

# Developing your faculties

John Launer

I cannot remember when I first came across the phrase 'faculty development' to describe training doctors how to teach, but I remember I found it puzzling. I had been involved in training general practitioners (GPs) for many years, but we simply talked about 'training the trainers' and that seemed a good enough description. I was not sure why doctors who taught medical students or trainees needed to consider themselves as faculty members in the same way as academics who taught astrophysics or ancient Greek. I would have been sceptical if anyone had told me that that my business card and email signature would one day bear the words 'Associate Dean, Faculty Development' as they now do, or that I would be talking on the subject at international conferences. This is ironic, but I hope the memory of my initial reaction makes me more tolerant when I come across people nowadays who are still as puzzled as I used to be.

There are in fact two very good reasons for thinking about faculty development in medicine: one is the idea of 'faculty' and the other is that of 'development'. Although virtually all doctors teach other people in the course of their work—often including nurses and support staff as well as junior doctors and medical colleagues—many do not think of themselves as being educators as well as clinicians. This is a pity. It means that doctors may assume they can teach well when they have never taken the trouble to find out if anyone else agrees. Conversely, some doctors only teach reluctantly because it comes with the job and they never consider the possibility they might learn to do it better and enjoy it more. Encouraging doctors to think of themselves as members of a teaching faculty as well as a clinical team gives them a clear identity as educators. It is a way of reminding them they have not only one worthwhile profession but two, and a responsibility to perform both of these equally well. Similarly, using the word 'development' rather than 'training' helps to emphasise that becoming a good

teacher is a continuous and long term process. Doctors need to develop as educators throughout their careers in the same way they are expected to undertake continual professional development as clinicians.

## JEWEL IN THE CROWN

The system for producing GP trainers has been a jewel in the crown of general practice in the UK for a very long time. However, for practical reasons, it is not possible to reproduce this system in secondary care. Virtually every hospital doctor needs to supervise more junior ones, as well as other professionals, so that most specialties cannot depend on a relatively small number of self-selecting teachers in the way general practice has. This fact delayed the introduction of systematic faculty development in secondary care for a long while, so that it only really took off in this country 5 or 6 years ago.<sup>1</sup> At the time this happened, I moved from being a GP educator to taking a role across the whole range of medical specialties—from surgery and anaesthetics to paediatrics and psychiatry. I was one of the first GPs ever to do this, and it was one of the best career moves I ever made.

Since then, I have noticed a complete revolution in the way faculty development has been taught and received in secondary care. Instead of being greeted with scepticism or resistance, the input of experienced GP educators is now actively welcomed. The principle of professionalisation is now accepted almost universally among hospital doctors. The requirements for teachers in secondary care have fortunately been kept flexible, so that clinical and educational supervisors can choose what interests them rather than following a set programme.<sup>2 3</sup> There has been a transformation in educational roles within hospital trusts, especially among training programme directors and directors of medical education. In many trusts, there are now local faculty groups in each speciality, meeting regularly to discuss trainees' needs and wider educational issues.

The number of hospital doctors who think about their educational roles seriously and systematically is probably higher than ever before, but there is still a long way to go. It could take a generation to make these changes irreversible as they

have become in general practice. While some places have surged ahead in raising the quality of postgraduate training, others are lagging behind. Research activity and management still carry more prestige than education in secondary care. There are always tensions between training on the one hand and clinical service on the other, so that money and attention are often siphoned from the former to the latter unless people stick up for training, and do so robustly. Senior hospital managers sometimes see trainees simply as part of the workforce, rather than understanding that their institutions receive funding to train them than just to provide medical care. Until now, faculty development has had far more resources in medicine than in other health professions: this causes understandable misgivings and needs to be redressed. The current reorganisations with the National Health Service could threaten some of the achievements of recent times, especially if established teams are broken up, functions are redistributed too rapidly, resources are withdrawn and organisational memory is lost.

The emergence of faculty development as an idea and an activity has been a real success story in the health service, but it will need systemic support to sustain and develop it further. No clinical service can survive without investing in the future. The most important aspect of this investment involves training the next generation of professionals, and making sure their teachers do this well. We should look forward to the day when every clinician in the health service answers the question 'what do you do?' with the answer: 'I look after patients, and I teach others to do so'.

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