Faculty development: Yesterday, today and tomorrow
Yvonne Steinert
McGill University, Canada

Faculty development: From workshops to communities of practice

“Participating in a faculty development workshop gives me a sense of community, self-awareness, motivation and validation of current practices and beliefs...”
Steinert, 2008

Faculty development, or staff development as it is often called, has become an increasingly important component of medical education, and most medical schools now offer formal faculty development programmes and activities. As McLean and colleagues have stated in their recent AMEE Guide “with demands on medical faculties to be socially responsible and accountable, there is increasing pressure for the professionalization of teaching practice”.
(McLean et al. 2008)

To date, most faculty development initiatives described in the literature consist of formal (or structured) programs such as workshops and seminars, longitudinal programmes and fellowships (Steinert et al. 2006). The goal of this Viewpoint, which complements AMEE Guide 33, is to broaden our perspective and examine both formal and informal approaches to faculty development. Moreover, although the most common definitions of faculty development refer to a planned program to prepare institutions and faculty members for their academic roles (Bland et al. 1990), this Viewpoint asserts that faculty development can occur in a variety of contexts and settings, and often begins with informal learning in the workplace.

Figure 1 provides a pictorial description of how faculty development activities can move along in two dimensions: from individual (independent) experiences to group (collective) learning, and from informal approaches to more formal ones. (Steinert, in press) This paper will briefly examine what takes place in each quadrant and how we can take advantage of these opportunities. As the reader will note, mentorship has been placed in the center of the figure, as any strategy for self-improvement can benefit from the support and challenge that an effective mentor can provide.

Learning from experience

It has been said that medical educators become adept at what they do by “the nature of their job responsibilities” and “learning on the spot”. (Steinert, 2008) Although this form of learning, which may occur in the classroom or in the clinical setting, is not often considered an approach to faculty development, it is vital to self-improvement. It can also be divided further into three categories: learning by doing; learning by observing; and learning by reflecting on experience.

Learning by doing is frequently described in the medical education literature as experiential learning. However, although it is highly valued as a form of learning in the clinical context, its benefits for the development of faculty members have not been described and merit further study. Learning by doing is also complemented by learning by observing. While the
concept of role modelling has also been described in the acquisition of attitudes and skills by students and residents (Cruess et al. 2008; Wright et al. 1997), it is equally neglected in discussions about faculty development. However, all of us can remember how we learned from role models, even if we sometimes try to exhibit behaviours in opposition to what our role models have demonstrated. Clearly, teachers can actively and consciously seek out role models, observe them, and learn from them, and we should work together to maximize this learning opportunity.

Reflecting on experience enhances both learning by doing and observing. Schön (1983) has described the importance of reflection in medicine and the key components of reflective practice that include “reflection in action” (which includes an analysis of what is being done) and “reflection on action” (which occurs after a particular action or situation has taken place). Lachman and Pawlina (2006) have added to this discussion by introducing the notion of “reflection for action” (which includes reflecting on what has been learned for the future). Whatever the nomenclature, self-awareness, critical analysis and the development of a new perspective are fundamental to the process of reflection, and we must identify the diverse ways in which this strategy can enhance the development of faculty members.

At times, keeping a log of teaching encounters or a journal can initiate the process of analysis and reflection. At other times, “notes to self” or viewing oneself on film can offer new insights into recurrent patterns or behaviors. Seeing colleagues in action can also trigger reflection. Whatever the venue, asking oneself a series of critical questions can help teachers begin to: break down complex teaching activities into understandable components; facilitate the examination of personal assumptions; encourage “experimentation” and try out new approaches to teaching; examine the effectiveness of specific teaching practices; and increase intentionality (Steinert, in press), as long as we remember that how teachers reflect on teaching practices is a very individual choice.

