments about the lack of support made by faculty developers on the 2001 survey, the senior faculty developers who participated in the interviews mostly spoke positively about their deans or department chairs.

Time and Workload Issues

A review of the 2001 survey responses and the interview data showed that many faculty developers also cited a third factor impacting their vitality: time and workload issues. The issues cited, however, varied based on the source of their frustration. Many mentioned the nature of being in a service position and being a generalist which lead to a constant stream of work and long hours in order to meet with necessary constituents. Michael alluded to the work hours when he explained that managed care has changed the nature of physicians' time, so that faculty developers need to go out to the physicians on the job during the hours they are available (often very early in the morning or in the evening) rather than having the physicians come to see the faculty developer during typical office hours.

Kim viewed these time/work load issues as the biggest challenge in her work and stated that it is especially hard to know what to say "no" to:

> Part of being responsive is what do you say "no" to that you are going to alienate, that is going to come back to haunt you ... I view us in a consultative support role, and if you turn people down, then they are going to go elsewhere. So it's hard to know what to say "yes" to sometimes and what to say "no" to.

For others, the full schedules of the people they were required to work with (physicians, medical students, residents) left little time for the faculty developers to work with these learners on faculty development issues. Fred highlighted this dilemma when he explained that the clinician faculty are "called upon to do more clinical time and so it's a real pressure to get people to succeed because they just don't have time to do a lot of the scholarly work." Michael added further evidence about this dilemma and explained that he believed that the lack of physician time is actually a result of what managed care has done to medicine:

> It used to be very easy for me to get people into our center for a day and get release time ... [but] the pressure on physicians for productivity and seeing more patients [is] at the expense of faculty development. It's difficult to convince hospitals and [to] negotiate with departments [about]... why what you're doing is going to be beneficial to them and why they should let a physician [be] released for a day and lose $3000 worth of income for the hospital.

Additionally, those faculty developers who had faculty status claimed that the need for constant productivity related to their service position and grant writing often interfered with their own efforts to do research and publish. Kathryn lamented that she has to do all her scholarly writing on her own time because she is so busy with her daily responsibilities and has no protected time for research even though she is a tenured professor.

Time and workload issues related to the general culture of medicine as well as to the specific cultures in the institutions at which the faculty developers worked. This factor was the cause of some of the stress that faculty developers felt or at the very least provided challenges they had to overcome to work with the faculty and physicians.

Conclusion

This section outlined the cultural/organizational factors that impacted the vitality of the faculty developers in this study. The general culture of medicine placed obstacles in the faculty developers' paths. The culture of one's institution was a critically important factor relating to the vitality of faculty developers in family medicine. The culture of an institution involved the value placed on faculty development, the impact of the college dean or department chair, and time and workload issues. Indicators related to the value an institution placed on faculty development included the funding of faculty development efforts, faculty status, and opportunities for advancement. The dean's or department chair's beliefs about faculty development impact faculty developers. Faculty developers believed that a factor of success in medical education is having deans or chairs who understood the purpose of faculty development, believed in it's value and demonstrated support for faculty development endeavors. Time and workload issues were often a source of frustration for faculty developers and were negatively linked to their vitality in medical education. Faculty developers in this study cite the lack of physician time for faculty development as a hindrance to their work as well as their workload and the need for constant productivity.

Many of the interview participants and survey respondents concurred with Paul's words when asked about significant factors: "Working in a medical education culture that values non-physicians [is a significant factor]. If the culture is right, everything else will fall into place if you are good at what you do."

Individual Factors Impacting Vitality

Educators working in medical faculty development also indicated a number of individual factors that impacted their vitality and success. Using both survey and interview data, this section will describe personal factors impacting faculty developers' vitality. The four personal factors (Table 7.10) noted most often by the interview participants were: 1) the ability to negotiate and work within the culture of medicine, 2) being flexible, 3) possessing generalist skills, and 4) having knowledge in one's content area.

TABLE 7.10

Individual Factors Contributing to Success in Medical Education

Factor[a]	Number n = 12	Percentage	Factor[b]	Number n = 51[c]	Percentage
Ability to Work within Medical Culture	6	50%	**Ability to Work within Medical Culture**	16	31%
Flexibility and/or Creativity	6	50%	**Flexibility and/or Creativity**	12	24%
Generalist Skills and Background	4	33%	**Knowledge of One's Own Content Area**	11	22%
Knowledge of One's Own Content Area	3	25%	**Self-confidence and/or Assertiveness**	11	22%

Note. [a] Data source was the open-ended responses from the 2001 survey of the 12 interview participants. Respondents could indicate multiple factors.

[b] Data source was the open-ended responses from the 2001 survey of the 58 participants who indicated 20% time spent in faculty development and 10 + years in medical education. Respondents could indicate multiple factors.

[c] n = 51 because there were seven surveys with no response to this question.

The next section explores how each of these four individual factors impacts vitality. The data in Table 7.10 are referred to in the sections on these four individual factors.

Ability to Negotiate the Medical Culture

The survey and interview data indicate that the most important individual factor for success for non-physicians working in faculty development was the ability to work within the medical culture. Fifty percent of the interview participants indicated this factor on their 2001 survey (Table 7.10). This factor relates to the faculty developers' personal ability to negotiate this culture, learn about medicine, and work with the constituents within the medical culture. For example, Kim stated on her survey that a significant factor is the "ability to understand and operate within a physician-dominated culture." Robert similarly stated that a significant factor is the "willingness to learn about clinical teaching and use that model in non-clinical teaching efforts."

Though some faculty developers in this study encountered difficulty with the culture, there were ways to assimilate into the medical profession. One senior faculty developer, Kathryn, preferred her work with physicians over her previous consulting in the K-12 education system because the physicians have a structure for working with consultants, and faculty developers definitely get a chance to work with them. She added one caution: "You often just get one [chance], but if you don't blow the first encounter you can come back for another one." Larry supported this notion of only getting one chance when he emphasized how important it was for faculty developers to be prepared with excellent contributions and presentations, because one never knows who might be in the audience.

Michael, whose main faculty development responsibilities occur in a clinical setting of a residency program, relied on observation and learning from experience to master the

medical culture. He related the educational principles he wanted to teach to medical situations he had observed: "You have to learn a little bit of medicine to really get your point across when you're doing the teaching and using examples to bring out your various educational dynamics in faculty development and precepting." Other senior faculty developers concurred that they had to have a solid understanding of the medical education system and also a repertoire of examples from medicine to use in their workshops to relate the education material to their physician learners' world.

So the ability to understand and negotiate the medical culture was a critical factor of success for these faculty developers. For the most part, all those interviewed acknowledged encountering some difficulties within the medical culture but were able to adapt to it, work with it, or accept it in such a way that the idiosyncrasies of the culture were no longer an obstacle.

Flexibility

Many respondents indicated possessing flexibility or creativity as an individual factor that contributes to success in medical education on the 2001 survey (Table 7.10). Flexibility and/or creativity was mentioned by 50% of the interview subjects on the 2001 survey and by 24% of the faculty developers from the larger sample population. It was also a factor of success mentioned by five senior faculty developers (42%) during the interviews.

Both the faculty developers in the interviews and the educators who completed the 2001 survey spoke of the need to be flexible when trying to solve problems or when working with the faculty and student learners in order to meet their different needs. This

flexibility can exhibit itself as creativity and resourcefulness and was sometimes described as being the ability to look for alternative strategies and of avoiding a "one size fits all" approach. Interview and survey responses also mentioned being flexible when it came to taking on new responsibilities and filling in gaps. This flexibility was mentioned in relation to patience and perseverance; faculty developers must realize that change happens slowly, and programs may develop on a different timetable than sometimes planned.

Generalist Skills and Background

The heading of "Generalist Skills and Background" is used to organize a number of personal factors that contribute to success according to the study participants. These Generalist Skills include multi-tasking, diversity of experiences and continued learning opportunities.

Multi-tasking

By definition, Generalists are boundary spanners who have interests and skills in a variety of areas. This role provides a constantly changing work agenda for the faculty developers, and those who are able to multi-task seem more likely to find career longevity in this role. Elements of multi-tasking include possessing good organizational skills which faculty developers like Barb state that they rely on "day in and day out." Another faculty developer, Kathryn, whose entire professional career has been in medical education, conveyed that the Generalist role is a balancing act; she said her job

sometimes involves hard work and long hours because she may work on a variety of projects and the projects constantly change so that her job is different each year.

For Generalists, multi-tasking also involves being self-directed or self-motivated. They end up working in so many different areas related to education partially because they are constantly looking for needs within the programs. Barb and Judith both mentioned the reoccurring phenomenon in their work of seeking out areas of need and working for improvement even if the need is outside the original scope of their job description. Barb articulated it this way:

> The whole time that I've been in the department [of family medicine] I've been kind of on the lookout for opportunities that seemed like they would be a good fit and they would be interesting things to do ... and when I would see something that looked like it might work, I would make a proposal to whoever the relevant person was... and say "Here's what I'm doing now, I see this area that people aren't paying enough attention to. I think I've got something to offer in that area." And I think that [being proactive] has really been essential ... nobody ever asked me to do a lot of the things that I've seen and volunteered to do.

