

Exploring the culture of faculty development: insights from Canadian leaders of faculty development

La culture du perfectionnement du corps professoral : la perspective des chefs de file au Canada

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Abstract

Background: Although the word culture is frequently mentioned in research on faculty development (FD), the concept is rarely explored. This research aimed to examine the culture of FD in Canada, through the eyes of leaders of FD in the health professions. Studying culture can help reveal the practices and implicit systems of beliefs and values that, when made explicit, could enhance programming.

Method: FD leaders from all Canadian medical schools were invited to participate in semi-structured telephone interviews between November 2016 and March 2017. The researchers used a constructivist methodology and theoretical framework located within cultural studies, borrowing from phenomenological inquiry to move beyond descriptions to interpretations of participants' perceptions. Constant comparison was used to conduct a thematic analysis within and across participants' interview transcripts.

Results: Fifteen FD leaders, representing 88% of medical schools (15/17) in Canada, participated in this study. Four themes characterized the culture of FD: balancing competing voices and priorities; cultivating relationships and networks; promoting active, practice-based learning; and negotiating recognition.

Conclusion: Although the culture of FD may vary from context to context, this study revealed shared values, practices, and beliefs, focused on the continuous improvement of individual and collective abilities and the attainment of excellence.

Résumé

Contexte : Culture est un mot qui revient souvent dans les études sur le perfectionnement du corps professoral (PCP) et pourtant, le concept en soi est rarement exploré. Notre objectif était d'examiner cette culture dans le contexte canadien du point de vue des chefs de file du perfectionnement du corps professoral dans les professions de la santé. En mettant en évidence les pratiques et les systèmes implicites de croyances et de valeurs, une telle analyse de la culture du PCP peut contribuer à l'amélioration des programmes.

Méthode : Des chefs de file du PCP de toutes les facultés de médecine canadiennes ont été invités à participer à des entretiens téléphoniques semi-structurés entre novembre 2016 et mars 2017. Les chercheurs ont utilisé une méthodologie et un cadre théorique constructivistes s'inscrivant dans les études culturelles, ainsi qu'une approche phénoménologique pour aller au-delà de la description et s'engager dans une interprétation des perceptions des participants. Nous avons effectué à une comparaison systématique dans le cadre de l'analyse thématique individuelle et transversale des transcriptions d'entretiens.

Résultats : Quinze leaders du PCP, représentant 88 % des facultés de médecine (15/17) au Canada, ont participé à cette étude. Quatre thèmes caractérisent la culture du PCP : concilier les voix et les priorités divergentes; cultiver les relations et les réseaux; promouvoir l'apprentissage actif et basé sur la pratique, et faciliter la reconnaissance.

Conclusion : Bien que la culture du PCP varie selon le contexte, cette étude a révélé l'existence de valeurs, de pratiques et de croyances communes axées sur l'amélioration continue des capacités individuelles et collectives et sur l'atteinte de l'excellence.

“When we meet, we have no trouble talking to each other, the words we use, our vision of what it [Faculty Development] is, I think is very similar” (P-02)

Introduction

Faculty development (FD) refers to “all activities health professionals pursue to improve their knowledge, skills, and behaviors as teachers and educators, leaders and managers, and researchers and scholars in both individual and group settings.”^(1 p.4) FD can drive educational program planning and delivery in the health professions (HP) and is often informed by local culture, highlighting the dialectic relationship between institutions and culture.² FD publications often reference culture, but there is little empirical research about the culture of FD in the health professions. Deeper understandings of the culture of FD, including its norms, values, beliefs, and practices, could help to make the implicit explicit and improve program effectiveness, guide program development, and enhance cross-cultural FD.

Previous studies have indicated that the culture of medical units or departments can determine how their members function.³⁻⁴ Additionally, health professionals involved in international FD, as teachers or learners, often cite culture as one of the factors affecting program success.⁵⁻⁶ The present study aimed to explore the culture of FD from the perspectives of the directors of FD units in Canadian medical schools. The specific research question was: What is the culture of FD in Canadian medical schools as perceived by the directors of each school’s FD program?

In this study, culture was conceptualized as an “integrated pattern of learned beliefs and behaviours that can be shared among groups and include thoughts, styles of communicating, ways of interacting, views of roles and relationships, values, practices and customs.”⁷ Using the cultural studies framework, culture was also theorized as “a contested and conflictual set of practices and representation” including text, images and codes of behaviour bound up with the process of formation and re-formation of social groups.⁸ Research into the culture of FD, can reveal the ways in which different members of a group have a sense of belonging to, or are attempting to reshape, the dominant culture.

