Continuing Professional Development for Faculty: An Elephant in the House of Academic Medicine or the Key to Future Success?

David A. Davis, MD, William F. Rayburn, MD, MBA, and Gary A. Smith, PhD

Abstract

The scope of change required by academic medical centers (AMCs) to maintain their viability and achieve their tripartite mission in the future is large; such reform is affected by numerous global, national, and local forces. Most AMCs focus their transformational efforts on organizational infrastructure (e.g., undertaking payment reform, developing new organizational structures, investing in information technology) and educational programs (with subsequent changes in undergraduate and graduate medical education curricula). Although useful, these efforts have failed to produce the kind of change required for AMCs to succeed in the future.

The authors of this Invited Commentary describe a key element missing from most of these reform efforts—the preparation of faculty for new models of health care and educational practice. To address this issue, they call for the effective, system-aligned presence of continuing professional development (CPD) programs. CPD combines continuing medical education, with its focus on content knowledge, and faculty development, with its focus on evidence-based learning methodologies, across the institution to produce a more robust, system- and outcomes-oriented program to facilitate both individual and organizational learning. If sufficiently supported, CPD programs can provide a platform for the human changes necessary to ensure the smooth transition of AMCs to new models of education, clinical research, and ultimately patient care.

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he future—perhaps in some instances even the existence—of the academic medical center (AMC) occupies our attention on a daily basis. Such considerations include questions about the AMC’s tripartite role in the training of health professionals for the future, in the generation of research discoveries, and in the provision of health care for patients. Success in these endeavors depends on the effective transition of the AMC from its current state to a better-defined but yet-to-be-realized future state. An obvious but frequently neglected mechanism exists to facilitate this transition to a more contemporary, seamless, and effective organization. In this Commentary, we explore the union of continuing medical education (CME) and faculty development to enable this transition to the AMC of the future. After all, learning is at the core of all improvement and change.

Imagining the Future

It is relatively easy to envisage, or perhaps outline, the future of the AMC. The Institute of Medicine report on the learning health care system, reports from the Association of American Medical Colleges (AAMC) and others on the future of the clinical academic world, and the Macy Foundation’s efforts in decreasing federal funding, new research and providers, teamwork); and outcomes (patient, system, and business metrics).5

Although this vision may be relatively clear, it is more difficult to see the forces that will shape it. These forces, frequent subjects of commentaries such as this one and board room discussions, are numerous—hospital and health system accreditation, payment reform, value-based purchasing, reform rebound, brand competition and breakdown, organizational misalignment, and comparative data. Given the academic nature of the AMC enterprise, the educational and research arms of the system are similarly buffeted by new forces and drivers. In education, they include physician recertification; imperatives and competencies from the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education; competency-based learning and assessment; fuller implementation of evidence-based teaching and learning practices; and interprofessional education.6,7 Similarly, the research enterprise is shaped by improving federal funding, new research models, and a perceived misalignment of training with current practice needs.8 Regardless of the forces, AMCs require significant reforms to meet future needs. Many have started this process with results that range from being highly successful (even if confined to one mission area) to frankly disappointing. In the next section, we discuss the reasons for this uneven success.

Elephants in the AMC

Although changes to organizational and fiscal elements of the AMC contribute
to overall reform, calls for change often ignore or downplay what is arguably the most important element—its human face, in particular the faculty and staff. A lack of preparedness for clinical, educational, and even research changes on the part of nearly all faculty substantially limits any lasting reform. In something akin to magical thinking, AMC leaders seem to assume that both clinical and basic science faculty, residents, and fellows—bright, hardworking human elements in the AMC—will acquire new competencies and adopt new roles automatically or with minimal training or feedback.

We believe that this oversight represents a large “elephant in the room” in the house of academic medicine. Specifically in the educational arena, faculty members who would normally be called on to teach, role model, and assess newly defined and emerging topics are commonly themselves unskilled in the recognition, teaching, and assessment of these competencies. This inability may be most apparent in quality improvement and patient safety but is evident in other domains as well (e.g., information technology, end-of-life planning, interprofessional collaboration, and evidence-based teaching that focuses on active learning and self-directed learning).10 Overlapping with these issues are changes necessitated by clinical and research imperatives (including more team-based care, a population health focus, cost-conscious care, scholarship in health system improvement, and change implementation). These changes are similarly new phenomena in which most faculty and staff possess little formal knowledge and few skills.

In a typical business enterprise, these deficits would evoke a significant, system-wide operational and implementation response, the cornerstone of which would be human performance improvement and organizational learning. The concept of the learning organization came about more than 25 years ago and organizational shifts that are necessary in the management world to address the driving role that it could occupy in promoting organizational change.