The ability to multitask and being self-motivated were frequently mentioned as individual factors of success for non-physicians in medical education. Medical faculty developers who possess this skill set may be more likely to remain in medical education than those who are not able to multitask or be self-directed.

Diversity of Experiences and Continuing Education

Senior faculty developers in the generalist role spoke about diversity in their training and previous experiences. This diversity was previously referred to when I introduced the faculty developers in Chapter 4 and when I discussed their entries into medical education in Chapter 5. The diversity of experiences most likely provides success in the generalist role because faculty developers are called upon to assist in many different

areas such as administration, computer technology, curriculum design, evaluation, grant writing, research design, statistics, and teaching. Approximately 8% of the educators from the 2001 survey indicated having a diverse background as a factor of success in medical education (Table 7.10).

In addition to having a diverse background, the generalist role for medical faculty developers relied on continuing education. Because generalists are constantly called upon for different projects, they need to continue to receive training in new areas of responsibility or engage in independent learning activities such as conferences and reading the published literature from a variety of fields. Many of these formal and informal learning experiences were discussed in Chapter 5 under socialization factors for medical faculty developers.

Numerous faculty developers commented on their own continuing education endeavors. Some spoke of the formal learning they received through workshops or fellowships while others spoke about learning from experience or self-directed learning opportunities such as reading the literature. Many spoke about education-related topics for their continuing education but others spoke of a willingness to learn about clinical teaching models and medicine in general so that they could use realistic examples when teaching physicians. Ray summed up the need for continuing education when he said, "As the world shifts, you have to kind of go along with it."

Faculty developers in this study demonstrated that being flexible with ideas and processes was an important factor in their success. Those who were able to adapt to changes seemed to persist in the field and remain vital.

Knowledge of One's Own Content Area

Another individual factor indicated by the 2001 survey data was a solid knowledge base in one's content area. Competency in, and familiarity with, the base knowledge needed for faculty development was indicated by 22% of the larger population of the non-physicians who completed the 2001 survey and by 25% of the interview participants (Table 7.10). Senior faculty developers often highlighted competency in base knowledge in their interviews.

Given the time limit on the telephone interviews, however, not all interviewees defined what they meant by "base knowledge" so I do not have conclusive findings as to what they believed comprises "base knowledge." Some of medical faculty development's base knowledge that was referred to during the interviews included learning theory, adult learning principles, instructional design principles, basic statistics, assessment design and test design, technology skills (especially using PDAs and PowerPoint presentation software, searching the literature on electronic medical databases, and possessing general knowledge about the internet and e-mail software at one's institution), and organizational development theories.

Although 25% of the senior faculty developers who completed the 2001 survey (Table 7.10) mentioned that it was important to have a solid base of knowledge in one's content area, my interviews did not allow time for expansion on what the knowledge base was comprised of. This is an area for further exploration.

Conclusion

This section discussed factors impacting the vitality of medical faculty developers. The factors were categorized into two general areas: 1) Cultural/Organizational Factors and 2) Individual Factors.

Cultural/Organizational Factors included the general culture of medicine, the value individual institutions place on faculty development, and the impact of the Dean or Department Chair. Faculty development often holds "second class" status within medicine and there is a general lack of leadership positions for educators. Those faculty developers who approach their work with an understanding of how to work within this culture may achieve greater longevity and vitality in their career. The faculty developers in this study emphasized that the culture in which they worked was a critical factor affecting their vitality. Cultures that supported the vitality of faculty developers included those who valued faculty development by providing funding for the programs, faculty appointments for the faculty developers and opportunities for advancement. Faculty developers frequently mentioned that having a dean or department chair who understood and valued faculty development was important for their success as non-physicians in medical education. Time and workload issues were commonly mentioned as a challenge in their work that could negatively impact their vitality.

Individual factors essential to faculty developers' success in medical education were also identified. Faculty developers indicated possessing an ability to understand and negotiate the medical culture as very important in their success. The data also pointed to the importance of being flexible, possessing generalist skills, and having a solid

knowledge base in one's content area as other key individual factors contributing to the vitality of non-physician faculty developers in medical education.

Chapter Summary

The chapter began with the definition of vitality by Woods et al. (1997) and then made a case for the vitality of the faculty developers involved in the interviews. In the second half of the chapter, cultural/organizational factors and individual factors impacting vitality were discussed. Medical faculty developers are affected by the culture of medicine as well as the culture of their institution. The value placed on faculty development both within the medical culture and within the institution greatly affects how much support faculty developers have for their work. Secured funding was one of the greatest challenges for medical faculty developers. The ability to understand and negotiate the medical culture, as well as being flexible and adaptable to the needs of one's organization, were two individual factors that appeared to be critical for faculty developers' vitality.

Chapter 8

SUSTAINING CAREERS IN MEDICAL FACULTY DEVELOPMENT: SUMMARY, IMPLICATIONS AND CONCLUDING THOUGHTS

Introduction

The purpose of this study was to explore the vitality of non-physician educators in medical faculty development. These senior non-physician educators had an interesting history within medical education because their programs and positions primarily grew out of federal funding initiatives that began in the 1970's. Today, many of these original educators are still holding positions within medical education even though the federal funding that began their work has been dwindling. This was a study that focused on the non-physician faculty developers who have remained in medical education and sheds light on how they sustained their careers despite funding changes and other challenges within medicine.

In addition, while an established literature base exists regarding faculty development *programs* in medicine, little has been published about the *professionals* who work as medical faculty developers. This study addressed this gap in the literature by first providing descriptions of medical faculty developers and their work, and then by explaining how senior faculty developers entered into medical education and how they sustained their medical education careers.

I utilized the literature on academic faculty vitality for this study as well as some of the literature on socialization. Together, this literature framed the study and guided the development of the following primary research question and three subordinate questions:

What factors impact the vitality of non-physician educators in medical faculty development?

- How were they socialized to medical faculty development?
- How do they describe their work?
- What are the factors that positively or negatively impact their vitality?

This study proved important on a number of levels. Medical faculty developers have not been studied before, so the descriptive nature of this study was important for characterizing these non-physicians engaged in medical faculty development. The findings highlighted important factors related to socialization and also described the work and roles of medical faculty developers. The largest section of this study focused on identifying factors that impacted the vitality of these senior educators in medical faculty development. Faculty development in medical education has been affected by the national changes brought about by cost containment strategies in health care delivery. This study brought to light some of the challenges that exist for non-physician educators working in the medical culture as well as other cultural/organizational and individual factors that support their work. The findings help illuminate what supports vital non-physicians in their medical faculty development careers.

Hitchcock (2002) recently published a study on *retired* professional educators who worked within the broader setting of academic medicine. The publication of this study, titled the Exemplar Project, conveyed that education professionals are interested in learning about the careers of others and that senior educators are interested in sharing their wisdom and experiences. My report on the vitality of medical faculty developers is

timely because my participants were all faculty developers who belong to a subset of this larger group of education professionals that Hitchcock and his colleagues studied. My study shares the experiences and factors of vitality of those educators who are still working in medical education and whose careers are linked to the federal funding initiatives that have an uncertain future.

Even though medical faculty development has expanded to more institutions and has grown as a career option, those currently involved may face a difficult future. The federal monies that have supported many of the early faculty development efforts in medicine are declining, and competition for the available grant funds is increasing. Title VII funding is in jeopardy as federal legislators look to make budget appropriation decisions this fall (Wittenberg, 2003). At this juncture, it is important that senior educators in medical faculty development share with colleagues how they have weathered changes, secured their positions and enhanced their vitality. This study provided an opportunity for senior educators to document their entry and socialization into medical education, their faculty development roles, and the challenges and supports that affect their vitality and their careers.

Chapter Overview

This chapter is organized to correspond to the data presented in Chapters 4 - 7. Within each section the findings will be discussed in relation to the literature. The first section provides a summary of who is doing medical faculty development. The next section summarizes the educators' entry into medical faculty development and their socialization experiences. The third section reiterates the findings about the work of faculty

developers through a summary of their roles. The fourth section summarizes the factors impacting the vitality of faculty developers. The final portion of this chapter discusses the recommendations and implications of this study and identifies areas for further research.

Summary of Methods

This study utilized two sources of data: a survey and telephone interviews. The initial step of this study was to survey all the non-physicians in the Society of Teachers of Family Medicine (STFM). The survey yielded a 74% response rate and included 606 completed surveys. The survey sample was narrowed to those respondents who were demographically deemed more vital (i.e., worked in medical education for ten or more years and involved in faculty development activities 20% of their time). Twelve medical faculty developers were then randomly selected from the narrowed survey sample. The twelve senior faculty developers completed hour-long telephone interviews and also answered some interview follow-up questions via e-mail.

This was a descriptive study that applied some of the previous knowledge about socialization and academic faculty vitality to a new population – educators working in medical faculty development. The significant findings gathered through the survey and interviews will now be summarized.

Summary of Findings

Who is doing medical faculty development?