Culture matters in education; it shapes and is shaped by the practices and organization of teaching and learning. One way of accessing culture and the symbolic values of human actions and interactions is to examine how people talk about what they do, through spoken or written text.⁹ Thus,

in line with previous research^{9,10} and definitions of culture,⁷ we believe that the practices, values and beliefs that embody FD in Canada can be revealed by the ways that health professionals talk about their work.

Methods

Theoretical framework and study design

The theoretical framework of cultural studies, which informs this research, views culture as a site where meaning is contested and where social life is mediated through meaning-making.⁸ The researchers used a constructivist methodology and theoretical framework located within cultural studies, while borrowing from phenomenological inquiry,¹¹ to determine the meaning that participants construct from their practices, symbols, and texts. The design is based on the study of the social practices of a group and the meaning of these practices, with a view to making said practices understandable phenomenologically.¹¹ By focusing on the leaders of FD, the team examined the culture of FD through their relative positioning as “carriers of a certain social identity and authority.”⁸ There is an identifiable system of shared meanings that is reproduced by social actors and communicated through certain representations or symbols.⁸ The cultural studies lens examines how social actors reinforce, challenge, resist and re-form meanings in their everyday lives through their actions, interactions, and imageries.

Reflexivity

Researcher reflexivity is an integral part of qualitative research that ensures that the researcher is continually aware of the assumptions that she brings to the research.¹² One of the researchers on this study (YS) is actively involved in FD and was probably known by the participants, as she has written extensively about FD. Apart from the mandatory anonymizing of the transcripts of the research participants before they were sent to this researcher, it was also necessary for this research to consider her positionality and assumptions about FD. During the data analysis stage, the researchers met continuously to ensure that the themes were derived from the data and not based on prior assumptions of the researcher involved in FD. For example, while it was surprising to this researcher that the participants did not feel recognized, as her experience was different, this point was important in the data and led to the theme of negotiating recognition. The other researcher (LDL) is an outsider to the field of FD and works within the area of Critical Race Theory in Education. She had to

account for her assumptions of the ways in which an Anti-Black Racism feminist lens informed her interpretation of the research data and the meaning that participants were making of their experiences.

Study sample

The study population consisted of the leaders of FD in all seventeen medical schools in Canada. They were invited by email to participate in a telephone interview to examine the culture of FD in medical education. The study sites represented the differing contexts in which FD occurs in Canadian medical schools.

Data collection and analysis

The interview protocol, included in Appendix A, consisted of semi-structured, open-ended questions which were based on the relevant FD and culture literature and pilot interviews with three individuals involved in FD. Moreover, in line with common practice in the field, interview questions and consent forms were sent to participants ahead of the interviews, for their consideration. Interviews were conducted between November 2016 and March 2017, in French and in English, and were transcribed verbatim according to the language in which they were conducted. Transcripts were sent to participants for approval before data analysis began. Data were organized and analyzed using a constant comparison method for Atlas.ti outlined by Freise.¹³ A codebook with rules of inclusion was developed for coding. Codes created inductively were organized into categories, and were compared within and across all transcripts, to arrive at themes.

Organization of FD in Canada

The organization of FD varies across medical schools in Canada.¹⁴ Although the overall purpose of FD is similar across institutions, institutional mandates dictate that FD units operate differently. For instance, some medical schools offer interprofessional FD, while others leave FD up to individual departments. Sometimes, FD programs are independent of Continuing Professional Education programs; at other times, there is a strong collaboration between the two programs. Frequently, one individual is responsible for leading and directing FD in the medical school. However, sometimes the leadership roles may be divided, with one person responsible for developing teaching-related aspects of FD and another person responsible for leadership development. In some medical schools, faculty developers are remunerated for leading workshops and participants are required to cover some of

the costs. In most cases, however, there is no fee to attend FD workshops or programs. FD activities are usually event-based, ranging from a couple of hours to several days or weeks. They also occur in-situ, as part of participants' day-to-day work. Some FD programs are longitudinal in nature, usually up to one year. In most schools, participation in FD is encouraged but not mandatory.

