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Informal faculty development in health professions education: Identifying opportunities in everyday practice

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ABSTRACT

Introduction: Faculty development (FD) supports health professions educators to develop knowledge, skills, and expertise. Whilst formal FD is a focus in the health professions education (HPE) literature, little is known about how FD occurs informally. We sought to identify opportunities and constraints for informal FD amongst health professions educators in the academic (university) setting and understand how they engage with these opportunities.

Methods: This exploratory study was conducted in one Australian university. Interviews and focus groups were conducted with undergraduate and postgraduate teachers and assessors (teachers) ($n = 10$); teaching team and program leaders (mid-level leaders) ($n = 8$); and senior (university-level) leaders ($n = 2$). We analysed data thematically and applied situated cognition theory.

Results: We identified three everyday educational practices that provide opportunities for informal FD in the academic setting: (1) applying evidence to; (2) evaluating; and (3) sharing, educational practice. Engaging with these opportunities was shaped by individuals' motivation and proactivity to engage in professional learning (effectivities) and organisational culture and structures (constraints).

Conclusion: Applying evidence to, evaluating, and sharing educational practice provide valuable contexts for ongoing learning in the academic setting. Assisting educators and organisations to recognise and leverage these 'in situ' FD opportunities is vital in fostering a continuous learning culture.

KEYWORDS

Staff development; informal faculty development; educational practices; affordances; constraints

PRACTICE POINTS

- Routine practices of applying evidence to, evaluating, and sharing educational practice provide health professions educators in academic (university) settings with opportunities (affordances) for informal FD
- Engaging with these opportunities (affordances) is shaped by the structure and culture of the workplace environment, and individual motivations and capabilities.
- Leveraging opportunities for informal FD requires both individual proactivity, and support and investment from educational and university leaders.

INTRODUCTION

Faculty development (FD) encompasses wide-ranging activities and mechanisms to assist health professionals to develop their educational expertise and meet the needs of their diverse educational roles (Steinert et al. 2016). Formal FD activities (e.g., workshops/seminars) feature prominently in the health professions education (HPE) literature (Steinert 2010; Steinert et al. 2016). Yet, FD also takes place informally, outside of formal, structured activities. FD can be considered a social enterprise (O'Sullivan and Irby 2011), occurring through community participation (Wenger 1999), social and peer networks (Campbell et al. 2019), and real-world experience (Brown et al. 1989). What remains unclear, however, are the aspects of day-to-day educational practices of educators in the health professions. By educational practices, we mean habitual, ongoing activities related to teaching and learning that provide opportunities to learn and develop educational expertise. In this paper, we adopt a situated perspective of learning that occurs through work and participation in authentic practices and environments (Billett 2001; Boud and Middleton 2003).

The focus of this study is the academic (university) setting, and the educational practices of university-employed staff who perform educational roles (i.e., academic health professions educators). Educational practices that occur outside of the academic setting (e.g., in clinical environments such as hospital and community health settings) are beyond the scope of this study.

To understand how FD can occur informally in the everyday work of academic health professions educators we used situated cognition theory, which recognises the interplay between the individual and their environment (Durning and Artino 2011; Torre and Durning 2015). This theory recognises that the environment creates conditions that invite learning (Billett 2001) and 'provide potential for action' (Kennewell 2001). These conditions are referred to as affordances. In the academic FD context, an affordance might include the availability of staff development activities. Affordances are, in turn, shaped by

constraints; the 'conditions and relationships ... which provide structure and guidance for the course of actions' (Kennewell 2001). In FD, constraints may include limited time to undertake FD, or limited access to participate in face-to-face FD. Finally, this theory recognises that an individual's unique skills and capabilities (effectivities) shape the way they engage with various affordances and navigate constraints (Michaels 2003). In FD, effectivities might include an individual's professional learning needs, or their motivation to engage in FD.

While situated cognition has been applied to understand how health professions educators integrate evidence into their work and translate new learning into practice (Onyura et al. 2015; Kumar and Greenhill 2016), it has not yet been applied to understand FD in the academic setting. We chose situated cognition theory to help us understand the interplay between health professions educators and the academic environment in the context of informal FD.

