CFAS Connects: CFAS Connects: Mission Accepted: Sustaining Faculty for Success as Medical Educators – A Checkup on Progress

May 24, 2023

2023 CFAS Spring Meeting Recap:

The 2023 CFAS Spring Meeting was the highest-rated CFAS meeting ever and very highly rated by overall AAMC meeting standards.

Presentation on New CFAS Committee:

CFAS recently launched a new committee (it's first new committee in some time), the Faculty as Medical Educators Committee (FAME) chaired by Lily Belfi, MD. Shirley "Lee" Eisner, PhD, is the committee's vice chair.

The charge of the committee is as follows:

"The CFAS Faculty as Medical Educators Committee is charged with identifying issues and challenges of relevance to faculty who are engaged in medical education (both clinicians and biomedical science educators), developing opportunities to discuss these issues and providing the faculty voice and perspective on educational matters that impact them, their learners, and their institutions. The work of this committee is to improve and nurture the role of faculty as medical educators and its approach will be to encourage open communication among educators and support creative solutions as faculty navigate the ever-changing landscape of undergraduate and graduate medical education."

Objectives include:

Engagement: Determine specific challenges faced by faculty educators that are impacting their ability to teach and engage with learners in a meaningful way. Support faculty by sharing best practices and advocating for positive change.

Value: Identify and promote key contributions of faculty educators to academic medical center and learners in the continuum of medical education. Develop strategies and mechanisms to improve the perceived value of medical educators at both the learner and administrative levels.

Evolution: Stimulate a national discussion on the needs of faculty educators during transitions in their career life cycle (new faculty, early-mid career, mid-late career, pre-retirement and beyond). Share concerns and strategies for success with AAMC leadership.

Communication: Facilitate bidirectional communication between faculty educators and AAMC resources for educators, and important updates on medical education.

Presentation at 2023 CFAS Spring Meeting:

A plenary session at the 2023 CFAS Spring Meeting used Poll everywhere to ask participants to enter open text responses to questions regarding their greatest challenges, achievements, and needs as medical educators. Themes included:

- Faculty educators facing multitude of challenges stemming from the many roles they play at their institutions

- Faculty feel that the full value of their contributions is not realized
- Resources are needed to support faculty dedicated to the educational mission

Challenges included getting access to time within the curricular schedule, excessive directives from institutions that interfere with clinical activities, teaching, and research, clinical duties competing with educator role, faculty have no "spare time," integration, struggling with time and lack of engagement, mismatch of student and school objectives, no time for observation, student engagement and well-being, faculty retention and isolation, lack of value of medical education, and effective hybrid teaching.

In spite of these challenges, faculty are rising to the occasion and people in the audience were able to highlight many achievements they had made, including:

- Not losing the passion and fervor for teaching
- Serving as a consultant on DEI content for a year
- Invitations to contribute to specialty specific content to curriculum

The things faculty reported to need the most in order to be successful were time and support.

The committee's initial work involves designing and distributing a survey to assess the current "state of the union" for faculty medical educators. This will be followed by an analysis phase where the committee will compile data and write a paper on findings. Finally, there will be a guidance phase where the committee will produce a list or recommendations or best practices based on the findings.

Discussion:

- There was discussion about the need to emphasize the business case for institutional leaders for investing in faculty retention.
- The committee will have liaisons to other CFAS committees to ensure it's representing all of the needs and all of the different kinds of educators.
- There was discussion about adapting the committee's survey to poll societies on what issues they care about regarding medical educators.
- With the expansion of health systems, some clinicians are having to take on educator roles when they didn't plan to pursue the educational mission.
- The faculty at an institutions' main site are going to have to find ways to ensure that education is standardized across the institution's different sites. This means that some faculty members at the main site are finding themselves stuck in roles as "accidental educator" at these other sites. The committee must capture the perspectives of these educators who are not at the main site and have found themselves in educator roles unintentionally.

Chat:

https://www.aamc.org/career-development/affinity-groups/cfas - this link takes you to a page with the meeting summary materials you can share with your faculty colleagues and society peers.

Eric, thank you for sharing materials from the CFAS meeting to bring back to our institutions

Hi from UT Southwestern in Dallas, happy to join for my first meeting of CFAS. Looking forward to being a part of this group.

Hi from Baylor College of Medicine in Houston! I'm also excited to join my first meeting of CFAS!

If there are any others folks joining us for the first time, please do introduce yourself on chat.

Hi everyone! I'm joining from UCSF. Excited to join my first meeting as well.

It's wonderful to see so many new people joining our group.

It's a critical part of our professional satisfaction also!

We should make sure to include faculty who are in all spheres on the development of this survey: basic science, clinical, educational track (EdD and MEd for example).

If we completed the survey at the meeting, is that sufficient? I think it's the same one.

Would also add as our systems expand and GME expands with it more "community" physicians will be critical to teaching students and residents.

As you speak, if you can also introduce your role in your institution.

Please sign up and share your interests on medical educator issues! If you click on the QR code it will enlarge.