Results

Interpretive understandings of the culture of faculty development

Fifteen individuals responsible for FD, three men and 12 women, representing 88% (15/17) of the medical schools in Canada, responded to the invitation to be interviewed; each interview lasted an average of fifty-minutes.

Four themes characterized the culture of FD in Canadian medical schools: (1) Balancing competing voices and priorities; (2) Cultivating relationships and networks; (3) Promoting active, practice-based learning; and (4) Negotiating recognition.

Balancing competing voices and priorities

All faculty developers reported that teaching was the primary focus of their FD programs. They generally held the belief that FD could be transformative and that everyone could improve through FD. However, translating this belief into practice required the balancing of competing voices and priorities, as represented by faculty members, programmatic needs, and institutional priorities.

For instance, participants reported that faculty members often experienced a tension between clinical work, research, and FD. This tension was often perceived as a "pressure of time" and "a challenge" in balancing FD with multiple other responsibilities. Additionally, the rewards for participation in FD were often seen to be less than those gained by participating in research for promotion and tenure. As one participant pondered:

How do we influence that belief system around [the idea that] teaching is important enough [so] that it displaces some of the other priorities in people's lives? I don't know the answer to that. I don't know how we would tip the balance. (P-07)

The challenge of balancing competing priorities was also seen in the choice of FD content, which was often based on departmental consultations, faculty surveys, discussions with deans or other academic leaders, or student evaluations. At times, the institutions' needs were not the

same as those of faculty members. For example, one participant reported that faculty members were not interested in the “humanities”, a subject prioritized by the institution. Faculty developers therefore had to be creative in balancing faculty members’ interests and institutional priorities:

[Faculty feel that they] don't need to go to any FD that's considered humanities. [So we have to] find other ways. We don't want to call it the humanities, but we need to incorporate humanities into all our offerings; people won't come if they think they don't need FD on humanities. (P-03)

Participants also commented that that some institutional beliefs suggested that FD was essential and designed to “fix problems,” a challenge that could not always be met and therefore caused considerable consternation:

I hear all the time; we're going to be doing competency-based medical education or we're going to be doing something [else], and people say, 'and we're going to need FD around that' and then they look at me, to do something about it. (P-04)

Other participants shared the belief that participating in FD might be viewed as looking after oneself, only possible when there was extra time, and one participant likened FD to an “educational spa” (P-08). Another participant summarized this perspective poignantly:

I had one educational leader here describe it to me as being the goalie in the hockey game, everybody is shooting pucks at you, and until the pucks stop coming, you can't leave the goalie net as a physician. So, when the pucks stop coming, then you have time for the other stuff including education, leadership, or administration. Like a parent, looking after yourself often comes last, and physicians see FD as looking after themselves. (P-07)

Language was another factor that influenced how FD was practiced in Canada. In trying to balance the needs of participants, language tended to sometimes limit the possibility of FD training across medical schools.

Sometimes there are great training sessions elsewhere in Quebec or Canada, but it is in English. It is also very difficult for us to invite a conference speaker or trainer when they are not Francophone. (P-13)

Cultivating relationships and networks

“Collegial,” “collaborative,” and “supportive” were the values expressed by many participants. In naming this theme, the word cultivating was chosen to suggest the intentionality expressed by faculty developers in “creating community;” that is, faculty developers’ beliefs in community motivated them to create an environment where FD was a “social happening” and they would deliberately structure FD activities to encourage networking and exchange. This goal, prior to the Covid-19 pandemic, was further achieved by including meals and refreshments to encourage discussions among attendees during breaks and by making FD “a social event” (P-08).

In multiple ways, the culture of FD was described as one in which strong relationships were valued and actively nurtured, not only among faculty members, but with other affiliated groups and stakeholders such as deans and hospital leaders who could support FD.

We have a very collaborative culture; we have strong relationships. I guess we actively cultivate the relationships we have with the education leaders at the hospitals. (P-12)

Some faculty developers bemoaned the fact that FD was largely voluntary, as this sent mixed messages to participants about its importance. One interpretation could be that the voluntary nature of FD in most institutions may have been linked to the creation of an inclusive environment that enabled everyone to participate and contribute.

The following reflection further highlights values associated with this theme, such as “sharing experiences” and “learning from colleagues”. Many faculty developers referred to FD as a “conversation” with colleagues that recognized their knowledge and expertise rather than a one-way transmission from experts to novice participants.