Our research questions were (1) What every day educational practices provide opportunities for informal FD amongst health professions educators in academic settings? (2) What factors influence how academic health professions educators engage in informal FD opportunities?

METHODS

This exploratory qualitative study involved interviews and focus groups with a diverse group of stakeholders within the academic environment.

SETTING

The study was conducted in the health and medical division of one Australian university after approval was granted by its Human Research Ethics Committee (Ref: 8501). The university was established in 1966 and has a large geographical footprint, spanning two states and territories, with multiple urban, rural, and remote campuses. Its health and medical division has approximately 260 full-time equivalent academic staff (65% of whom are women) and over 2500 students across 21 undergraduate and postgraduate teaching programs. In recent years, a university restructure resulted in organisational and leadership changes, centralisation of services, and changes to academic and professional staff roles, including the establishment of a teaching only academic pathway.

PARTICIPANTS

Participants were university-employed staff from the health and medical division and included: (1) those involved in teaching, supervision, facilitation, and/or assessment of healthcare students (teachers) (n = 10); (2) leaders of teaching teams, courses, teaching programs and disciplines (e.g., course

coordinator/discipline head) (mid-level leaders) (n = 8); and (3) senior leaders and managers with strategic oversight for education (university-level leaders) (n = 2) (see Table 1).

Table 1. Participant demographic data

Participants (n=20)	Teaching Program*	Geographical Setting	Educational Qualification	Educational Experience	Age (years)	Gender
<ul style="list-style-type: none"> University-Level Leaders (n=2) Mid-Level Leader (n=8) Teachers (n=10) 	<ul style="list-style-type: none"> Clinical Care (n=13) Biomedical Science (n=3) Population Health (n=2) 	<ul style="list-style-type: none"> Metropolitan (n=16) Rural (n=4) 	<ul style="list-style-type: none"> Yes (n=7) No (n=13) 	<ul style="list-style-type: none"> < 1 year (n=3) 1-5 years (n=3) 6-10 years (n=3) 11-20 years (n=3) 21+ years (n=8) 	<ul style="list-style-type: none"> < 30 (n=1) 31-40 (n=3) 41-50 (n=6) 51-60 (n=9) 61+ (n=1) 	<ul style="list-style-type: none"> Female (n=15) Male (n=5)

*Excludes university-level leaders

Teacher and mid-level leader participants were involved in both undergraduate and postgraduate programs spanning the disciplines of behavioural health, biotechnology, health professions education, medical science, medicine, and rural and remote health.

The study was advertised across the division using several mechanisms (i.e., eNewsletters/emails/presentations). Recruitment occurred via an online registration form and subsequent contact was made via email.

DATA COLLECTION AND ANALYSIS

Data were collected in two sequential phases. Phase 1 (December 2019-January 2020) involved semi-structured interviews (conducted by KK/AM/VJR) with teachers and mid-level leaders. Phase 2 (June-July 2020) involved focus groups (conducted by JR) with teachers and mid-level leaders, and interviews with university-level leaders. Sample data collection questions are outlined in Table 2.

Table 2. Sample data collection questions

Data Collection		Participant Group	Purpose	Sample Questions
Phase	Method			
1	Interviews (n=13)	Teachers and	To discuss participants' learning needs, priorities, and aspirations	How do you develop professionally as an educator?
		Mid-level Leaders		What sort of things are you aspiring to do or to achieve in your role as an education lead?
2	Focus Groups (n=3)	Teachers and Mid-Level Leaders	To explore FD approaches	What sort of informal opportunities give rise to learning for you? Can you describe these?
	Interviews (n=4)	University-Level Leaders	To understand institutional perspectives on education workforce development	What are your core priorities when it comes to the supporting and helping to develop the education/teaching workforce in this College/in your portfolio, and why?

Phase 1 data were analysed using inductive thematic analysis (Braun and Clarke 2006) by two sub-groups (VJR/ ASW and KK/SMK/AM). This resulted in a preliminary coding framework which informed Phase 2 data collection and was then refined during Phase 2 data analysis (initially conducted by JR/KK before involving all researchers). During the final stage, data were theoretically interpreted using situated cognition constructs (i.e. affordances, constraints, effectivities) (Greeno 1994; Billett 2001; Michaels 2003; Durning and Artino 2011). NVivo 12 (QSR International Pty Ltd., Melbourne, Australia) was used for data analysis.