It is probably also important to define what is a "medical educator"? Obviously the preclinical and clinical clerkships. When does it start? We have many educators who do premed teaching. When does it end? Does CME and MOC education count?

That can be part of the discussion of defining the role of the medical educator now.

This is the first task of the FAME committee.

Faculty identity is an issue as medical schools became health systems over the past 20 years. Employment does not equate to an educator identity.

These clinical educators at outside sites represent an incredible opportunity as well as a challenge.

Teach people in rural areas they are more likely to stay in rural areas.

and faculty at the junior, mid, and senior levels--while we share many of the same needs and struggles, we are also all so different I am learning.

I think that other topics that could be explored are some of the new needs or demands for faculty development in the changing landscape of medicine that many of us did not get exposure to in training— competency-based evaluations, digital media and AI, leading effective inter professional teams, etc.

I second that more efforts on supporting the growing needs of today's medical educators.

I love the idea of doing society outreach on specific topics like this. I'm open to getting feedback from any reps whose appointing societies are doing interesting work in the area... would be great to create outreach on this topic.

Here in rural Michigan, we have over 600 community educators (volunteer educators). We give them free CME opportunities, access to Medical Library, pathway to promotion and recognition of excellence at annual event. There's also representation on the Faculty Council. We're hoping to increase their activity in rural clinical trials. All of this gives them greater notoriety in their local community. A big hurdle: they often open their personal work e-mail but not the university e-mail.

APGO has a workgroup looking at member engagement and how to support the wide range of educators we support (including vice chairs of education, rural educators, those in non-traditional teaching settings).

Not just the time. The point is teach physicians or specialists in answering the STEP questions. If it is not in the first aid is a little bit hard.

This is a great question to include in the survey, we do need to figure out the best way to distribute this survey to those educators.

The educator role is evolving. We used to be asked to deliver content so that students could learn it. Now I feel like we are moving toward more of a curator of content to identify good content in an area, and then our face-to-face effort is more about facilitating the difficult problem-solving activities and activities where practice is important, as in communication of difficult news.

One can get all the protected time they want…… on nights and weekends! There is tremendous pressure on universities to keep faculty in clinics…..with decreased reimbursements this is going to get worse!

From the student perspective, we need to acknowledge that they want to learn. They want to be good physicians. Traveling to the campus in Miami traffic takes 2 hrs out of the day. This takes time from studying. If they can watch the recording at double speed and learn the content, then why shouldn't they be able to? Let's leverage that. Give them that, and tell them that they are responsible for that on their own. Use the time in class for tough stuff, and assessment.

The teaching burden can also involve outreach to undergrads and high school students which addresses LCME standards.

This is one of the themes that also emerged during our plenary session. How do we explore the alignment of learner expectations for their medical education and physician identity with medical educators' expectations and physician identity.

I wonder if a focus on medical education will decrease physician workforce reduction in that state?

Our faculty practice recently changed the renumeration and salary structure. I have noticed that I had a much more difficult time recruiting faculty for simulation and other education sessions this spring than ever before. I believe that the imperative to meet their clinical productivity expectations outweighed the education mission for some faculty.

That's why we have these calls - to see there are so many shared experiences.

Has anyone critically looked if the quality or variation of teaching differs between/within the "mothership" versus outside?

Interprofessional education and teaching, that broadly includes clinicians, basic scientists, and non-faculty professionals is an increasingly important and valued component of what needs to taught and demonstrated to our students. In order to accomplish or facilitate this, there is a need for those that focus their activities in the lab, clinic, and on education. There is a value to having teachers of diverse backgrounds and expertise to participate in the learning environment.

I agree with the new practice pressures and new practice models which are all about productivity and access, and a reluctance to include teaching time or desk top time within the clinical session. My impression is that the educational leaders and the practice leaders are not seeing and navigating the co-missions for education. This goes back to one of the goals for ensuring how educators given and add value to the overall enterprise.

Maybe this is a thought: students learn prof identify...through professional identity formation sessions with clinicians while they get the foundational sciences from educators who have the time to do all the necessary work around an integrated curriculum i.e. generate good assessments integrated courses, etc.

From an economic perspective, we can also think about the best use of the dollars we have to spend. How much does this session cost? Should the plastic surgeon or the dermatologist do this? Do they have the expertise? Can we afford them? Or should we get the medical educator to do this because they have the time, the educational organizational skills and assessment skills to do this better?

Agree yes that is how the system thinks right now anyway keeping clinicians to focus on income…which in our institution helps pay for education

For dermatologists…. Interesting reading about quality teaching in rural areas: A book: Dermatology in Rural Settings: Organizational, Clinical, and Socioeconomic Perspectives

A survey just to see WHO is doing the educating?

And who is being educated.

I like the idea of interviewing maybe CEO and chancellors to see what models are out there to pay for education.

If you are interested in exploring the changing relationship and alignment between educators and learners to understand better expectations and insight that both groups can offer, please indicate in the survey to join the committee or reach out to us to share your interest.

I think the need to understand who is responsible for the education at Medical Schools is a great starting point.