It's not really an expert educator who is teaching the teachers who don't know anything. There is someone facilitating a conversation who has maybe had the opportunity to do some more rigorous literature review on best practices and is sharing that information. But at the end of the day, we are really coming together to think things through as a group. We believe in collegiality. (P-02)

FD relationships were also associated with the notion of cultivating identities. As one participant noted, “We do lots of stuff around mentoring and career development, which

is an important piece that helps us cultivate identities as faculty members” (P-12). Another participant commented that “[FD] kindles the part of your identity that may get lost in your other responsibilities” (P-02).

According to many participants, the institutional practice of FD helped cultivate relationships and identity because FD offered opportunities for repeated contact, sharing and collaboration. In fact, FD was seen as a hub for interprofessional collaboration and networking, building a sense of “community” among participants.

Promoting active, practice-based learning

Participants described the culture of faculty development as one that promoted experiential learning, highlighting the importance of being “learner-centered”, “interactive” and “practical”. As a result, FD practices included an emphasis on small group discussions and face-to-face sessions, rather than pre-recorded webinars and podcasts, which were sometimes considered “passive”. FD practices also included practical activities aligned with the overall pedagogical approach of the institution, allowing participants to implement specific educational strategies more easily. As one participant explained, faculty members choose programs that “seem more practical and less esoteric” (P-03). Faculty developers were also motivated to offer programs that would meet students’ needs. For instance, the reflective practice that was expected of students was taught and modeled in FD activities.

We try to make the teaching for students and teachers coherent. As an example, in the last few years we have introduced reflective practice, mentorship and group work to students – to help build communities of practice. More recently, we have added these reflective approaches to our work with teachers as well. (P-13)

Ensuring the experiential nature of FD also led to activities in faculty members’ workplaces and a “bespoke FD,” tailored to individual needs.

For example, they may say they have a meeting every Wednesday morning...and they ask us to come as they have allocated time for [FD] during this meeting. It is very popular. (P-11)

The desire to promote continuous improvement and therefore be relevant and “learner-centered” was also evident in the ways that FD was offered, either as a discipline-specific or interprofessional activity. This choice seemed to be driven by institutional beliefs and structural

considerations. For example, one participant advocated for the benefit of discipline-based FD:

We believe that adult learners want to see the learning as relevant to what they are doing. So, we strongly believe that FD has to be disciplinary based. If we are doing FD with a group of “Emerg Docs”, we ground our instructions in the practices of teaching in that discipline and we use examples and languages consistent with that emergency discipline... We believe that what you call pedagogical content knowledge is discipline-based. (P-07)

Another participant tried to achieve a similar connection between FD and practice by offering interprofessional programming. They believed that FD lends itself well to interprofessional collaboration because certain topics (e.g., giving feedback) are similar, regardless of whether the student learner was a medical resident or physiotherapy student.

One of the things I adhere to, I think there is a strong value placed on Interprofessionalism, so the program for FD is interprofessional in all its offerings. So, rather than talk about medical education we use the term health sciences to make sure that we are inclusive because we realize that FD is not profession-specific; we encourage interprofessionalism in our facilitators and in our audience as well.” (P-09).

The importance of FD to the university and to society was also underscored by several participants, and this holistic conceptualization of FD was central to this practice-based theme.

I think it’s important for us to be responsive to community needs as well. I think we have to pay attention to what society and community is expecting of a university professor, of a clinician, of a medical educator. Society has said that we’re not actually satisfied with the quality of physicians that are out there, so we need to have a different model of training people and FD is going to help deliver that change in the education model. I think we have to be responsive to society. (P-11)

Negotiating recognition

Participants’ insights suggested a recognition of FD’s importance among faculty members who participated in FD activities. Specifically, faculty developers reported that FD was often highly valued. “There are very few meetings where FD doesn’t get mentioned... FD as a term is

represented in formal documentation as well as informal conversations.” (P- 09)

At the same time, however, this recognition was not always true for educational leaders or those who did not attend activities, as exemplified here: “It is not habitual for a lot of people to say gosh, I need some FD; for some people it wouldn’t be on their radar.” (P-10) There was also a concern that FD was primarily considered when colleagues were struggling, especially with teaching, and one participant questioned how FD could be recognized as more than a way to address weaknesses:

You know addressing people’s weakness is important; but in terms of improving overall teaching experience at our institution, wouldn’t it be better to continue to build and grow people who are [already] strong and enthusiastic teachers?” (P-06)

Negotiating recognition was relevant at both the institutional and individual level. On the one hand, there was an institutional belief that FD was important; it was included in strategic plans and each medical school had an online FD presence. On the other hand, several faculty developers reported feeling undervalued and commented that it was a struggle to get participants to enroll, especially as FD was considered voluntary in most schools.