Survey Findings:

The larger survey of non-physician members of the Society of Teachers of Family Medicine (STFM) yielded 377 individuals (62%) who indicated time spent on faculty development activities. The survey showed that many non-physicians were involved in faculty development activities to some extent, although 76% of the 377 respondents worked in faculty development less than 20% of their time. Thus, only 15% or ninety-one of total survey respondents reported spending significant time in faculty development.

These 91 non-physician faculty developers indicated that they spent 20% or more of their time in faculty development (Appendix H); however, the same institutions employed a number of respondents who completed the survey. I was surprised that there were so few non-physicians working full-time in faculty development and that there seemed to be even fewer family medicine departments employing full-time non-physician faculty developers. The small percentage of full-time faculty developers could indicate that a number of family medicine departments probably do not have a non-physician educator committed to providing faculty development for their family medicine faculty. It is also possible that physicians, who were not included in the study sample, may be holding these positions.

Additionally, although those who were doing faculty development less than 20% of their time were excluded from the interview sample, their existence (n=286) demonstrates

that perhaps many departments consider faculty development as a part-time endeavor that individuals can add on to their existing work. Another explanation of the large number of non-physicians doing faculty development as only a small part of their responsibilities could be attributed to the fact that many educators may have to become generalists and work in a variety of education areas in order to maintain their positions in departments that could be facing budget cuts. Perhaps this lower time commitment devoted to faculty development indicates that non-physician educators in medicine need to assist in the education process at a variety of levels and in a variety of ways and not just through full-time faculty development positions.

Interview Findings

The medical faculty developers interviewed for this study were selected within specified parameters: (a) they must have been working in medical faculty development for at least ten years and (b) they must have identified that at least twenty percent of their work time was spent on faculty development. These parameters narrowed the interview pool considerably and allowed me to focus on those senior educators who worked full-time in medical faculty development.

Bland and Bergquist (1997) defined senior faculty members using four criteria: 1) full time, 2) tenured, 3) working in a collegiate institutions for many years (usually at least 15), and 4) more than 45 years of age. On average, the interview participants in this study met three of the four criteria. They were all 45 years of age or older and were all full time employees. They had all worked in medical education for more than the fifteen years as defined by Bland and Bergquist, although two had worked in medical faculty development for only fourteen years as of spring 2002. Where the participant group

failed to meet Bland and Bergquist's definition of a senior faculty member was that they were not all tenured by their institution. Instead only seven faculty developers (58%) held tenured faculty positions at their institution. In addition, all but one of the participants held a doctoral degree. Most held a terminal degree in education, educational psychology, curriculum and instruction, or sociology.

Those who participated in the interviews spent the majority of their time organizing or facilitating faculty development workshops, designing educational programs, and providing consultations to individual faculty. Eighty-three percent of the interview participants were employed by a medical college or university. They were typically located in a Department of Family Medicine and were often given the title of Director of Faculty Development. The next section reports the findings to the three subordinate research questions and links the findings of this study to the literature.

How were non-physician faculty developers socialized to medical faculty development?

This study confirmed that there is no defined point of entry for a career in medical faculty development or medical education. The faculty developers in this study entered into their careers in the medical culture through a variety of ways; however, graduate school opportunities commonly played a part in their start in medical faculty development. None knew about medical faculty development before starting their graduate education and there were no formal degree programs available to train individuals specifically for a career in medical faculty development. Although some of the senior faculty developers in this study took their first job in medical education while

graduate students, generally they were older than typical graduate students, and many were financially supporting their families and themselves. They did not approach their first medical education position as an internship or an opportunity for exploration, but rather approached it as a job or career. There was little opportunity for the kind of traditional anticipatory socialization discussed by Merton (1957a) that would have allowed the participants to explore the profession and begin adopting its values prior to entering medical faculty development as a career.

Most of the interview participants' entries into medical faculty development were marked by serendipity in which a work opportunity arose or a previous colleague involved them in medical education. There was no formal plan for their entry into medical faculty development as a career. After their first position in medical education however, most of the participants made a conscious decision to continue working in the medical environment. As faculty development opportunities grew in the late 1970's and into the 1980's, the interview respondents assumed those responsibilities and grew in their roles. While serendipitous opportunities began their medical education careers, the faculty developers acknowledged that this field was a good fit for them and that they had made a conscious decision to continue in the profession.

Non-Interpersonal Strategies of Socialization

The medical faculty developers in this study learned their work and roles on the job. I found that the two non-interpersonal strategies of trial and error and observation were used most frequently to acquire medical faculty development knowledge and competency. This finding supported the previous work of Ostroff and Kozlowski (1992)

who also found that observation was relied upon to the greatest extent, and that trial and error were used to some extent by the newcomers in their study who were in their first work experience after graduating from bachelor's degree programs.

Previous research (Ashford, 1986; Miller & Jablin, 1991) cited by Ostroff and Kozlowski (1992) also reported that official organizational literature was frequently relied upon for socialization. However, I did not find the same result. Instead, only one of the twelve interview participants reported relying on an existing handbook or job description. My finding may mean that this type of official organizational literature does not exist or is not common. Another possibility is that since medical faculty development is still fairly new to many organizations, training materials for medical faculty developers may not yet have been developed.

Interpersonal Strategies of Socialization

In this study, mentors, colleagues and supervisors were all identified as playing a part in the socialization process for most of the participants. Mentors played the most important role by helping faculty developers make connections with the right people, grow their programs or develop their own careers.

Ostroff and Kozlowski (1992) reported that supervisors and co-workers played an important role in the socialization process but that mentors did not rank as high. The fact that mentors rated higher than supervisors and co-workers in my study could be related to the fact that medical faculty development is still a relatively new and emerging profession with fewer members than most. These national mentors are the initial guides for many faculty developers just starting new programs. My results could be linked to

the nature of medical faculty development in that some of my participants were often the only educator in their department or college so there were few co-workers to help socialize them to their work. By necessity, they sought out national colleagues as mentors. The fact that mentors were reported to be most important to the socialization process may also be related to the age of study participants and their places of employment. Unlike the subjects in Ostroff and Kozlowski's study who were young (average age was 23 years) and primarily working in business or engineering, my participants were older (the majority were between 55-64 years), and they were working in higher education. The difference may also reflect the use of the term "mentor." While this is a relatively familiar term to educators, it can be interpreted as either a formal relationship or an informal relationship. In their survey of newcomers, Ostroff and Kozlowski defined their use of the term "mentor" as a formal relationship. In my study, I allowed the educator participants to interpret the term "mentor" for themselves, so some may have included both informal as well as formal mentoring relationships. A final reason for the differences in my findings and those of Ostroff and Kozlowski could be that Ostroff and Kozlowski surveyed newcomers twice within the first five months of their employment, while my exploration of medical faculty developers' socialization was a retrospective study that asked participants to reflect back on their entry into the profession. Perhaps mentoring relationships are not established until after one has been employed for longer than five months. Socialization to all the facets of working as a faculty developer within medical education occurred over a longer period of time and seemed to rely on multiple formal and informal mentoring relationships to broaden junior faculty developers' knowledge and competencies.

Concluding Thoughts about Socialization to Medical Faculty Development

In general, this study confirms what was already known about socialization. However, there were some differences that can be attributed to the unique qualities of medical faculty development. Unlike many traditional professions that have been studied elsewhere, there was no defined entrance point for a career in medical faculty development and no specific training that was universally required. I learned that there were no formal opportunities for early anticipatory socialization as identified in previous literature. Instead, these faculty developers first entered the profession as a means to secure financial support often while in graduate school or even later in their professional careers.

Bland (2001) noted that a thorough socialization and having an advisor/mentor were common characteristics of productive faculty members. In contrast, my study showed that a thorough, formalized socialization for faculty developers to medical education was lacking and most of the faculty developers learned the specific knowledge and competencies of medical faculty development while on the job through observation and trial and error. As in Bland's work, however, mentors played a significant role in the career development of educators in medical faculty development and medical education. These are all interpersonal and non-interpersonal strategies for socialization that have been identified by previous researchers.

How do non-physician medical faculty developers describe their work?

In the process of exploring the medical faculty developers' vitality, I inquired about their actual work. I found that they approached their work in slightly different ways

depending on how they defined their roles. Their approaches to their faculty development work were categorized into three general roles: 1) Facilitator of Individual Development, 2) Generalist, and 3) Educational Expert. These terms were derived from the data of this study and were not mutually exclusive in that most faculty developers engaged in two or three roles simultaneously.

All the faculty developers in this study identified the Facilitator of Individual Development role. This role fulfills the main purpose that they were hired to do -- to initiate professional development endeavors for academic and/or clinical faculty within the medical college. As faculty developers continued in their careers, many expanded their Facilitator role to the Generalist role. The Generalist faculty developers (n=10) provided educational expertise to their departments and colleges beyond the original scope of faculty development, and in doing so, became more valuable to their institutions. Those who identified with the Generalist role were self-motivated and enjoyed the practitioner side of their work. Perhaps a connection could be made here to previous volunteer and work experiences. In particular, the five interview participants who worked in the Peace Corps or other international education program prior to working in medical education stand out although many other interview participants documented volunteer work on their CVs. It is possible that those who had previous experience working in community service may be more likely to embrace the role of the Generalist and make themselves available to serve their departments in whatever ways they could.

