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Fundamental Teaching Activities in Family Medicine Framework: Analysis of Awareness and Utilization

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Introduction: In 2015, the College of Family Physicians of Canada, in performing their commitment to supporting its members in their educational roles, created the Family Medicine Framework (FTA). It was designed to assist family medicine educators with an understanding of the core activities of educators: precepting, coaching, and teaching within or beyond clinical settings. Given that an examination of member awareness of FTA has not been previously undertaken, our primary objective was to conduct an evaluation on its utility and application.

Methods: In partnership with College of Family Physicians of Canada Faculty Development Education Committee members, we used a practical participatory evaluation approach to conduct a two-phase mixed-methods evaluation of the FTA. We distributed an electronic survey in French and English languages to Canadian faculty development, program, and site directors in family medicine. We then conducted follow-up interviews with self-selected participants.

Results: Of the target populations, 12/15 (80%) faculty development directors (FDDs), 12/18 (66.7%) program directors, and 34/174 (19.5%) site directors completed the electronic survey. Subsequently, 6 FDDs, 3 program directors, and 3 site directors completed an interview (n = 12). Findings indicate that awareness of the FTA was highest among FDDs. Facilitators who encourage teachers to use the FTA and barriers for low uptake were also identified.

Discussion: This evaluation illuminated that varied levels of awareness of the FTA may contribute to the low uptake among education leaders. We also suggest future research to address possible barriers that hinder effective applications of the FTA in faculty development initiatives.

Keywords: faculty development, family medicine, teaching activities, evaluation

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Promoting consistent, good-quality education through faculty development activities is a priority in family medicine.[1] With the implementation of competency-based medical education (CBME) systems, medical teachers require faculty development support to prepare them with effective strategies for training and assessing learners in this new climate.[2] Over the past decade, the field of faculty development has grown substantially, with more than 100 published articles describing the outcomes of short- and long-term educational interventions.[3] Despite the growing efforts to build programs for the professional development of clinical teachers, a recent systematic assessment yielded a lack of strong evidence to support the decisions made for choosing faculty development activities.[4] Furthermore, evidence on the organizational changes that evolve from faculty development initiatives has been largely underexplored.[3]

In performing their commitment to supporting its members in their educational roles, the College of Family Physicians of

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Canada (CFPC) created the Fundamental Teaching Activities in Family Medicine Framework (FTA) in 2015. Designed to assist family medicine educators, programs, and faculty developers understand the core activities of teachers, the FTA emphasizes the importance of precepting and coaching within and outside of clinical settings.[5] Intended to guide teacher development and frame faculty development needs for assessment or curricular programming, the FTA provides a roadmap for a novice to experienced teachers in family medicine. However, before this evaluation, there was minimal understanding about teachers' awareness of the FTA. Thus, the purpose of this project was to evaluate its awareness, application, and utilization in Canadian departments of family medicine, their educational programs, and by family medicine teachers.

For the purposes of this innovative project, we conceptualized "awareness" as a self-assessment of generalized knowledge about this framework.[6] Application-wise, we refer to an operational definition endorsed by the Canadian Institutes of Health Research, "an iterative process by which knowledge about [the FTA] is put into practice".[7] For those aware of and applying it, our evaluation sought to further understand their experiences with using the FTA within their academic roles (ie, utilization).

EVALUATION METHODOLOGY

We used a practical participatory evaluation (P-PE) approach[8] to conduct an evaluation of the FTA. This P-PE approach involved a partnership between the research team and key stakeholders from the CFPC's Faculty Development Education Committee. By establishing a partnership between the research team and three Faculty Development Education Committee members, we leveraged the professional practices of evaluators and first-hand knowledge provided by non-evaluators to conduct an evaluation in a formative, improvement-based context. This expert panel advised on project design, development of data collection protocols and instruments, project implementation, and validation of findings. We considered strategies from explanatory, sequential mixed-methods research as a compatible approach to conducting a utilization-oriented evaluation. From an epistemological standpoint, mixed-methods inquiry enables a broad yet comprehensive understanding of how the FTA supports faculty development practices. The quantitative examination allowed us to first gather information about the current landscape with how the framework is being used. Next, key informant interviewing encouraged us to better understand how academic leaders viewed the FTA. Thus, an evaluation guided by mixed-methods and P-PE approaches helped justify the social accountability needs for faculty development and capacity building across family medicine education communities. Exemption from research ethics for this two-phase mixed-methods evaluation was granted by the University of Ottawa Research Ethics Board.

Phase 1

Participants

For phase 1 participation, a CFPC administrator identified and contacted all 15 faculty development directors (FDDs), 18 postgraduate program directors (PDs), and 174 site directors (SDs) in Canadian university departments of family medicine.