Notably, existing approaches at AMCs focus on knowledge development and management rather than on developing personal mastery, teamwork, and double-loop learning, which are fundamental to the learning organization. Most AMCs appear reluctant to undertake the effort to become a learning organization, although most have two existing functions that could promote the individual and organizational learning and improvement that the future requires—CME and faculty development programs. However, neither entity has assumed or, in most instances, been provided the opportunity to assume the driving role that it could occupy in promoting organizational change.

Three issues have created this phenomenon. First, both CME and faculty development programs traditionally have relied heavily on one-time workshops and sessions, lecture-based updates, and training and conferences for which improvement metrics (e.g., learner progress, patient outcomes, or system alignment) are either rarely collected or underused when available. Second, CME is most often perceived by academic faculty as a function of their particular specialty societies and unrelated to their operational or functional work at the AMC. With exceptions, neither CME nor faculty development has focused to a significant extent on health system needs or care gaps (e.g., cost, quality, teamwork, improved teaching and learning models) or on more effective delivery models (e.g., regularly scheduled series or longitudinal programs that promise greater efficacy) to build and reinforce individual competencies and system effectiveness. Third, CME and faculty development programs are typically underresourced and isolated from each other and the AMC’s functional systems (e.g., quality improvement, safety reporting, learner assessment). This contrasts with more effective specialty-society-based CME.

In short, the current operating mode of CME and faculty development programs, although necessary and meeting accreditation requirements and the roles to which they traditionally have been assigned, is insufficient for these entities to be engines of change in their institutions.

Effective, System-Aligned Continuing Professional Development

To ensure the transition described above, we envisage a functional marriage between CME and faculty development programs to create the model increasingly termed continuing professional development (CPD). CPD has been defined by the World Federation of Medical Education as including “all activities that doctors [health professionals] undertake, formally and informally, to maintain, update, develop, and enhance their knowledge, skills, and attitudes in response to the needs of their patients.”11 Although useful, this definition does not embrace the professional development of other academic staff or address the educational and research elements of the AMC’s tripartite mission. Therefore, to acknowledge the union of CME and faculty development beneath the CPD umbrella, we recommend expanding the definition by adding “and to meet their roles as providers, teachers, and scholars and to develop the AMC as a learning organization.”

With this AMC-based definition of CPD, we must consider the different missions and functions of each professional development entity that would benefit from closer engagement to support the future AMC. CME programs generally exist within specialties or with a focus on the alignment of systems across specialties. They build on participants’ existing expert knowledge to increase competency in medical practice. In other words, CME programs excel at knowledge dissemination and systems thinking, which are critical to the learning health care system. Faculty development programs, on the other hand, teach the learning and cognitive sciences that participants generally lack so they can better teach their specialty. In addition, faculty development programs focus on the learning processes rather than knowledge dissemination and increasingly are moving away from formal programming and into supporting informal learning, workplace learning, and communities of practice, which are essential to learning organizations.14,15
In the changing world of medical education, faculty development professionals can no longer assume that medical educators already know the content they are meant to teach and only need professional development to learn how to better teach that content. Even relatively young faculty members likely did not learn about milestones, entrustable professional activities, quality improvement, patient safety, or interprofessional education during their own training. Competency-based and systems-based education require that faculty possess both content knowledge, which is the strength of CME, and educational-methods knowledge and workplace learning, which is within the realm of faculty development.

CPD also needs to be placed within a 21st-century model of learning, which grounds the development of individuals within the learning culture of the entire organization and incorporates evidence-based and workplace-based approaches beyond traditional formal programs. Despite the prominence of formal offerings in CME and faculty development, most learning that leads to behavior change that results in improved patient and learner outcomes occurs in the workplace. Therefore, CPD programs need to be integrated with learning organizations that foster clinical audits; coaching and feedback to engage deliberate practice; communities of practice; and spaced, just-in-time learning. Evidence-based and workplace-based approaches to CPD will require several elements: (1) support from school, hospital, and health system leadership, with the alignment of organizational goals, like that of a CLO; (2) further integration of the education enterprise with the research and clinical enterprises; (3) alignment with other policies (accountability requirements, reimbursement); (4) resource commitment (funding and time protection) from the AMC or health system; and (5) attention to the relationship between practice data, learning needs, and outcomes of learners and patients. Perhaps most important, it will require significant reform and combined efforts of both CME and faculty development programs. For example, the refinement or alignment of the skills and knowledge acquired in specialty-society-generated CME programs to adapt clinical learning to the functional and operational setting of the AMC, using evidence-based learning methodologies derived from the expertise of faculty development professionals, may be required. Once accomplished, and in concert with other AMC changes, we believe that the adoption of a coherent and effective CPD model will facilitate the transition of current AMCs to a more robust and patient-centered model for the future, rather than be an elephant in the room.

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References