A smaller group of faculty developers (n=7) embraced the Educational Expert role. These faculty developers took on a formal or informal leadership role within their institutions. They were often more engaged in administration and research than the

practitioner side of faculty development. It appears that there was a general progression of roles and that, the longer one remained in medical faculty development, the more likely one was to take on the Generalist role or even the Educational Expert role.

The categories of faculty developers' roles that emerged from my work are a new contribution to the literature. Other researchers have not organized the work of faculty developers in the same way nor have they developed role titles to describe medical faculty developers' various approaches to their work. Perhaps educators working in medical faculty development might want to further explore and evaluate the roles described here, and possibly define the competencies needed for each role.

In what way are educators in medical faculty development vital?

An exploration of the vitality of educators in medical faculty development was the focus of this study. I first illustrated the vitality of the senior faculty developers in this study using Woods' et al. (1997) definition of vitality, which encompassed four dimensions: retention, career satisfaction, a range of professional activities, and contributions to the profession. That section of this study presented data that made the case that these professionals are vital in their work as medical faculty developers.

In summary, the senior educators in this study had worked an average of nineteen years in medical faculty development and over half intend to remain in the field for at least six more years. All but one reported that they were "satisfied" or "very satisfied" with their medical education career. The data from both the 2001 survey and interviews pointed to four elements of career satisfaction: 1) the people with whom they work, 2) specific aspects of their work, 3) the ability to contribute, and 4) the support networks in

place for faculty developers in family medicine. The medical faculty developers worked in a range of professional activities including faculty development and consulting, curriculum development, grant writing, administration, and scholarly research and writing.

Many of the participants were active in professional organizations. Most made an effort to involve themselves in scholarly endeavors; however, this is probably their weakest dimension of vitality. Quite often the scholarship that these medical faculty developers engaged in only described faculty development programs or teaching strategies. This is partially reflective of the practitioner (rather than researcher) nature of their positions. In most instances, it appeared that their institutions' mission or bias affected these faculty developers' scholarly productivity. Seven out of twelve participants interviewed indicated that scholarly work by faculty developers was not highly valued by their institution. In some cases, the faculty developers did not hold a faculty rank and therefore scholarly work was not essential for their tenure, pay increases, or opportunities for promotion. Institutions often placed a higher value on their time spent consulting and placed more emphasis on the number of hours they worked, number of workshops they ran, number of committees they sat on and/or the number of faculty or students they serviced. In addition, greater emphasis was often placed on writing and applying for grants that could generate income for the institutions rather than publications, which might only generate recognition.

What are the factors that impact the vitality of educators in medical faculty development?

Next, this study explored factors that positively or negatively impacted the vitality of medical faculty developers. The findings on the factors were separated into two general categories: cultural/organizational factors and individual factors that emerged from the data but that share similarities to categories defined by Bland and Bergquist, 1997 and Bland, 2001.

Cultural/Organizational Factors that Impact Vitality

The overall culture of medicine in which these faculty developers worked influenced their vitality. The structure of medicine posed challenges for some faculty developers because they were often viewed as "second-class" to the physicians. Faculty development programs are often funded by grants and the programs are often discontinued once the funding runs out. Given these challenges, faculty developers need to continually prove their value to their medical colleges or hospitals.

A supportive environment is the cultural/organization factor that was ranked as most important for the success of non-physicians in medical education. Environments that support the vitality of faculty developers, value faculty development and often provide faculty developers with stable funding, faculty appointments, and opportunities for advancement. The dean's or department chair's understanding of faculty development usually sets the tone for the degree to which faculty development is integrated in the education programs. If the department or school leaders held positive beliefs about

faculty development, the faculty developers usually held faculty appointments, were funded by the institution to some extent, and had opportunities for advancement.

The greatest cultural/organizational challenges reported by the faculty developers were time and workload issues. The participants in this study reported encountering fewer opportunities to work with physician faculty because managed care is necessitating that physicians spend more time doing patient care. Faculty developers are often spending more time traveling en route to the physicians' worksites in order to provide professional development on-site. Faculty developers are often working longer hours than they did before the expansion of managed care in order to be available when the physician faculty are available to meet. The growth of faculty development at some institutions also means that there is always education work to be done and so faculty developers need to manage their time carefully.

Similarly, Bland's (2001) work also included having a supportive environment as an indicator of a productive faculty. She showed that institutions that provided their faculty with the resources necessary to do their jobs, provided academic freedom and autonomy, and valued the faculty members' contributions often had more productive academic faculty members. These elements were also highly regarded by medical faculty developers as factors that impacted their success.

Individual Factors that Impact Vitality

Individual factors that emerged from this study pertaining to the success of educators working in medical faculty development included the ability to understand and negotiate the medical culture, being flexible, possessing generalist skills and having a solid base of

knowledge. Bland (2001) also identified some individual characteristics of productive academic faculty. My study on vital and productive faculty developers (some of whom were also tenured faculty) yielded some similar results when compared with Bland's findings. Like Bland, my study showed that the attributes that I termed "generalist skills" are connected to vitality. The "generalist" attributes or skills that corresponded with Bland's are: 1) being personally motivated, 2) engaging in multiple, simultaneous projects, and 3) possessing in-depth knowledge of their area. Additional findings from my study are also similar to those in Bland's work. For example, I found that many faculty developers in this study benefited from having a mentor early in their career; they also benefited from having a network of education colleagues within the medical field. Professional organizations that provide resources and networking opportunities to support faculty developers, such as the Society of Teachers of Family Medicine, were critical to the vitality of the faculty developers. Professional organizations provided a similar source of support for the faculty members in Bland's study of productive academic faculty.

Concluding Thoughts about Vitality

These twelve medical faculty developers met most of the criteria described in the literature about productive, vital senior faculty members, although the fact that they worked in medicine created some differences. These differences included the lack of faculty appointments for some of the medical faculty developers and also the practitioner focus of their work rather than a research focus. They encountered some of the same work stresses noted in the literature for academic faculty, especially with respect to time

and work load issues. They lacked a thorough socialization and often reported a sense of "second-class" status or isolation associated with being the only educator in a medical setting. Some of these stresses are similar to those found by Sorcinelli (1992) in her study of junior academic faculty. Overall, however, the medical faculty developers in this study learned to adapt to or overcome some of these stress points in order to successfully work within medical education for more than a decade. This study points toward the importance of a supportive environment (department or college) as the salient cultural/organizational factor. The ability to work within the medical culture, flexibility, generalist skills and content knowledge were the most significant individual factors found in this study.

Recommendations and Implications of this Study

The implications of this study are primarily of interest to educators involved in medical education; however, there are also implications for a larger audience. The findings may be of interest to novice educators in medical faculty development, and senior educators working within the medical culture. Graduate students in education considering a career in medical education may also learn from this study. Additionally, this study provides useful information to deans and department chairs regarding factors that may impact the vitality of the educators working for them and ways to sustain the careers of educators working in medical faculty development. Professional organizations, governing boards, and funding agencies that make policy and funding decisions that affect medical faculty development programs might also find relevance in the results of this study.

This chapter continues with a discussion of overall topic areas: 1) Socialization Opportunities and Career Strategies, 2) Support for Faculty Development, and 3) Professional Responsibilities. Within each area, implications will be discussed for professional organizations, institutions, and individuals.

Socialization Opportunities and Career Strategies

This study explored the socialization and career paths of twelve senior medical faculty developers. Their stories raise questions and recommendations for professional organizations, institutions and current educators in medicine as well as those considering this career field.

Recommendations for Professional Organizations

Professional organizations within the field of academic medicine as a whole may want to collect data and disseminate information about training and experiences critical for medical faculty developers. More research about medical faculty development and faculty developers may be needed to strengthen the visibility of the contributions of educators to medical education. Information about career strategies, medical faculty development knowledge and competencies could be gathered from those faculty developers who entered this career field in the 1970's and 1980's and are now nearing retirement. Hitchcock (2002) and his colleagues have done one such inquiry with the "Exemplars" in academic medicine that presented the career wisdom of selected individuals identified as Exemplars. Their collective wisdom was presented at the Central Group on Educational Affairs (CGEA) conference in 2001 by the researcher and authors who were involved in the study and has been published in installments in

Advances in Health Sciences Education from 2002 to the present. Similar inquiries that document the contributions of professional educators in medicine need to be done under the guidance of a professional organization in order to gather this wisdom from senior medical faculty developers before they retire. Such findings should be disseminated in a broad fashion to benefit current educators who can learn from experienced educators.

Professional organizations may want to develop and implement a formal plan for recruiting, training and sustaining competent education professionals in medical faculty development. A planned, visible approach could encourage new professionals to establish long-lasting careers and support current faculty developers as they establish their vitality. In essence, what faculty developers do for medical faculty needs to be done for the faculty developers themselves. For example, STFM currently sponsors a mentoring program for new academic physicians every year; perhaps a mentor program for *new medical faculty developers* could be offered. Within a formal mentor program, senior faculty developers can share knowledge and insights for junior faculty developers that can strengthen this career field.