Data Collection and Analysis

We developed a survey to examine the degree of awareness, application, and utilization toward the FTA. Before survey distribution through Qualtrics, we piloted the surveys to determine the appropriateness, comprehensibility, and feasibility.[9] The final surveys consisted of 38 questionnaire items; 33 were closed-ended, and 5 were open-ended (see **Material I, Supplemental Digital Content 1**, http://links.lww.com/JCEHP/A155). We administered the surveys online in both English and French (translated by a professional translator). To maximize participation, we adhered to a modified version of Dillman[10] Tailored Design Method when distributing the surveys. After the initial distribution of the survey (September 7, 2018, to FDDs and PDs; October 3, 2018, to SDs), CFPC administrators subsequently sent two email reminders to potential respondents for survey completion (September 26 and October 10, 2018, to FDDs and PDs; and October 17 and October 31, 2018, to SDs). Data collection for the survey was officially closed on November 23, 2018. We also reminded potential respondents about the ongoing surveys in-person at research conferences hosted during this recruitment period (ie, International Conference on Residency Education, Family Medicine Forum). K.E. and C.G. analyzed all closed-ended survey responses in IBM SPSS v.25 using descriptive statistics (ie, frequencies and percentages for dichotomous rating items) and analyzed text responses to open-ended items using qualitative content analysis.[11]

Phase 2

Participants

We used convenience sampling to identify individuals to participate in an interview.[12] R.L.K. and M.V. emailed information letters to eligible participants who on their surveys expressed interest to participate in the second phase.

Data Collection and Analysis

We developed interview guides in English and French to elucidate participant perspectives about the FTA (see **Material II, Supplemental Digital Content 2**, http://links.lww.com/JCEHP/A156). All expert panel members piloted the interview guides, and then, they were translated to French by a professional translator. The final interview guides included 15 open-ended questions about the facilitators and barriers that may influence use of the framework, as well as questions to explore participants' needs, factors for buy-in, and ways to apply the FTA.

Between January 8 to May 30, 2019, R.L.K., D.A., or M.V. conducted 30- to 60-minute semistructured interviews with participants in their preferred language through telephone. All interviews were audio-recorded and transcribed verbatim. Using NVivo v.12, the interview transcripts were independently analyzed by two researchers (R.L.K. and D.A.) after thematic analysis.[13] R.L.K. and D.A. first generated initial codes to organize the data at a granular level and then used them to search for major themes. In addition, selected transcripts were reviewed by two expert panel members for codebook verification, and any differences were resolved before generating conclusions. We used a mix of deductive and inductive coding to ensure that key themes were not missed or force-fitted into a pre-existing coding system.

Integration of Phase I and Phase II

The mixing of data collection and analytical strategies occurred at two stages. The first point of integration occurred before the start of phase II. To preserve the sequential nature of this evaluation, we integrated the survey findings into the design of the interview guides. The second point of integration occurred at the final stage of data analysis. Using a "merging integration" technique, we linked key findings and presented meta-interpretations for both phases on a side-by-side joint display.[14]

RESULTS

Demographics

A total of 58 participants completed the survey (overall response rate of 28%): 12 FDDs, 12 PDs, and 34 SDs in Canadian university departments of family medicine, resulting in 80%, 66.7%, and 19.5% individual response rates, respectively. Demographic details about the surveyed participants are presented in Table 1. Most FDDs and PDs had 1 to 5 years of experience within their academic roles and are distributed across different geographic regions of Canada. Most SDs held a leadership role for program development in Western Canada or Ontario regions, but none were previously involved with constructing the FTA.

Of the 12 participants who were interviewed, 6 were FDDs (1 Francophone), 3 PDs, and 3 SDs across several Canadian provinces: British Columbia, Alberta, Manitoba, Ontario, and Quebec.

TABLE 1.
Participant Demographics

Characteristic	*N*	*n* (%)
Academic role	39	
FDD*		12 (30.8)
PD		9 (23.1)
SD		18 (46.2)
Years in role		
FDD	10	
Less than 1 y		1 (10)
1–5 y		8 (80)
6–10 y		1 (10)
PD	7	
Less than 1 y		1 (14.3)
1–5 y		4 (57.1)
6–10 y		2 (28.6)
SD	14	
Prefer not to specify		14 (100.0)
Region of Canada		
FDD	11	
Western Canada		3 (27.3)
Eastern Canada		2 (18.2)
Ontario		4 (36.4)
Quebec		2 (18.2)
PD	7	
Western Canada		2 (28.6)
Eastern Canada		1 (14.3)
Ontario		2 (28.6)
Quebec		2 (28.6)
SD	14	
Western Canada		4 (28.6)
Eastern Canada		0 (0.0)
Ontario		10 (71.4)
Quebec		0 (0.0)
Involved in developing the FTA		
FDD	11	4 (36.4)
PD	7	2 (28.6)
SD	14	0 (0.0)
Leadership role in educational program development		
PD	7	6 (85.7)
SD	14	12 (85.7)

*Two FDD participants served delegate roles: professor and director.