REFLEXIVITY

The study's researchers (all employed by the university in which the research was undertaken) have varied professional backgrounds (allied health, education, nursing, prehospital care, public health, medical science), academic roles (teachers, mid-level leaders), and career trajectories. Additionally, the research team members live and work across a range of metropolitan and rural areas. These diverse perspectives informed our interpretations of the data, enhancing the study's credibility and rigour.

RESULTS

We identified three everyday practices that provide opportunities for informal FD: (1) applying evidence to educational practice; (2) evaluating educational practice; and (3) sharing educational practice.

APPLYING EVIDENCE TO EDUCATIONAL PRACTICE

Identifying and using educational literature to underpin teaching practices was a key mechanism by which educators developed their educational expertise. Engaging with the educational evidence was motivated by individuals' everyday needs and questions about their teaching. As one participant noted, drawing on the educational literature helped to consider interdisciplinary perspectives on teaching and learning helped to consider interdisciplinary perspectives on teaching and learning:

I think there [are] some really useful learnings to be had from the broader educational literature, particularly if we want to look towards the future and interdisciplinary education. (Interview 10, mid-level leader)

Yet educators sometimes encountered conflicting evidence, making it difficult for them to manage and integrate contrasting perspectives:

I find it difficult to reconcile opposing information about pedagogy and use, if the research says two different things about what should be done in teaching. (Interview 1, teacher)

This was compounded by a lack of familiarity with the HPE literature and educational terminology. Together, these challenges prompted participants to seek out experts (i.e., those more familiar with the evidence), and through this, develop educational alliances:

... collaboration with experts in different areas [would help to make professional learning more impactful] so that I can learn from them or that I have a better understanding of what they can offer so that I don't have to reinvent the wheel. (Interview 5, mid-level leader)

EVALUATING EDUCATIONAL PRACTICE

Another mechanism for academic health professions educators to develop their educational expertise was through 'monitoring and evaluating [teaching] to ensure that it's having the right outcomes' (Interview 6, teacher). Evaluating educational practices provided participants with an opportunity to learn more about articulating problems of practice, asking critical questions, and obtaining useful feedback and evaluative information.

Participants cited limitations of rigid evaluation mechanisms that make it difficult 'to demonstrate that you are reflective and that you are making changes and that they [the changes] have an impact' (Focus Group 1). This provided an impetus for participants to gather information about alternative ways of obtaining feedback about their teaching:

I think if there were better ways to evaluate my teaching, that'd be something that I'd be looking to

try and get more information on. (Interview 8, mid-level leader)

Subsequent to this new learning, some participants explained that they had begun trialling the use of different evaluation mechanisms:

We've incorporated a couple of different ways to try and gather information from students through different survey mechanisms beyond the SETs [student evaluation of teaching survey] for example, because the return rate for the SETs is so low that it doesn't help me that much [to] understand detail about what we need to change (Focus Group 1)

SHARING EDUCATIONAL PRACTICE

Sharing educational practice was a mechanism by which educators could learn with, and from, others, but this was not ubiquitous. Where sharing did occur, it was typically informal, occurring within local teaching teams and/ or settings:

I think it's a vicarious process, we support each other, we have an open kind of door around, 'Can I come into your teaching? Can we do informal peer stuff?' (Interview 10, mid-level leader)

Sharing educational practice was impeded by limited institutional spaces for collaboration and collective sense-making, a predominantly individualistic educational culture, and poor visibility of educational experts and expertise within the university. This meant that sharing educational practice was often ad-hoc and opportunistic:

I've recently discovered that there are actually quite a few experts in the university, and if I was able to link with them better and earlier, I think we could have done a better job of it ... these are [university] experts [within my institution] ... that I talked to at a conference. So, I feel it's quite ironic; it's ironic that we are based in the same ... university building and we actually started engaging in conversation at a conference. (Interview 9, teacher)