A professional group of medical faculty developers may want to explore the existing training materials and orientations for medical faculty development. This group could then develop a Handbook for Medical Faculty Development detailing necessary competencies and knowledge, and the unique qualities of working in the medical environment, similar to The Handbook for New Practitioners put forth by the Professional and Organizational Development Network in Higher Education (POD).

Recommendations for Institutions

Institutions may want to examine closely how faculty developers are oriented to medicine and trained for their positions. In his work, Van Maanen (1978) came to the conclusion that socialization is too important to be left to "inertia" and requires "thoughtful action" (p. 36). Some institutions may decide it is valuable to develop concrete job descriptions, faculty development handbooks, and perhaps a formal orientation program to ensure that new hires are acclimated to the medical culture and understand their responsibilities.

Institutions may also want to provide opportunities for their educators to engage in professional development and networking activities. The medical faculty developers in this study indicated that regional and national conferences provided opportunities for mentoring, networking, and learning. These activities continue to socialize educators to their positions in medicine and promote role continuance.

Recommendations for Individuals

The educators' stories of entry into medical faculty development could be of interest to graduate students considering a career in medical faculty development or medical education. Current medical faculty developers also might find some confirmatory data from the stories of entry presented in this study.

Individuals working in medicine may also learn from the discussion of the socialization strategies used by the medical faculty developers in this study. For example, discussions with some of the senior faculty developers highlighted the

importance of developing support networks. Individual educators can do this by keeping in contact with their professional discipline and by actively participating in regional and national organizations for those in medical education.

This study also highlighted the importance of other education professionals in medicine as mentors. Junior and mid-career faculty developers could actively seek out mentors and advisors from the contacts they make in professional associations and within their institutions. Quite often the mentors were senior educators already in the medical field but other times they were educators at another medical institution or other professionals and physicians who had insights to share with the faculty developers. Senior faculty developers may want to make themselves more available to newer educators in medicine as a result of seeing the importance of mentors in the growth of individuals and the field as a whole. Tierney and Rhoads (1993) noted that the senior academic faulty in their study took on mentoring roles that included "the symbolic leader, the trail guide, or the oral historian" (p. 53). Further research is needed to explore whether or not senior educators in medical education fill the same mentoring roles that Tierney and Rhoads documented for academic faculty.

Support for Faculty Development

The support that educators in medical faculty development encountered from the physicians and colleagues in their department, their institutions, and from professional organizations played a critical role in their career vitality.

Recommendations for Professional Organizations

The most critical area of support that professional organizations can impact is funding. As previously documented, the Title VII funds which support many medical faculty development programs may not continue or may be diverted elsewhere. Professional organizations within family medicine should continue to work as a collective unit to lobby for the continuation of Title VII funding that enhances the quality of teaching within family medicine and ultimately may provide better care for their patients. Historically, faculty development has improved the quality of teaching and was integral in the growth of family medicine (Bland et al, 1997). If Title VII funding continues, professional organizations may wish to extend the historical efforts of faculty development and continue to use it as one of the mechanisms to reach its goals.

Professional groups and organizations can also work together to seek other sources of funding. They may also provide training to educators in medicine about how to find and apply to these other funding sources. Additionally, professional development conferences sponsored by professional organizations can provide opportunities for networking, the creative sharing of ideas, and career support and renewal.

Recommendations for Institutions

This study suggests that faculty developers who have other education colleagues to work with are more satisfied with their careers and remain in the field. Faculty developers who worked in isolation commented about the stress of being the only educator among scientists and physicians. They often had to seek feedback and support from outside their institution. Therefore, institutional leaders should think carefully

about where to "house" faculty developers so that they will have the greatest chance for success by reaching the most faculty and advancing the mission of the institution. This study draws no conclusions as to the best location for medical faculty development programs but does note that the interview participants in this study were housed in Family Medicine departments, in a central office such as the dean's office or an office for educational support services, or in a residency clinic. No specific concerns were raised about any of these locations; however location needs to be considered so that faculty developers can be situated in an environment that is most likely to foster success and match the mission of the department or institution.

Other institutional factors of support mentioned by the respondents included providing faculty appointments within the medical college to faculty developers, institutional funds to support their work, and opportunities for advancement within the college. Institutions could examine if they provide these factors and consider enhancing the appointments, funding, and advancement opportunities for the medical faculty developers within their institutions to provide support for their career vitality.

Recommendations for Individuals

Individual educators in medical faculty development could use the factors of vitality discussed in Chapter 7 to assess the support provided by the institution at which they work, along with assessing their own personal qualities, knowledge base, and skills. Evidence of institutional support mentioned in this study included providing faculty appointments within the medical college for educators, secure funding, and support for faculty development and educational principles from the department chair or dean.

The educators in this study found initial success by seeking out physician faculty who were receptive to the insights of a professional educator. Quite often, these endeavors began within the family medicine department. As faculty developers found success, they often expanded their roles and served other areas of the medical school. Some also worked with other faculty development programs within the larger institution (i.e. university). This suggests that the location within the medical college of the faculty developer could be important and that individual faculty developers should be aware of who their constituents are and consider who they might reach out to in the future to expand their faculty development efforts.

Professional Responsibilities

Professional organizations, institutions and individual educators may want to consider a number of recommendations that I have placed under the general heading of "professional responsibilities." Some of the responsibilities include role development, research and publications, securing funding, and documentation of outcomes.

Recommendations for Professional Organizations

The medical faculty development profession needs to encourage its members to do more research about their work and to disseminate their knowledge to be shared among all faculty developers in medical education. Public sharing of knowledge and programs will demonstrate the value of faculty development in medicine and strengthen its position. In addition, faculty developers as a group need to continue to work on helping academic physicians legitimize their teaching roles. They must continue to look for other

areas that can benefit from the educational expertise of a faculty developer and other constituents who can benefit from their knowledge. These strategies may continue to demonstrate the value of faculty developers and stimulate an interest in faculty development within medicine.

The faculty developers in this study raised many concerns about the funding of their positions and programs. They expressed concern over the lack of institutional funds and the reliance on one source, the Bureau of Health Professions' Title VII, for the majority of the grant funding. Some of the ideas mentioned previously may stimulate and increase the commitment of institutional funds; however, other sources of grant funding need to be sought out by the profession. Faculty developers should seek out positions of leadership within medical organizations and within other educational organizations in order to expand the name recognition of medical faculty development and demonstrate the commitment of its professionals.

This study may also raise the question of whether this is the time to consider ways to establish medical faculty development as a profession. Presently medical faculty development does not meet the formal definition of a profession, but medical faculty developers might ask whether professional organizations such as STFM's Group of Faculty Development or Generalists in Medical Education should work to "professionalize" this field? If so, to what extent does it already meet the definition of a profession? According to the literature, a profession is defined by five criteria: 1) a systematic body of theory, 2) regard by the general public as having professional authority over the knowledge and skills in that field, 3) sanction of the community – individuals use the title only with appropriate training, 4) a code of ethics to regulate

behavior, and 5) a professional culture (language, symbols, norms) of its own (Auster, 1996). Others also note that a profession has required training, a collegial discipline, a base of specialized knowledge, and a service, rather than a profit, orientation enshrined in its code of ethics (McGuire, 1993).

The "professionalization" of medical faculty development could lead to some challenges as well as successes. One challenge is the potential risk of developing "red-tape" and creating a difficult system of professional standards to navigate. A benefit of professional standards could be the increase of professional competencies and knowledge for the collective group of medical faculty developers. Certification standards may increase the status of faculty developers within medicine. Funds collected for certification and continuing education seminars could be returned to the profession to lobby for government funds or could be used to finance a new source of funding directly from the professional organizations.

Professional organizations may want to lead a discussion on this topic and consider some of the following questions: What benefits might accompany the professionalization of medical faculty development? What are the drawbacks? If professionalized, would the "red-tape" of required training and other standards get in the way of opportunities for positive work? Could the number of faculty developers involved be increased by collaboration with professional organizations within other areas of health and medicine such as nursing, veterinary medicine, or pharmacy that use faculty developers?

Recommendations for Institutions

Institutions may also impact the professional responsibilities of medical faculty developers. The work and roles of the faculty developers described in this study indicated that they did more than just run faculty development fellowships. The majority of the medical faculty developers in this study expanded their roles in order to provide essential expertise in curriculum design, program and learner evaluation, and departmental research.

This study points towards characteristics of medical faculty developers who are successful working in medical education. The individual factors of vitality could be used as partial guidelines for hiring educators to work with the faculty and programs. This study suggested that a solid background in educational theory and principles, and previous experience in education or medicine were indicators of success. Institutions may also want to seek out educators who have previously demonstrated the Generalist skills of multi-tasking, self-motivation and a desire for continuing education. Flexibility and the ability to understand and work within the medical culture were also highly ranked. Further studies on the characteristics, work habits, and personalities of those faculty developers who possessed this "ability to work within the medical culture" could be done in order to better understand and recognize this ability.