Survey

Table 2 presents information about the degree of awareness of the FTA among academic leaders. Our findings indicate that most FDDs, PDs, and SDs were familiar with the framework's content through various methods of dissemination (eg, CFPC website/events and colleagues). Hard copy and electronic versions of the framework were accessed similarly across stakeholder groups. Reported by academic leaders, the perceived purposes for using the FTA included education programming in faculty development or career planning for clinical teachers. Several respondents also believed that the FTA serves as a self-reflective tool for improving their own teaching practices.

In application, Table 3 describes the current and future uses of the FTA in family medicine education programs. Applications of the FTA in educational programming were reported highest among FDDs. Specifically, participants identified that the FTA helps them establish program standards for faculty development, develop educational resources for clinical teachers, and promote faculty development activities. Some PDs agreed that the framework can be used to support teachers of family medicine residency programs (eg, inform assessment approaches). Contrarily, most SDs did not identify clear applications of the FTA within or beyond clinical contexts.

Our evaluation measured the extent to which the FTA is operationalized in family medicine education programs. Table 4 outlines the approaches that FDDs, PDs, and SDs performed to use the FTA. When asked to rate the usefulness of the FTA, academic leaders scored clarity, utility, and feasibility of the FTA document as moderate to high. However, most participants reported that the level of utilization at their institution remained low to none. Although some participants accessed the online repository of educational materials about the FTA, several did not or perceived them to be underdeveloped.

Interviews

Based on our interviews with academic leaders, we identified five key themes describing their perceptions of the FTA. Exemplar quotes for each theme are presented in Table 5.

Align FTA With Current Teaching Values

Respondents identified underlying individual and collective values that motivate their teaching practices in family medicine (eg, importance of life-long learning, institutional support, and existing teaching model). As experienced practitioners, they felt accountable to perform the teaching role well. Most respondents agreed there is a fundamental need for teaching trainees to become qualified family medicine physicians. Some respondents believed that the establishment of family medicine as its own unique department signifies the importance of good, coherent teaching practices that are specific to this discipline.

TABLE 2.
Awareness of the FTA

Survey Items	FDD N	FDD *n* (%)	PD N	PD *n* (%)	SD N	SD *n* (%)
Awareness of the FTA	12	12 (100.0)	12	9 (75.0)	34	18 (52.9)
Method of awareness*	12		9		18	
College meeting		8 (66.7)		5 (55.6)		7 (38.9)
Website		4 (33.3)		3 (33.3)		3 (16.7)
Newsletter		1 (8.3)		1 (11.1)		0 (0.0)
Local meeting		1 (8.3)		3 (33.3)		6 (33.3)
Provincial meeting		1 (8.3)		2 (22.2)		2 (11.1)
National meeting		5 (41.7)		4 (44.4)		6 (33.3)
Other (eg, colleagues)		6 (50.0)		2 (22.2)		1 (0.0)
Format of framework accessed*	12		9		18	
Hard copy		12 (100)		8 (88.9)		10 (55.6)
Electronic		12 (100)		8 (88.9)		11 (61.1)
Have not accessed		0 (0.0)		0 (0.0)		3 (16.7)
Perceived purpose of the FTA*	12		9		18	
To provide teachers with an understanding of the activities that are expected of them, depending on their task(s)		8 (66.7)		6 (66.7)		9 (50.0)
To provide a road map for teachers to guide their self-reflection and continuing professional development		9 (75.0)		9 (100.0)		13 (72.2)
To assist programs, departments, and faculty members in developing educational programming for faculty development		10 (83.3)		8 (88.9)		11 (61.1)
To provide an organizational framework for faculty development materials, tools, and strategies, both locally and nationally		8 (66.7)		6 (66.7)		9 (50.0)
Other†		2 (16.7)		0 (0.0)		1 (5.6)
The FTA as a self-reflective tool	12	7 (58.3)	9	4 (44.4)	18	5 (27.8)

*Respondents selected all options that apply.

†Additional responses received: all of the above; transform principles into practical reflection exercises; not practical; another physician has oversight over faculty development activities.

Highest Awareness of FTA Among Faculty Developers

When asked about their perceptions of the FTA, participants generally agreed that it is conceptually sound, with the content laid out with good clarity and in a well-organized manner. Several FDDs and PDs further commented on the FTA elements that resonate well with the current CBME model in family medicine. Specifically, one FDD described the FTA as "a competency framework for teachers" and encouraged that the FTA should be referenced when assessments of clinical teachers need to be conducted.