University-level leaders recognised the importance of developing a culture of trust and reciprocity within a centralised institutional model (as was the case in the study setting), to facilitate sharing of practice, informal learning, and feedback conversations:

It's really important for people to trust that the feedback that they can get about their teaching is going to come from someone who understands what they're trying to do and has credibility, in their eyes, to provide them with that feedback. (Interview 16, university-level leader)

In summary, participants overwhelmingly identified the need to be proactive and motivated in identifying and heeding opportunities for professional learning. This was eloquently described by a focus group participant:

As an educator, you have to be looking to develop yourself, and if that's not happening, then you will never get these opportunities ... They don't magically thrust themselves upon you. You have to be looking. (Focus Group 3)

DISCUSSION

This study identified three everyday educational practices that provide opportunities for informal FD for health professions educators in the academic setting. Successful engagement with these opportunities is influenced by various constraints of the environment and the skills/abilities (effectivities) of academic health professions educators.

In applying evidence to educational practice, educators developed an awareness of how to source, integrate and appraise evidence from the educational literature. Constraints such as the diversity and quality of evidence, coupled with educators' lack of familiarity with the HPE literature and its terminology, prompted participants to partner with educational experts to translate evidence into practice. Effective knowledge translation requires both personal skill-building to access, appraise and utilise evidence, and working in partnership with peers (Onyura et al. 2015).

Evaluating educational practice provided a context for educators to learn how to problematise, ask critical questions, and obtain and utilise feedback. Constraints such as restrictive evaluation frameworks and difficulties demonstrating the impact of educational improvements, prompted participants to learn about alternative evaluation mechanisms, and consider how to incorporate these into their own evaluation practices. Supporting educators to develop evaluative thinking has been identified as vital for educational quality and innovation (Earl and Timperley 2015).

Sharing educational practice provided educators with opportunities to develop social capital (Hean et al. 2013) by communicating and calibrating their practice and learning with and from others. The constraints of limited spaces for collaboration and collective sense-making, an individualistic educational culture, and poor visibility of experts and expertise, meant that meaningful sharing of practice was often opportunistic. Reframing teaching as a social practice enables attention to be given to the communal and social elements of educational practice (D'Eon et al. 2000), including the development of a culture of trust.

This research highlights the importance of supporting individual educators to recognise opportunities for

informal FD that exist in their everyday work (in this case, the academic university setting) and strengthen their capabilities to navigate these affordances and constraints. This can be achieved by assisting health professions educators to examine and critically appraise various individual, social and environmental factors that enhance and/or inhibit their ongoing learning in the context of everyday work. Institutions can foster informal FD by facilitating the development of educational alliances and partnerships; creating physical and/or virtual spaces for shared enterprise; and recognising and valuing the significant professional learning that can occur in the context of everyday educational practices.

LIMITATIONS

Although this study was limited to a single academic institution, sampling diverse participant voices provided us with rich insights into the opportunities (affordances), constraints, and effectivities associated with informal FD. These diverse perspectives were reflected in the research team, contributing to the study's credibility and rigour. Future studies could examine opportunities and constraints for informal FD in other teaching contexts beyond the academic setting such as workplace-based environments (e.g., hospital or community settings).

The over-representation of women, whilst reflective of the gender balance of the study setting, suggests the findings are gendered. Future research could canvass male perspectives to understand the role that gender may play in shaping individual effectivities. Finally, to counter the limitation of participants' self-reports, future research could involve direct observations of educators to understand how informal FD unfolds in practice.

CONCLUSION

Situated cognition theory enabled us to identify three everyday educational practices that provide opportunities (affordances) for informal FD for health professions educators in the academic setting. These affordances included: applying evidence to educational practice; and evaluating and sharing educational practice. Leveraging the rich and diverse opportunities for professional learning that can be found within everyday work in the academic setting requires both individual and organisational effort.

DISCLOSURE STATEMENT

The authors report no conflict of interest. The authors alone are responsible for the content and writing of the paper.

GLOSSARY

Environment: Physical, cultural, institutional, and social contexts for FD.

Affordance: Opportunity for action in the environment.

Constraint: Condition that structures and guide's action.

Effectivity: Individual skills/capabilities to engage with the affordance.

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