**Learning from peers and students**

Moving along the dimension of informal to formal approaches highlighted in Figure 1, we should consider the benefits of learning from peers and students. Peer coaching, sometimes called co-teaching, has particular appeal for clinical teachers because it occurs in the practice setting, enables individualized learning, and fosters collaboration. (Steinert, 2005) It also models aspects of clinical practice (Flynn et al. 1994): the identification of individual learning goals (e.g. improving specific teaching skills); focused observation of teaching by colleagues; and the provision of feedback, analysis and support. As a result, we should consider ways of enhancing this faculty development strategy, especially as it allows clinical teachers to learn about each other as they teach together. (Showers and Joyce, 1996) And yet, the majority of teachers are reluctant to seek feedback from their peers. Why is this? What can we do to help teachers see the benefits of asking a colleague to observe them and to provide feedback after a specific teaching encounter? (Newman et al. 2009) Soliciting feedback from students and residents can be equally worthwhile. In fact, the following questions can trigger a useful discussion after a specific teaching encounter: What did you learn today? What about this encounter was helpful to you? What could we have done differently to make it more useful to you? It is unfortunate that feedback of this nature is not routine (Steinert, in press), especially as an appreciative inquiry of student or resident evaluations can be a valuable strategy for the professional development of faculty members.

**Workshops, seminars and longitudinal programs**

The activities in the third quadrant in Figure 1 are the most commonly cited faculty development initiatives. For example, workshops are popular because of their inherent flexibility and promotion of active learning. Teachers value a variety of teaching methods within this format (Steinert et al. 2006), which is commonly used to promote skill acquisition
(e.g. lecturing or small group teaching skills), to prepare for new curricula (e.g. problem-based learning) or to help faculty adapt to new teaching environments (e.g. teaching in the ambulatory setting).

Fellowships of varying length, format and emphasis have also been utilized in many disciplines. More recently, integrated, longitudinal programmes have been developed as an alternative to fellowship programmes or sabbaticals. These programmes, in which faculty commit 10-20% of their time over 1-2 years, allow health care professionals to maintain most of their clinical, research, and administrative responsibilities while furthering their own professional development. (Steinert, in press) Programme components typically consist of a variety of methods including university courses, monthly seminars, independent research projects, and participation in staff development activities. Integrated longitudinal programmes, such as a Teaching Scholars Program, have particular appeal because teachers can continue to practice and teach while improving their educational knowledge and skills. (Gruppen et al. 2006; Steinert and McLeod, 2006) In addition, these programmes allow for the development of educational leadership and scholarly activity in medical education.

Certificate or degree programmes are also becoming increasingly popular in many settings. In part, this is due to what some authors have termed the “professionalization” of medical education and several authors have argued for the need to certify medical educators and work to ensure global standards; others do not agree and worry about disenfranchising keen and committed educators. (Eitel et al. 2000; Purcell and Lloyd-Jones, 2003) Cohen and colleagues (2006) have provided an update on twenty-one master’s programmes in medical education. As these authors suggest, an advanced degree in medical education can offer essential grounding in educational theory and practice while providing the foundation for educational research and scholarship. They can also be particularly helpful to individuals interested in educational leadership, administration or research.

In summary, it is these more formal activities (which occur primarily in a group format) that are most often synonymous with faculty development and that should be maintained as we explore additional avenues of professional development.

**Work-based learning and communities of practice**

Moving to the last quadrant in Figure 1, we approach two important strategies for learning: work-based learning and communities practice. Work-based learning, which is often defined as learning for work, learning at work, and learning from work, (Swanwick, 2008) is closely tied to the notion of experiential learning, as “learning on the job” is often the first entry into teaching and education. In fact, it is in the everyday workplace, where teachers conduct their clinical, research and teaching activities – and where they interact with faculty, colleagues and students – that learning most often takes place. It is therefore very helpful to view everyday experiences as “learning experiences” and to reflect with colleagues and students on learning that has occurred in the work environment. (Boud and Middleton, 2003) In many ways, it is unfortunate that we do not currently view work-based learning as a forum for staff development, as by working together in a clinical or classroom setting and discovering opportunities for learning, teachers can acquire new knowledge and develop novel approaches to teaching and learning. It is also interesting to note that staff development activities have traditionally been conducted away from the teacher’s workplace, requiring participants to take their “lessons learned” back to their own contexts. Perhaps it is time to reverse this tradition and think about how we can enhance the learning that takes place in the work environment. By working together and participating in a larger community, clinicians and basic scientists can build new knowledge and understanding, and develop approaches to educational problems and challenges. (Lave and Wenger, 1991)