FDDs, PDs, and SDs also pointed to the FTA document's lack of user friendliness as a key challenge for clinical preceptors to readily access and apply its concept in their teaching practices. Although several respondents were aware that the FTA is a component to accreditation standards, they expressed uncertainty whether their preceptors were fully aware of its content. This concern primarily arose from the document's excessive length, along with their hesitations about readers' ability to interpret related terminology without previous teaching experiences.

In addition, some respondents raised doubts about the educational leader domain. They recognized that a domain should be tailored toward the leadership aspect of family physicians; however, discussions are necessary on how to make this domain relevant to a range of clinical or academic roles that family medicine physicians can have. Finally, respondents have critiqued that compartmentalizing teaching activities into domains is a limitation of the FTA because it may not reflect how family medicine training is delivered routinely.

Applying FTA to Build Faculty Development Resources

Many participants gained assurance and insights from the FTA on how to conduct their academic roles in family medicine. One FDD described a working initiative to introduce a video series outlining the three FTA domains, which will become accessible on their institution's faculty development website. At the PD level, another participant referenced the FTA concepts when decisions about residency program changes need to be made (eg, assessment methods). The examples in Table 5 further depict how participants addressed each teaching domain in practical terms.

Shared Interests for Meeting Education Standards Facilitate FTA Use

Main facilitators to using the FTA included the requirement for faculty development programs to meet accreditation standards and the promotion of teaching activities in family medicine. Several FDDs were successful in sharing information about the FTA through e-newsletters, word-of-mouth, and social media initiatives. A FDD further commented that when the framework was introduced to individuals with interests in medical education, such ideas were better received than by those who did not. Likewise, respondents perceived those preceptors with experience in clinical teaching may relate more to the FTA concepts.

Competing Priorities or Lack of Institutional Support Hinder FTA Use

FDDs, PDs, and SDs also highlighted barriers to using the FTA. They most frequently noted time and competing priorities to attend faculty development events as logistical barriers. Participants indicated experiencing reduced buy-in with end-users who questioned the impacts of using the FTA or had limited understanding about the framework. Finally, some respondents alluded to varied confidence with fully using the FTA when the framework is not compatible with intradepartmental or interdepartmental values for faculty development.

TABLE 3.
Application of the FTA Framework

Survey Items	FDD		PD		SD	
	N	*n* (%)	N	*n* (%)	N	*n* (%)
Use of the FTA for educational programming	12	9 (75.0)	9	4 (44.4)	16	3 (18.8)
Use of the FTA for FDDs*	12					
To develop strategies for teachers working with learners experiencing progression challenges		2 (16.7)		—		—
To evaluate educational programs		1 (8.3)		—		—
To apply and develop your individual program standards		4 (33.3)		—		—
To engage stakeholders such as your institution and the CFPC		3 (25.0)		—		—
To use and develop resources		4 (33.3)		—		—
Do not currently use the FTA		1 (8.3)		—		—
Other		6 (50.0)		—		—
Use of the FTA for clinical preceptors*			9		16	
To explicitly embody the roles, attitudes, and competencies of a family physician in clinical work		—		2 (22.2)		4 (25.0)
To promote and stimulate clinical reasoning and problem solving		—		1 (11.1)		1 (6.3)
To give timely, learner-centered, and constructive feedback		—		1 (11.1)		4 (25.0)
To use assessment tools to document observed learner performance according to training level		—		0 (0)		1 (6.3)
To use reflective processes to refine clinical supervision		—		2 (22.2)		3 (18.8)
To help learners design and update their individual learning plans		—		2 (22.2)		2 (12.5)
To guide comprehensive periodic progress reviews informed by the learners' self-analyses		—		2 (22.2)		0 (0)
To assist learners in their professional development		—		1 (11.1)		2 (12.5)
To adjust teaching interventions to support learners facing progression challenges		—		2 (22.2)		3 (18.8)
None of the above		—		2 (22.2)		7 (43.8)
Other (ie, not sure, orientation training)		—		2 (22.2)		2 (12.5)
Plans to use the FTA*	12					
To develop strategies for teachers working with learners experiencing progression challenges		5 (41.7)		—		—
To evaluate educational programs		3 (25.0)		—		—
To apply and develop your individual program standards		5 (41.7)		—		—
To engage stakeholders such as your institution and the CFPC		5 (41.7)		—		—
To use and develop resources		5 (41.7)		—		—
Other		2 (16.7)		—		—
Use of the FTA by teachers outside of clinical setting*			9		15	
To prepare teaching sessions		—		0 (0)		3 (20)
To facilitate teaching sessions		—		2 (22.2)		1 (6.7)
To reflect on teaching sessions		—		3 (33.3)		0 (0)
None of the above		—		5 (55.6)		8 (53.3)
Other (eg, respondent not sure)		—		1 (11.1)		3 (20)
A person is responsible for creating faculty development programming	12	10 (83.3)	9	9 (100.0)	16	14 (87.5)
Informed by the FTA framework?	10	7 (70)	8	7 (87.5)	13	9 (69.2)
Institution supports faculty development activities	12	11 (91.7)	8	8 (100)	16	15 (93.8)
FTA strategies to develop faculty development education*	12		9		16	
Needs assessment		7 (58.3)		6 (66.7)		5 (31.3)
Implementation		6 (50)		3 (33.3)		4 (25)
Evaluation of educational activities		4 (33.3)		3 (33.3)		7 (43.8)
Program adjustment		4 (33.3)		3 (33.3)		4 (25)
Adjust learning plans to support learners with progression challenges		2 (16.7)		2 (22.2)		5 (31.3)
Adjust educational programming to support learners and teachers		6 (50)		4 (44.4)		3 (18.8)
Develop resources to support learners and teachers		9 (75)		4 (44.4)		8 (50)
None of the above		2 (16.7)		2 (22.2)		3 (18.8)
Other		1 (8.3)		0 (0)		0 (0)