Institutions may also want to provide time, guidance and incentives for their educators to publish about their work and education programs in addition to other scholarly research. Institutional leaders may consider these questions: Would the professionalization of medical faculty development help or hinder their organization? Would professional standards help institutions hire competent educators? Would the

expense of trainings, certifications and professional memberships be too costly for their institution or would the benefits of the trainings and memberships be worth the expense? These are some of the questions institutional leaders may ask themselves in order to determine the extent that they would support the professionalization of educators in medical faculty development.

Recommendations for Individuals

Individuals may assemble a number of suggestions about their professional responsibilities from this study. The three faculty development roles identified in this study might prompt medical faculty developers to think about what roles they currently play and perhaps encourage them to consider other roles that may enhance their career vitality. Data from this study points to the need for faculty developers to assume and establish at least two roles in their institutions in order to have vital careers. It appears that facilitating individual development, although their main responsibility, must be coupled with the strong leadership skills of an Educational Expert or the multitasking and trouble-shooting of a Generalist. The twelve faculty developers in this study met the definition of career vitality and all performed multiple roles within their institutions. Further research is needed to explore these roles and the possible implications mentioned here.

This study also implies that educators in medicine are responsible for developing their own vitality and asking institutions to provide support. They need to seek out opportunities for collaboration and integration within the larger system of the department or medical college. Educators can no longer be isolated or confined to just running a faculty development fellowship; instead connections need to be made with other existing

education programs and personnel that need educational assistance across and between institutions.

The participants in this study also emphasized that it is essential that educators better document and show the results of their work in medical faculty development. The call for outcomes and evidence is critical for faculty development's growth in medicine and reflects trends in education and business organizations for documentation of time use and outcomes of work.

Through the exploration of the vitality of the faculty developers in this study, it could be inferred that educators need to produce more rigorous research and scholarly publications about their work. The field of education as a whole struggles over the issue of defining scholarship, so the concern about the practitioner nature of the medical faculty developers' scholarly work mirrors what is occurring in the field of education as a whole. The field of medicine demands an evidence-base for practice as well as for education. This is difficult to provide in education, as outcomes are often contextual and descriptive in nature. Thus, at times, educational theory comes under attack by the medical community. Colliver (2002) wrote a cautionary note for medical school faculty that highlights some of the problems with education theory. Ultimately, he makes the argument that "we know very little about how the brain works - - certainly nothing that would inform practice in medical education" (p. 1220). Colliver provides insight into the struggle that educators often face working in medicine because education cannot provide the same kind of "solid" evidence that is routinely scrutinized by physicians. Whitcomb (2002) also discussed the "marginal significance" and narrow scope of medical education research. He believes medical education lacks studies that provide evidence about the

effect of education programs on learners. At the national level, the academic community is challenged to take more responsibility for ensuring that medical education programs are producing doctors who are well prepared and providing high quality care. Standards of competency and desired outcomes are being developed and educators are developing curricula to reflect this outcomes approach.

Closely linked to documentation and outcomes is the issue of funding. Professional educators in medical faculty development also need to be concerned about locating monetary support for their programs and positions. Almost all the participants in this study faced pressures to secure funding for their positions and programs. Faculty developers need to consider sources of funding other than the Title VII monies from the Bureau of Health Professions (BrHP). It is clear that the funding from the BrHP for faculty development efforts will continue to be more difficult to obtain. Faculty developers also need to look for other sources of funding from *within* their institutions, from regional philanthropists and from national funding endowments. Indeed, educators in medical education doing faculty development may want to approach their institutions with documentation of their work and its value to request departmental/institutional funding for their programs.

Conclusion

In summary, recommendations were made in three areas for professional organizations, institutions and individuals. The first section discussed recommendations that these three groups can take regarding socialization opportunities and career strategies. The second section posited ideas regarding ways these three groups can

support faculty development in medicine. The third section provided recommendations and raised important questions about professional responsibilities for these three groups. These implications, recommendations and questions provide a starting point for discussions by these three groups, as well as other outside constituents, which may contribute to enhancing the future of educators in medical faculty development.

Further Research

This chapter closes with a discussion of future research. Because this was the first study on medical faculty developers, it was important to gather the initial descriptive data. Repeating the survey from this study may be worthwhile to do every few years in order to track changes in the number of professional educators in medical education and in the work they do. Future researchers may also want to expand the sample of faculty developers studied and expand upon the research methods used.

Expanding the Sample

The interview sample for this study was limited to twelve full-time faculty developers who had been in this career field for at least ten years and were drawn from a family medicine organization. Future research might select a different sub-set to sample (for example, non-physicians in internal medicine, administrative leaders within offices for faculty affairs or medical education, or faculty developers in other health professions such as nursing, pharmacy or veterinary medicine) that may yield different results. Further research could explore medical faculty developers at other stages of their careers -- for example, junior or mid-career faculty developers. Other research could also focus

on former faculty developers who did not stay in medical faculty development. That research might uncover organizational and individual factors that impacted why they did not persist in medical faculty development. This future research might also pinpoint needs and challenges at the institutional and professional levels. A study of the socialization and roles of junior faculty developers could explore factors leading to role continuance or role failure.

Expanding the Research Methods

Future research could explore the larger group of medical faculty developers beyond the initial demographics gathered in this descriptive study. This future research could be done in the form of comparisons, case studies with observations, as well as interviews with the faculty developers' learners, colleagues, deans and department chairs. Case studies and observation would examine "real time" data rather than relying upon senior faculty developers to provide retrospective information on their careers. An in-depth case study approach would go beyond the one-hour time commitment of my interviews possibly providing even more useful data. Richer data would allow greater exploration of the different types of learning that occur during socialization and could be linked to the work of Ostroff and Kozlowski (1992) and other researchers.

Other research methods may also be able to overcome some of the difficulties I faced, especially in regards to measuring scholarly productivity. Other qualitative methods could include the voices of administrative leaders in the faculty developers' institutions or their learners regarding the effectiveness of the medical faculty developers' work and productivity.

Concluding Thoughts

This study explored the careers and vitality of senior medical faculty developers in order to understand how they sustained their careers through a changing medical climate. In addition, my research contributes to the existing knowledge on socialization and provides new knowledge about the work roles of medical faculty developers. The majority of the study focused on defining and exploring the vitality of these education professionals. The participants in this study highlighted individual characteristics and cultural/organizational factors that assist and challenge their professional growth.

The future of medical faculty development is unclear at this time. The funding of many faculty development programs is being driven by outside constituents. However, there seems to be a growing need for faculty developers to help incorporate the ACGME competencies into the graduate medical education curricula, teaching and evaluation. It is my hope that this study provides support for the work of educators in medical faculty development that can be used by these outside constituents and that it provides important information for individual educators to use for sustaining their careers in medical faculty development.

APPENDICES

APPENDIX A

SURVEY OF NON-PHYSICIANS OF STFM

Dear STFM member:

You have received this survey because you are listed as a non-physician member of the Society of Teachers of Family Medicine (STFM). I am also an STFM member and a doctoral candidate at Michigan State University. I am asking that you complete the enclosed survey as part of my dissertation study. This survey should take no more than fifteen minutes to complete.

This survey will investigate the work of non-physicians in medical education (e.g. curriculum development, faculty development, evaluation). Semi-structured interviews will further explore non-physicians' roles and their vitality in medical education. STFM has had a longstanding involvement and commitment to faculty development and your survey responses are important for assessing the roles of non-physicians in medical education and selecting diverse interview candidates.

You indicate your voluntary agreement to participate in this research project by returning the survey and of course, you are free to skip any question that you prefer not to answer. Your individual responses will remain confidential. Responses will be reported in aggregate form wherever possible and all identifiers will be removed or changed to protect your privacy to the maximum extent allowable by law. There is no compensation for participation in this study. You may be contacted to participate in the interview portion of this study.

Please return your survey by November 15, 2001 in the enclosed postage-paid envelope.

If you have any questions about your participation in this study or if you would like to receive the survey via an e-mail attachment, please contact me at shannon2@pilot.msu.edu or (248) ***-****.
I would appreciate your response by 11-15-01 and thank you for your interest.

Sincerely,

Maureen Shannon, M.A.
Doctoral Candidate
Department of Higher, Adult and Lifelong Learning
Michigan State University

Please note, the focus of this study is on non-physicians with experience in medical education (including curriculum development, faculty development and evaluation).
If you are 1) a non-physician without medical education experience or 2) a physician, you have received this survey in error. Please return your uncompleted survey in the postage paid envelope to avoid follow-up mailings. Thank you.

DIRECTIONS: Please fill in the blank or place an [X] on the box before the answer that best matches your response. Unless otherwise noted, please check only one response per question. This survey should take no more than 15 minutes to complete. Please return your survey by November 15, 2001 in the enclosed envelope.