The notion of a “community of practice” is closely tied to that of work-based learning. Barab and colleagues (2002) have defined a community of practice as a “persistent, sustaining,
social network of individuals who share and develop an overlapping knowledge base, set of beliefs, values, history and experiences focused on a common practice and/or mutual enterprise. In many ways, becoming a member of a teaching community can be a critical step in becoming a better teacher. More specifically, Lave and Wenger (1991) suggest that the success of a community of practice depends on five factors: the existence and sharing by the community of a common goal; the existence and use of knowledge to achieve that goal; the nature and importance of relationships formed among community members; the relationships between the community and those outside it; and the relationship between the work of the community and the value of the activity. A community also requires a shared repertoire of common resources, including language, stories and practices. (Wenger, 1999) In diverse ways, belonging to a community of practice builds on the collegiality that we often witness in clinical medicine and can be an important venue for faculty development, which in turn can lead to the development of a community of practice. (Steinert et al, in press) As medical educators and faculty developers, we need to help our colleagues value the community of which they are a part (e.g., by celebrating its existence, members and resources) and find community (e.g., by building new networks, creating opportunities for exchange and support, and sustaining relationships). A colleague has offered the following perspective: “If you are able to immerse yourself in a group, it gives you so much. If you start with some experience, and you mix yourself into a group with like interests, you get much more out of it... It’s being able to look at things critically with education glasses on … the same way you would look at a patient with, you know, diagnosis glasses on, or treatment care glasses on. It’s a different approach, a different way of looking at things...”

Mentorship

Mentoring is a common strategy that is used to promote the socialization and development of academic medical faculty (Bligh, 1999). However, it is an underutilized strategy for professional development and should be considered as an explicit approach in faculty development. Mentors can provide guidance, direction, support or expertise to faculty members in a variety of settings. They can also help teachers to understand the organizational culture in which they work and introduce them to invaluable professional networks. (Walker et al. 2002) Daloz (1986) has described a mentorship model that balances three key elements: support, challenge, and a vision of the individual’s future career. This model can serve as a helpful framework for faculty development, especially as we have seen that finding a mentor – and being mentored – has been considered one of the most critical aspects of the process of becoming a better teacher. (Steinert, 2008) We should also work to recognize the value of this important activity and help colleagues to identify their needs and actively seek a mentor, knowing that at times multiple mentors for diverse purposes are both recommended and beneficial.

Conclusion

Glicken and Merenstein (2007) have stated that faculty members often come to medical teaching with the “wisdom and experience that dictates what their students need to know” although they have not been trained for the job at hand. With the goal of increasing capacity and professionalizing teaching, we should aim to: maximize experiential learning and role modelling by promoting reflection and self-awareness; encourage faculty to take advantage of peer coaching and assessment; offer workshops, seminars and longitudinal programmes whilst remembering that these more formal strategies can build on, and incorporate, more informal approaches; and find new opportunities to promote work-based learning and communities of practice. Clearly, faculty development will retain an important profile in medical education; it is our responsibility, however, to explore both formal and informal approaches to achieve our objectives in this domain.
References


Notes on Contributor

Yvonne Steinert, a clinical psychologist and Professor of Family Medicine, is the Associate Dean for Faculty Development and the Director of the Centre for Medical Education at McGill University.

Dr. Yvonne Steinert, McGill University, 1110 Pine Ave West, Montreal, Quebec H3A 1A3, Canada. Phone: 514-398-2698. Fax: 514-398-6649. E-Mail: yvonne.steinert@mcgill.ca.


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