*Respondents selected all options that apply.

DISCUSSION

An evaluation of the FTA in family medicine education yielded insights about its awareness, application, and utilization among academic leaders. As depicted in Table 5, awareness of the FTA seems to be highest at the FDD level and to a certain extent at the PD level. Currently, use of the framework is mainly at the level of FDDs to develop faculty development workshops. Users of the FTA generally agreed the framework document is conceptually sound, and it presents the content clearly and in a well-organized manner. The main facilitators for its utilization include promoting faculty development and teaching activities in family medicine. Areas of improvement focused on ways to deliver the FTA content in a user-friendly fashion for preceptors who perform these teaching activities. For programs lacking institutional buy-in or protected time to advance their educational role, academic leaders voiced their struggles with understanding how FTA concepts can support faculty development efforts.

TABLE 4.

Utilization of FTA Framework

	FDD		PD		SD	
Survey Items	**N**	***n* (%)**	**N**	***n* (%)**	**N**	***n* (%)**
FTA strategies to implement faculty development/educational programming*	11		9		14	
Collaboration across sites		4 (36.4)		3 (33.3)		8 (57.1)
Collaboration across program specialties		2 (18.2)		1 (11.1)		2 (14.3)
Collaboration across health professions		2 (18.2)		1 (11.1)		2 (14.3)
Application and development of educational standards and objectives		5 (45.5)		1 (11.1)		5 (35.7)
Stakeholder engagement in identifying expectations		5 (45.5)		0 (0.0)		3 (21.4)
Stakeholder engagement in advocacy		1 (9.1)		0 (0.0)		1 (7.1)
Deploy necessary resources		4 (36.4)		2 (22.2)		4 (28.6)
Develop necessary resources		7 (63.6)		5 (55.6)		3 (21.4)
Leadership succession planning		2 (18.2)		5 (55.5)		2 (14.3)
Innovation		1 (9.1)		4 (44.4)		2 (14.3)
None of the above		1 (9.1)		2 (22.2)		2 (14.3)
Other		1 (9.1)		0 (0.0)		1 (7.1)
Current operationalization of the FTA in educational programs	11		9		14	
Basic level: The FTA referred occasionally		7 (63.6)		2 (22.2)		9 (64.3)
Advanced level: Most of the FTA incorporated		2 (18.2)		2 (22.2)		1 (7.1)
Leadership level: The FTA integrated seamlessly and helps other programs		2 (18.2)		2 (22.2)		0 (0.0)
Not currently using the FTA		0 (0.0)		3 (33.3)		4 (28.6)
To what extent is the FTA:	11		9		14	
Helpful						
Not at all		0 (0.0)		2 (22.2)		0 (0.0)
To a small extent		2 (18.2)		1 (11.1)		3 (21.4)
To a moderate extent		4 (36.4)		3 (33.3)		8 (57.1)
To a great extent		5 (45.5)		3 (33.3)		0 (0.0)
I do not know		0 (0.0)		0 (0.0)		3 (21.4)
Feasible to implement						
Not at all		0 (0.0)		0 (0.0)		1 (7.1)
To a small extent		5 (45.5)		3 (33.3)		4 (28.6)
To a moderate extent		3 (27.3)		3 (33.3)		4 (28.6)
To a great extent		3 (27.3)		2 (22.2)		2 (14.3)
I do not know		0 (0.0)		0 (0.0)		3 (21.4)
Understandable						
Not at all		0 (0.0)		0 (0.0)		0 (0.0)
To a small extent		2 (18.2)		1 (11.1)		3 (21.4)
To a moderate extent		4 (36.4)		6 (66.7)		8 (57.1)
To a great extent		5 (45.5)		2 (22.2)		3 (21.4)
I do not know		0 (0.0)		0 (0.0)		0 (0.0)
Comprehensive						
Not at all		0 (0.0)		0 (0.0)		1 (7.1)
To a small extent		2 (18.2)		0 (0.0)		1 (7.1)
To a moderate extent		5 (45.5)		3 (33.3)		8 (57.1)
To a great extent		4 (36.4)		6 (66.7)		4 (28.6)
I do not know		0 (0.0)		0 (0.0)		0 (0.0)
To what extent are you implementing the FTA:						
To review your programs?	11		9		14	
Not at all		3 (27.3)		3 (33.3)		4 (28.6)
To a small extent		3 (27.3)		1 (11.1)		6 (42.9)
To a moderate extent		4 (36.4)		4 (44.4)		2 (14.3)
To a great extent		1 (9.1)		1 (11.1)		0 (0.0)
I do not know		0 (0.0)		0 (0.0)		2 (14.3)
To review your individual program standards?	10		9		14	
Not at all		3 (30.0)		1 (11.1)		6 (42.9)
To a small extent		3 (30.0)		4 (44.4)		5 (35.7)
To a moderate extent		4 (40.0)		3 (33.3)		1 (7.1)
To a great extent		0 (0.0)		1 (11.1)		0 (0.0)
I do not know		0 (0.0)		0 (0.0)		2 (14.3)
To engage stakeholders?	10		9		14	