The fact that FD did not produce easily “measurable” outcomes also led to the perceived need to negotiate recognition. As one individual stated:

Because the outcome is not measurable in numbers it’s hard—and so [key stakeholders] tend to rely a lot on the leadership belief. They need to believe strongly that it’s important because it’s hard to provide numbers and dollars in terms of the outcomes, compared to other areas. (P-06)

As a result, faculty developers believed that they had to advocate for FD and constantly meet with educational leaders, including deans and department chairs, to promote FD offerings.

Negotiating recognition was also related to broadening the definition of FD and promoting the role of scholar and researcher to members and academic leaders:

If somebody says to you, I’m the Associate Dean of FD, if it’s not explained what that role is, it’s hard to know. We had focused for a long time on teaching aspects of FD without expanding to other areas, so there’s the perception that it’s limited to some specific roles. I

don’t think we highlight the scholarship of FD enough, so we need to have it more visible. (P-05)

Further, negotiation was perceived as a two-way street, and faculty developers sought more recognition of their programs by trying to add value to their offerings:

People are so busy so that whenever we try to offer or develop something new for FD, we want to make sure that it’s going to be value-added in terms of the time that’s involved to do something.” (P-11).

Value was also added through accreditation of FD activities and by what one participant described as the practice of “piggybacking” FD onto other events that were seen as more highly valued. For example, piggybacking sometimes meant finding complementarity between Continuing Professional Development (CPD) and FD to embed FD topics in a CPD program. It was also a practice that was used to counter the belief that CPD could be a “threat” to the future of FD in some schools. One participant described opportunities for complementarity as follows:

Often a safe prescribing course would fall strictly under CPD, so that would be continuing medical education, to update your clinical skills; but as a teacher, you really also need to have that [information] to be able to teach your residents or your learner appropriately, so that’s where that overlap happens. (P-14)

In diverse ways, negotiating recognition reflected the sub-cultures operating within the institution that may have contributed, or acted counter, to the goals of a FD program.

Discussion

Culture is dynamic and contextual, and it evolves through innovation, discovery, or diffusion.¹⁵ When McLeod and Steinert examined the history of FD in Canada in 2007, they found that FD in medical education had grown and evolved considerably.¹⁶ Fifteen years later, a scoping review on culture and FD revealed that no study had explored the culture of FD empirically.² This exploration of Canadian FD aims to address this gap. O’Sullivan and Irby¹⁷ observed that we know very little about the context in which FD activities unfold. This research aimed to address this void.

The results of this study suggest that Canadian faculty developers perceive FD as a balancing act between competing voices and priorities and a hub for cultivating relationships and networks. It is also seen as an example of practice-based learning, that is core to continuous

improvement and recognized through negotiation. Although study participants did not express a singular view of the culture of FD, which was likened to a “chameleon,” common values, beliefs, and practices were shared and recognizable by leaders of FD across the country.

In several ways, the findings of this study relate to two other studies about FD in Canada. Baker and colleagues¹⁸ explored faculty developers’ roles and experiences to inform our understanding of competence in FD. In so doing, they highlighted the critical role of “situated context” as well as three processes that can enhance the competence of faculty developers. Our study’s findings on culture can help to further our understanding of the FD context that these authors recognized and inform the processes of negotiating, constructing and attuning FD, which they identified. In another study, Kolomitro and colleagues,¹⁴ examined how the institutional context can influence faculty developers’ capacity to fulfill their mandate. They also identified the critical role of context and concluded that FD must be adequately recognized and resourced to be effective, a finding which is reflected in our theme of negotiating recognition.

In examining the results of this study, it is important to note that Canadian FD occurs in the context of medicine in Canada—a system of healthcare which is mostly publicly funded. Additionally, FD in Canada has a long history, with a firmly established place in medical education.¹⁹ This national context (of recognition and established presence in medical education) helps to shape the culture of FD at the institutional level as described by the fifteen FD leaders. However, despite the prominence given to FD at the national level, there was evidence of the need for more recognition of FD in some medical schools.