1. Please indicate your gender:

   ❑ Male
   ❑ Female

2. Please indicate your current age range:

   ❑ 20-34
   ❑ 35-44
   ❑ 45-54
   ❑ 55-64
   ❑ 65 or older

3. Please indicate ALL completed academic degrees (specify major/field of study for each degree):

   ❑ Associate's in _____
   ❑ Bachelor's in _____
   ❑ Master's in _____
   ❑ Doctorate in _____
   ❑ Other _____

4. Please indicate any academic programs in progress:

Program	Anticipated Degree	expected completion date

5. Please indicate your primary work setting:

   ❑ Not currently employed in medical education (**SKIP TO QUESTION 13**)
   ❑University or Medical College (specify department) _____
   ❑ Hospital or Residency Program
   ❑ Private Corporation (other than hospital or medical center)
   ❑ Foundation
   ❑ Other (please specify) _____

6. Please list your current job title(s) including any faculty rank:

   _____

   _____

7. How many years have you been working in your current position? _____

8. How many years have you been working in medical education? _____

9. Please indicate how your current position is funded (**check all that apply**):

   ❑ Institutional or departmental funds
   ❑ External grants
   ❑ Other: _____

10. On average, how many hours do you work per week?

    ❑ < 20 hours
    ❑ 20-29 hours
    ❑ 30 –39 hours
    ❑ 40-54 hours
    ❑ >55 hours

11. Considering your typical month, please indicate the percentage of your time devoted to the following activities (time should add up to 100%):

    _____% Administration (i.e. meetings, paperwork, supervision)
    _____% Faculty Development (i.e. workshops, 1:1 faculty consultation)
    _____% Curriculum Development
    _____% Grant Writing
    _____% Research and Publication
    _____% Classroom Teaching (for university credit hours)
    _____% Clinical Teaching
    _____% Service/Outreach to institution, profession, community
    _____% Student Advising
    _____% Other: _____
    _____% Other: _____
    100%

12. Please indicate how many more years you intend to work in medical education:

    ❑ < 5 years
    ❑ 6-10 years
    ❑ 11-20 years
    ❑ 21-30 years
    ❑ More than 30 years
    ❑ Unsure

13. What have you liked best about working in medical education?

_____

_____

_____

_____

_____

14. What has been the most difficult part about working in medical education?

_____

_____

_____

_____

_____

15. How satisfied are you with your medical education career choice? (please check one)

o Very satisfied
o Satisfied
o Neutral
o Unsatisfied
o Very unsatisfied

16. In your opinion, what are the significant factors that contribute to the success of non-physicians in medical education? (please describe)

_____

_____

_____

_____

_____

THANK YOU FOR COMPLETING THIS SURVEY.
You may be contacted to participate in the interview portion of this study.
You can request an electronic version of this survey at shannon2@pilot.msu.edu

RETURN BY 11-15-01 TO: Maureen Shannon [insert return address]

Concerns about your rights as a participant may be directed to my doctoral advisor, Ann E. Austin, PhD, at (517) 355-6757 or to David Wright, PhD, Chair of the University Committee on Research Involving Human Subjects at (517) 355-2180. UCRIHS approval for this project expires on October 5, 2002.

APPENDIX B

LETTER TO NON-RESPONDENTS OF SURVEY

[insert return address]
September 15, 2001

Dear STFM Member:

Three weeks ago I sent you a survey and requested your assistance in my dissertation research regarding the experiences of non-physicians working in medical education. If you have already completed and returned the survey, thank you very much for your participation. If you have not completed the survey yet, I ask that you take fifteen minutes to complete it and return it to me today. If you need another copy of the survey, please contact me at shannon2@pilot.msu.edu or 248-***-****.

I want to reassure you again that your individual responses will remain confidential. Responses will be reported in aggregate form whenever possible and all identifiers will be removed or changed to protect your identity. Your privacy will be protected to the maximum extent allowable by law. This research project is being conducted for the purposes of a dissertation. There is no compensation for participation in this study.

Thank you again for your interest in this research study. Please return your completed survey by November 1, 2001.

Sincerely,

Maureen Shannon, M.A.
Doctoral Candidate – Department of Higher, Adult and Lifelong Education
Michigan State University
East Lansing, Michigan

APPENDIX C

INTERVIEW INVITATION

Dear :

A few months ago you completed a survey regarding your faculty development work as a part of my dissertation study. I am pleased to report a 73% response rate to the survey! Using predetermined criteria, the pool for potential interview candidates was narrowed and interview candidates were randomly selected. Additional criteria were then used to insure that the 20 candidates represented the general population of those faculty developers who completed the survey.

I am writing to you today to invite you to participate in the interview portion of this study. The audiotaped interview will be completed over the phone at a mutually convenient time and should take approximately one hour. The interview consists of open-ended questions that will ask you to reflect back on your entry into medical education, discuss how your current faculty development role has evolved and share how you remain motivated and vital to the profession. I am hoping to begin interviewing by the end of February and to be completed by the beginning of April.

Please take a moment to consider this invitation and then respond to this e-mail with an accept or decline. If I do not hear from you by February 20th I will call your office to inquire about your interest. If you accept, we will select a mutually agreeable time for the interview and a confirmation letter and consent form will be sent by US mail. You will also be asked to submit your curriculum vita. I want to assure you that your identity will remain confidential. In reporting results, I will use pseudonyms and change other descriptions so that you cannot be identified.

Thank you again for completing the survey. I hope you will consider participating in the interview portion of this study regarding the socialization and professional identity of non-physician faculty developers who remain vital to primary care medical education. I look forward to your response.

Sincerely,

Maureen Shannon, M.A.
Doctoral Candidate – Michigan State University
Department of Educational Administration
shannon2@pilot.msu.edu
(248)***-****

APPENDIX D

CONFIRMATION LETTER TO INTERVIEW PARTICIPANTS

[insert return address]

[insert name and address]

Dear **[insert name]:**

Thank you for agreeing to participate in the interview portion of my dissertation study entitled Work, Socialization and Professional Identity: How Non-Physician Faculty Developers Remain Vital to Primary Care Medical Education. Your telephone interview is scheduled for **[insert date and time]**. The interview will take approximately one hour and will provide an opportunity for you to discuss your medical education work, how you learned your role and how you maintain your productivity.

Please review the enclosed consent form and contact me if you have any questions at shannon2@pilot.msu.edu or (248) ***-****. The signed consent form and your C.V. should be returned to me in the enclosed envelope by **[insert due date].**

Thank you again for your interest in my study. I am looking forward to talking with you on **[insert interview date].**

Sincerely,

Maureen Shannon, M.A.
Doctoral Candidate – Department of Higher, Adult and Lifelong Education
Michigan State University

APPENDIX E

INTERVIEW PARTICIPANT CONSENT FORM

Title: Work, Socialization and Professional Identity: How Non-Physician Faculty Developers Remain Vital to Primary Care Medical Education

Researcher: Maureen Shannon, M.A.

Doctoral Advisor: Ann E. Austin, Ph.D.

You understand that the research project in which you are agreeing to participate is a dissertation study on the socialization and work of non-physicians in medical education. It will invite you to discuss your work, how you learned your roles and how you maintain your productivity and vitality.

You will be interviewed for approximately 1 hour. The interviews can take place either in person or over the telephone. During the interview you will have the opportunity to reflect on previous socialization experiences and current work experiences. Interviews will be audiotaped with your permission. Audiotapes will be destroyed after transcription and confirmation of accuracy.

You further understand that the researcher will hold your responses in strict confidence, and that no comments will be attributed to you in any report on this study. Only the researcher will be aware of your identity. Names and identifiers will be removed or changed for your protection and responses will be reported in aggregate form whenever possible. Your privacy will be protected to the maximum extent allowable by law.

This research project is being conducted for the purposes of a dissertation. The research findings may also be included in an article submitted to a national journal for publication. There is no compensation for participation in this study.

Rights as a Research Subject: If you have any questions, now or in the future, about your participation in the study or the uses to which the results will be put, please contact Maureen Shannon at (248) ***-**** or Ann Austin, Ph.D. at (517) 355-6757. You may withdraw your consent and discontinue your participation at anytime by contacting Maureen Shannon. If you have any questions about your rights as a research subject please contact Ashir Kumar, Ph.D., Chair of the University Committee on Research Involving Human Subjects at (517) 355-2180.

By signing this form, you give consent to take part in this study. Your participation is voluntary, and you can withdraw participation in this study at any time. You have received a copy of this consent form for your records.

_____

Participant's Printed Name

_____ _____

Participant's Signature Date

Please check one statement below:

_____ You give consent for the interview(s) to be audio taped. At any time, you may ask that the tape recorder be stopped.

_____ You do not give consent for the interview(s) to be audio taped.

_____ _____

Principal Investigator's Signature Date

Please return with your C.V. at least one week prior to your interview appointment to: Maureen Shannon
[insert return address]

UCRIHS approval for this project expires: October 5, 2002

APPENDIX F

INTERVIEW PROTOCOL

(NOTE: The questions below indicate the basic interview protocol. Because they are open-ended questions, it is possible that the conversation will evolve within the general domain of these questions. ■ = possible probes)

NAME _____
PHONE NUMBER _____
DATE & TIME _____
INTERVIEW TALK TIME _____

Thank you for agreeing to participate in this study. The purpose of this study is to explore how faculty development roles are established in medical education and how faculty developers maintain their vitality in the profession. In particular, I will be asking how you learned about the culture of medicine, how your professional role has developed, barriers and supports that affect your work, and how you maintain your productivity and vitality in the profession.