(*Continued*)

TABLE 4.
Utilization of FTA Framework (Continued)

Survey Items	FDD		PD		SD	
	N	*n* (%)	N	*n* (%)	N	*n* (%)
Not at all		4 (40.0)		1 (11.1)		5 (35.7)
To a small extent		5 (50.0)		4 (44.4)		6 (42.9)
To a moderate extent		1 (10.0)		4 (44.4)		1 (7.1)
To a great extent		0 (0.0)		0 (0.0)		0 (0.0)
I do not know		0 (0.0)		0 (0.0)		2 (14.3)
To use resources?	10		9		14	
Not at all		3 (30.0)		1 (11.1)		5 (35.7)
To a small extent		2 (20.0)		4 (44.4)		6 (42.9)
To a moderate extent		5 (50.0)		2 (22.2)		1 (7.1)
To a great extent		0 (0.0)		2 (22.2)		0 (0.0)
I do not know		0 (0.0)		0 (0.0)		2 (14.3)
To develop resources?	10		8		14	
Not at all		1 (10.0)		1 (12.5)		6 (42.9)
To a small extent		2 (20.0)		3 (37.5)		5 (35.7)
To a moderate extent		5 (50.0)		3 (37.5)		1 (7.1)
To a great extent		2 (20.0)		1 (12.5)		0 (0.0)
I do not know		0 (0.0)		0 (0.0)		2 (14.3)
To develop educational programming?	11		9		14	
Not at all		1 (9.1)		1 (11.1)		3 (21.4)
To a small extent		4 (36.4)		4 (44.4)		7 (50.0)
To a moderate extent		1 (9.1)		2 (22.2)		1 (7.1)
To a great extent		5 (45.5)		2 (22.2)		0 (0.0)
I do not know		0 (0.0)		0 (0.0)		3 (21.4)
To develop strategies for working with learners experiencing progression challenges?	10		9		14	
Not at all		6 (60.0)		3 (33.3)		4 (28.6)
To a small extent		2 (20.0)		3 (33.3)		4 (28.6)
To a moderate extent		0 (0.0)		2 (22.2)		4 (28.6)
To a great extent		2 (20.0)		1 (11.1)		0 (0.0)
I do not know		0 (0.0)		0 (0.0)		2 (14.3)
Use FTA for accreditation purposes	11	3 (27.3)	9	2 (22.2)	14	0 (0.0)
Accessed online resources for the FTA	6	6 (54.5)	3	3 (33.3)	1	1 (7.1)
Not accessed	5	5 (45.5)	6	6 (66.7)	13	13 (92.9)
Did not access but aware of resources	4	4 (80)	2	2 (33.3)	6	6 (46.2)

*Respondents selected all options that apply.