Faculty developers and faculty members who participate in FD programs and activities do so largely on a voluntary basis. Questions can be raised about the sustainability of this model of FD and how participation on a voluntary basis can promote inclusivity. Who gets to volunteer time to improve their pedagogy? Who is included and who is excluded from faculty development based on volunteerism?

The lens of cultural studies also highlights tensions within FD in Canada. Silences and omissions are as critical as that which is spoken in the study of culture, and questions can be raised about the perceived silence on issues such as race and ethnicity in FD in our interviews. Did the research team create a space for these discussions, or did we validate and

inadvertently justify this silence? And has FD’s attention to equity, diversity and inclusion increased post-pandemic?²⁰ Overall, it is recognized that a culture of FD that is committed to supporting the professional development of faculty members requires institutional leadership and support for FD. The values of collaboration, collegiality, responsiveness, and active participation, which embody the culture of Canadian FD, can help FD leaders to fulfil their roles.

Study limitations

As many participants in this research study readily pointed out, examining culture requires prolonged immersion in research sites. However, personal interviews can provide rich insights into peoples’ understanding of their lived experiences. The shared language that emerges from FD is evident in this research and highlighted in the opening quote. As well, comparing faculty developers’ accounts produced credible themes on the culture of FD, some of which were already reflected in the literature. A limitation of this approach, however, is that people may be more inclined to talk about positive aspects of their experiences in a single interview on the telephone. An ethnographic study could provide more in-depth understanding of the culture of FD, as could an exploration of FD leaders’ and participants’ perspectives in different settings. In fact, the values and institutional beliefs that shaped the practices identified in this research may be similar in other contexts where there is a focus on the collective and where health care is not mainly profit driven. It should also be noted that this study was conducted prior to the Covid-19 pandemic. It is highly possible that some aspects of the culture of FD will have changed post-pandemic.

Directions for future research

As noted above, an institutional ethnographic study could provide additional understanding of the culture of FD in Canada, through “thick descriptions”²¹ from multiple stakeholders across diverse FD structures. Such a study could also provide a more fulsome portrait of the interplay between institutional and leadership characteristics and culture. Work on race, ethnicity, class, gender, and disability in FD should also be examined, given the need for FD to help faculty members acquire skills in these critically important areas and contribute to social justice. Lastly, the exploration of FD leaders’ and participants’ perspectives in different countries could strengthen international collaboration and cross-cultural FD.

Conclusion

Participation in FD programs and activities in Canada remains largely voluntary. Efforts to attract participants face the challenges of perceived relevance, competing priorities, time constraints, and a lack of formal recognition for professional development. At the same time, a focus on continuous improvement, marked by community building, individual and collective responsiveness, and active, practice-based learning to achieve excellence, motivates faculty developers to achieve their goals. Studying the culture of FD in this way can help to reveal its implicit systems of values and beliefs that, when made explicit, may enhance program design and delivery.

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Appendix A. Interview questions

1. Which of the following terms do you use to refer to programs designed to help medical faculty in their teaching, leadership, and scholarly activities?
 - Faculty development
 - Staff development
 - Professional development
 - Continuing professional development
 - Other _____
2. How long have you been involved in faculty development at your institution? What is the title of your position? What is your academic background and professional degree?
3. What are the goals of your faculty development program? Is faculty development mandatory or voluntary at your institution?
4. What activities do you offer in your faculty development program?
5. How do you motivate faculty members to participate? What are some of the barriers or considerations to participation in, or implementation of faculty development or _____, at your institution?
6. What do you understand by the term culture? What do you think is the culture of faculty development at your institution?
7. If we think of *practices* as habitual or customary actions or ways of doing something, what would you say are some of the practices of faculty development at your institution?
8. What are the assumptions and beliefs of faculty development in your institution?
9. Is there a story of a faculty development program or initiative that you are particularly proud of that you can share? What in particular made you proud?
10. Is there a story of a faculty development program or initiative that did not meet your expectation for success? What in particular would you say was the reason for failure?
11. Thinking about faculty development or _____ in your institution, what are the norms, values and beliefs of your institution that influence faculty development?

12. Would you say there are specific attributes of faculty development that are uniquely Canadian?

13. What other factors do you think impact on faculty development or _____ in Canada?

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