I'd like to remind you of the details of the consent form. Your identity will remain confidential. I will use pseudonyms and change other descriptions so that you cannot be identified. The audiotape of this interview will be erased after it has been transcribed. You may ask to have the tape recorder stopped at any time during the interview. The interview should take approximately one hour.

DISCUSS PROTOCOL USE
Do you have any questions before I begin taping?
Let me start the tape... I'll begin by asking you to tell me a little bit about your current position...

1) Describe your typical responsibilities as _____ at _____. ▪ How much autonomy do you have in 1) deciding what to work on 2) deciding how to accomplish a task? ▪ How do you prioritize these responsibilities?	
2) Describe your entry into medical education. ▪ How and when did you enter faculty development in medical education? ▪ What sort of orientation did you receive to your various position(s) in medical education? ▪ Did you encounter any difficulties initially negotiating the medical culture? ▪ At what point did you recognize medical education as your career?	

3) How do you define your faculty development role (what does it mean to you)? ▪ What knowledge or skills do you use most often to enact this role successfully? *4) Please comment on who or what has shaped your understanding of your role?* - What were some of the major factors that influenced your career path and your decision to stay in medical education? ▪ Education and Training ▪ Previous Experiences ▪ Supervisors ▪ Coworkers and Physicians ▪ Organizational factors ▪ Mentors ▪ National Colleagues and Associations ▪ Observation ▪ Experimentation ▪ Training Manuals ▪ Readings/Books/Articles ▪ Life-situations such as finances, spouse, etc. Was there ever a time when your role was confusing or unclear? Describe * How does your role fit into the culture and mission of your organization(s)? * Are you still developing in your professional role? What is responsible for that?	
4) What do you find as most rewarding about your faculty development work? 5) What do you find most challenging about your faculty development work? ** Some of those who completed the survey commented on working in isolation; others about not having colleagues in their own discipline. Ave either of these ever been factors for you?	

6) You have been working in medical education for _____ years; to what to do you attribute your longevity in medical education to? ▪ What keeps you motivated in your work? ▪ Your CV shows that _____ what has helped or hindered your scholarly productivity? ▪ What does it take to be successful in medical education? ▪ The survey indicated that the supportiveness of one's work environment is one of the factors that affect success in medical education. What are your thoughts on this? ▪ Some respondents to the survey mentioned the importance of recognizing that you are a "guest" in someone else's home; what is your reaction to this concept?	
7) In what way do you feel your career or work situation is unique from other faculty developers? 8) What is the future of faculty development in medical education? ▪ How will the faculty developer's role change? ▪ What could be done to strengthen faculty development in medical education? ▪ What concerns do you have about the future of the profession?	
9) Is there anything else you would like to add about your work in medical education?	
Thank you very much for participating in this study. What is the best number to reach you at if I need to clarify anything we've discussed today?	

APPENDIX G

INTERVIEW FOLLOW-UP E-MAIL QUESTIONS

Please take a few moments to respond to the following questions. You may reply via e-mail attachment, US mail or fax ASAP. Your responses will remain confidential and you may skip any question you prefer not to answer. Thank you again for your time – you should be able to complete this in less than 10 minutes.

1) Reflecting on your FACULTY DEVELOPMENT WORK, please indicate the **percentage of time** you are involved in the following over a typical year (take the average between a grant renewal year and a non-renewal year). Scan all items first in order to select the best response (some overlap was unavoidable). Leave the line blank if you have no percentage of time in a category. Percentages should add up to 100%

TEACHING and LEARNING
_____ Consulting with faculty regarding their professional development/ academic career
_____ Facilitating or organizing faculty development workshops for faculty or attendings
_____ Facilitating or organizing workshops for residents, interns, or students regarding education or research issues
_____ Teaching a classroom course with university credit attached

ORGANIZATION
_____ Instructional design (alone or in committee)
_____ Organizational development (strategic planning, staff development, etc)

RESEARCH
_____ Assisting faculty with their research
_____ Doing your own research and writing

EVALUATION
_____ Observing formal teaching (classroom or hospital/clinic) and providing feedback
_____ Observing clinical teaching and providing feedback
_____ Program/course/site evaluations
_____ Learner evaluation

ADMINISTRATION and SERVICE
_____ Grant Writing
_____ Administration of faculty development programs (grants, budget, personnel, paperwork)
_____ Department/Program meetings essential to work
_____ Committee meetings (local/institution) outside of department work
_____ Regional or National committee work
_____ Own professional development (conferences, classes, reading)

_____ Other: _____
_____ Other professional responsibilities not related to faculty development
100% TOTAL

2) Rate the following sources of feedback about your faculty development work to indicate how often you rely on them to influence your work?

Number sources using the following scale:

0= do not rely on or do not receive
1= rely on very little/ have little influence
2= rely on/have some influence
3= rely on most often/ is a primary source of feedback

_____ Informal feedback from colleagues in faculty development (local or nationally)
_____ Informal feedback from other faculty or colleagues in institution
_____ Formal feedback from Department Chair or Supervisor
_____ Formal feedback from colleagues (peer review)
_____ Feedback from your learners
_____ Feedback from editors or peers regarding research, presentation or publication submissions
_____ Feedback from grant funding agencies
_____ Self-reflection and personal goal setting standards
_____ Formal recognition by institution, memberships or society (honors or awards)
_____ Other: _____
_____ Other: _____
_____ Other: _____

3) Which of the following helped you learn your faculty development role?

X all that apply

_____ Formal orientation to role and work by your institution
_____ Formal education or training prior to role
_____ Continuing education while in faculty development position (conferences/classes)
_____ Previous work experience in education or medicine
_____ Previous work experience in areas outside of education or medicine
_____ Supervisor
_____ Coworker in department:
____ in faculty development role ____ in other roles within department
_____ Mentor (other than above)
____ in institution ____ regionally/ nationally

_____ Department/institution handbook or job description
_____ Observation of other colleagues doing their work in a similar position
_____ Trial and error or trial and success ☺
_____ Seeking answers and ideas from the published literature

_____ Other: _____
_____ Other: _____

4) What has kept you working in faculty development and/or medical education?

X all that have had a significant influence

AND

Circle or * * the three that have had the most impact

_____ Ability to impact society
_____ Collegial relationships at institution
_____ Collegial relationships regionally or nationally
_____ Contact with medical students and residents
_____ Feeling that it is too late in career to change field or area of work
_____ Feeling that it is too much effort to leave medical education
_____ Financial rewards that come with the position
_____ Flexible schedule/ hours - autonomy of work
_____ Institutional factors (such as a supportive dean, stable finances, etc)
_____ Interest in medicine
_____ Job satisfaction – you like the work tasks
_____ Manageable workload
_____ National recognition by colleagues
_____ Opportunities to do research and scholarly work
_____ Opportunity to use the content-area in which you were trained
_____ Personal situations (such as spouse's career, stability for children, job location, life events)

_____ Other: _____
_____ Other: _____

Thank you for your responses. I appreciate your continued involvement in this study.

Return ASAP to:
shannon2@msu.edu
OR
Maureen Shannon
[insert return address]
OR
Fax to 248-***-****

APPENDIX H

DEMOGRAPHICS OF SURVEY RESPONDENTS WITH 20% TIME SPENT IN FACULTY DEVELOPMENT (N=91)

Gender	Age	Highest Degree	Discipline of Highest Degree	Percentage of Time Spent
Male 33	20-34 yrs. 5	Bachelor's degree 3	Education 30	Faculty Development Mean: 30.3% Mode: 20% Range: 20–80%
Female 58	35-44 yrs. 13	Master's degree 25	Psychology/Ed. Psych. Counseling 30	
	45-54 yrs. 43	Education Specialist degree 1	Sociology/ Anthropology 6	Curriculum Development Mean: 14% Mode: 20%
	55-64 yrs. 28	Doctorate degree 62	Social Work 6	
	65+ yrs. 2		Public Health 5	Classroom Teaching and/or Student Advising Mean: 6% Mode: 0%
			Curriculum Design 4	
			Others 10	

Primary Employer	Funding Source	Areas of Responsibility Note: Total exceeds 91 because some respondents had more than one area	Faculty Rank
University or Medical College 62	Institutional Funding 37	Faculty Development 35	Professor 12
Hospital/Clinic 21	Grant Funding 10	Research 10	Associate Professor 13
Foundation or Corporation 7	Combination of Institutional and Grant Funding 41	Behavior Science 10	Assistant Professor 24
Retired 1	Other 2	Graduate Education 7	Other (clinical faculty, educator, instructor) 14
	Retired 1	Medical Student Education 6	No Faculty Rank Indicated 28
		Academic Affairs/ Faculty Affairs 4	
		Other Programs 11	

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