To the best of our knowledge, this evaluation is the first to examine the awareness and application of the FTA—a recognized framework for family medicine education in Canada—among academic leaders. Awareness of the FTA primarily came from national meetings hosted by CFPC and word-of-mouth sharing among colleagues. This resonates with O'Sullivan and Irby's[15] expanded model of faculty development that focuses on fostering two communities of practice: the faculty development and workplace communities. Overall, academic leaders reported that the FTA presents helpful strategies to build faculty development education in the areas of needs assessment, evaluation, and resource development. Many respondents believed that the FTA enabled them to perform faculty development initiatives of higher quality or inform education program changes. The FTA has been used to help coach residents, organize academic roles of the physician, and achieve faculty promotion. Thus, although successful utilization of the FTA varies between departments, several academic leaders noted positive changes in organizational development, along with a prevailing institutional culture that further supports and rewards teaching excellence.

Despite the positive findings on satisfaction, we have limited knowledge on the actual impact of faculty development activities based on the FTA or costs associated with its utilization. Future research is needed to understand the longitudinal impacts of the FTA on academic programs, including implications for its scalability. To drive the field forward, additional research should explore the possible "axes of difference" that contribute to the effectiveness of scholarship guided by the FTA.[16] Although we attempted to unpack the professional identities and cultural tensions that govern faculty development efforts, a greater understanding on which FTA concepts best support the needs of individual programs will aid in its translation, both locally and internationally. Similar to the challenges encountered with implementing the Triple-C curriculum in family medicine,[17] program adaptations made to integrate the FTA concepts may disrupt intradepartmental and interdepartmental relationships, particularly if educators and their institutions embraced different models for faculty development. Thus, resistance to rolling out a new educational model across distributed academic departments also needs to be addressed.

TABLE 5.

Side-by-Side Joint Display of Evaluation Findings on the FTA

Themes	Interview Findings	Survey Results	Meta-interpretation
Align FTA with current teaching values	"...we've been successful in transitioning our faculty development times, and our retreats to something that appeals to something everybody has in common... they may practice in different settings, they may practice different types of medicine, but they fundamentally are all part of this department because of their role to some degree as teachers." (participant 4, FDD)	Narrative findings: "Our site is involved in the provincial program curriculum mapping exercise and in distribut[ing] the program preceptor education opportunities info." (SD) "...Support from the chair of our department in the form of developing international faculty development..." (FDD)	Institutions with supportive teaching values encourage faculty development among family medicine educators.
Highest awareness of FTA resources among FDDs	"Some of it's [the document is] a nice summary—a list of three roles of clinical preceptor, teachers outside the clinical setting and educational leader, list the tasks and activities... I look at the task and activities and I can quickly sort of make a decision on which one that we may focus on." (participant 3, FDD) "...It was a challenge for us to take from the theory and the terminology that existed in the framework and translate to frontline, real life sort of scenarios." (participant 10, SD) "...The document is quite definitive in its difference between a teacher, a preceptor and a learner, and I think the reality is that those can all be occurring at the same time...this would be better thought about as an integrated model" (participant 12, SD)	All FDDs, most PDs, and half of SDs surveyed knew about FTA. FDDs, PDs, and SDs learned about the FTA through CFPC-hosted meetings. Most have accessed hardcopy and electronic versions of FTA. 16.7% SDs have not accessed related online resources. Educational programming for faculty development and guide for professional development identified as the main purposes for FTA. Most agreed FTA to be a self-reflective tool for professional advancement. Narrative comment: "Awareness of roles and opportunities for professional development." (SD)	Awareness of the FTA seems to be highest among FDDs, to a certain extent with PDs, and minimally with SDs Users of the FTA agree the document is conceptually sound, and it presents the content in a clear, well-organized manner.
Applying the FTA to build faculty development resources	Clinical preceptor domain—"...for activities that are observed within the family medicine clinic, the primary preceptor has a chance to observe them and so we entrust competency decisions to them, specifically in the use of Entrustable Professional Activities to those observable behaviors." (participant 7, PD) Outside clinical setting domain—"...they [residents] have a half day a week that's pure didactic sort of teaching, and then they have a core day...we do create environments there where either some of the preceptors are actually subject experts... myself and the co-site director often will attend these sessions..." (participant 10, SD) Educational leadership domain—"...the activities sort of housed within that umbrella would be things like financial literacy for example, change management, more administrative focus as opposed to education...the task[s] or activities under the educational leader role, like program evaluation, curriculum development, that would be subsumed under the teacher role." (participant 3, FDD)	75% FDD reported using the FTA for educational programming. 44% PDs and 18% SDs reported using the FTA to support clinical precepting activities. 41% of FDDs have plans to use FTA in their educational programs. More than 50% of PDs and SDs do not believe FTA is used by teachers outside of clinical settings. Most acknowledged receiving institutional support for faculty development programming informed by the FTA. FTA strategies were used by 75% FDDs and 50% SDs to develop learning resources and 66%% to conduct needs assessments for faculty development education.	The FTA is mainly applied at the level of FDDs to develop faculty development workshops.

(*Continued*)

From our interviews, educational leaders offered suggestions to addressing these barriers and implementing the FTA at a larger scale. Participants believed that a CFPC-endorsed curriculum based on the FTA can support the conceptualization of faculty development programs across Canada. Taking a "train-the-trainer" approach, users of the FTA recommended a repository of assessment tools and educational resources to be created for clinical teacher advancement. Participants were also supportive of establishing site champions, institutional recognitions, or incentives as strategies for better uptake. Thus, applicability of this framework can be promoted by integrating FTA content into residents-as-teachers opportunities and preceptor evaluations.

Limitations

Our findings are limited by the self-reported nature of the data. We inferred lack of awareness and uptake of the FTA from academic leaders who did not participate. It was also beyond the scope of our evaluation to determine agreement with real-time educational practices. We did not apply standardized measures for assessing utility or awareness because they cannot

TABLE 5.

Side-by-Side Joint Display of Evaluation Findings on the FTA (Continued)

Themes	Interview Findings	Survey Results	Meta-interpretation
Shared interests for meeting education standards facilitate FTA use	"FTA gives a way of describing the behavior that's expected. It gives people who are underperforming simply because they've not been taught how to teach outside the classroom" (participant 4, FDD) "I have an administrator who actually does it, and it really helps people like her understand where this is coming from, you know to see the bigger picture" (participant 5, FDD) "I'm just actually looking at page 10 which maybe is your page 13 that has a clinical preceptor and then clinical coach and competency coach in different chapters and activities. I actually find that page the most useful, particularly when introducing the students in your faculty, just because it really does kind of lay out some of the differences in those roles and gives them a few more sort of tangible examples" (participant 9, PD)	63% FDDs referred to the FTA occasionally. Some FDDs (n = 3) and PDs (n = 2) use FTA for accreditation purposes. Narrative comments: We linked our teaching certificate program requirements to the FTA framework. (FDD)	Embracing shared goals for competency-based education in family medicine can promote meaningful applications with the FTA.
Competing priorities or lack of institutional support can hinder FTA use	"We've also switched to a different model of offering faculty development, that's taken a bit of a back seat in my own thinking. . . now that the planning is more dispersed it takes a lot more forcefulness on my part to get it out there." (participant 2, FDD)	PDs and SDs did not find the FTA to be helpful, feasible to implement, understandable, or comprehensive to the same degree as FDDs. 33% PDs and 28% SDs do not use the FTA. Narrative comments: "It doesn't match my reality in my program. The concepts in the out of clinic teaching aren't organized in a useful way for me." (FDD) "Il est inconnu. Il est un référentiel théorique mais peu pratique. [It is unknown. It is a theoretical framework, but impractical]" (PD) "There are so many things coming at preceptors every day I find it hard to get them to take on more." (SD) ". . . the main challenge has been getting buy-in from our Department chair—who does not seem to acknowledge the relevance of using the FTA in our performance reviews/job descriptions. (FDD)	Improvements should focus on ways to deliver the FTA content in a user-friendly fashion. Without adequate resources, teachers and academic leaders struggle to understand the relevance of FTA in faculty development.

be operationalized to meet all our evaluation needs. A limitation to the interview component of this evaluation is the limited information about how the implementation of FTA was supported across different levels of educational leadership (eg, available resources to disseminate the framework and sustain its use across diverse educational contexts). Finally, although we cannot examine the transferability of an evaluation's findings to other educational programs or stakeholders, we believe similar approaches can be considered with future evaluations on faculty development initiatives supporting CBME.

CONCLUDING REMARKS

The FTA framework is an undertaking to provide clinical teachers with a foundational understanding of the activities expected of them, as well as support educational developers to provide faculty development activities in family medicine. This pan-Canadian evaluation study offered evidence on the impacts of the FTA on academic leaders. Limitations to this project include restricted generalizability to other stakeholder groups and minimal information on the impact of individual scholarship activities informed by the FTA. Based on this evaluation, future agendas to improve the uptake and utilization of the FTA in various educational contexts are encouraged.

Lessons for Practice

- The FTA is conceptually sound, with the content for each educational domain laid out clearly and in a well-organized manner.
- Helpful applications of the FTA include, but are not limited to, planning and promotion of faculty development events and teaching activities in family medicine education.
- Family medicine educators can also consider the FTA as a guiding framework for developing residents-as-teacher training and preceptor assessment opportunities.

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