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Faculty Development as Transformation: Lessons Learned From a Process-Oriented Program

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Abstract

Background—Faculty development programs tend to be oriented around content, yet many have produced positive outcomes unrelated to the content. We describe a faculty development program that utilized the processes of shared reading and guided reflection espoused by narrative medicine.

Description—To date, 25 preceptors in the Foundations of Clinical Medicine course have participated. The program consists of weekly seminars in which participants actively engage with text as a basis for conversation around content as well as teaching strategies.

Evaluation—Using qualitative methods, we examined notes from seminars, in-depth interviews, and review of curricular documents; we used conceptual frameworks from education as interpretive lenses. Participants recognized both personal growth and transformation in relationships with each other, which created the opportunity, and the means, to address and reshape norms and teaching practices at the institution.

Conclusions—Process-oriented faculty development programs may foster growth of individuals, contribute to transformation in relationships, and ultimately influence teaching practices.

BACKGROUND

Longitudinal faculty development programs for clinician educators tend to be oriented around content, that is, they focus on education theory, principles, and/or practices for effective teaching, educational leadership, curriculum design, scholarship, or evaluation.^{1,2} The syllabi of such programs reflect a carefully planned sequence of learning events designed to transmit and apply desired content via such strategies as didactic presentations, group discussions, role plays, scholarly projects, and reflective exercises. Reports in the literature document the potential of these programs to achieve their primary aims of helping participants acquire the desired knowledge, skills, or attitudes.^{3–12}

Although other longitudinal faculty development programs share this content-orientation, they also call attention to process-oriented, secondary aims such as helping participants enhance personal reflection and form supportive interpersonal relationships.^{13–15} For example, one program was designed to promote acquisition of specific teaching skills that also promoted reflection and relationship formation.¹⁴ Indeed, a review of longitudinal faculty development programs suggests that achieving secondary aims may be as important, and more “future proof” or sustainable, than achieving primary aims, that is, the acquisition of knowledge, skills, and attitudes.¹ Extending this assumption one step further, might there

be value, then, in an alternate approach to faculty development, one where process is primary and content is secondary?

In this article, we seek to address this question by sharing our findings from an ethnographic evaluation of a process-oriented faculty development program at Columbia's College of Physicians and Surgeons (P&S). Briefly, the process-oriented faculty development program was funded by a National Institutes of Health grant with the primary aim of promoting the social and behavioral sciences in medical education. To accomplish this aim, the leader of the program held weekly seminars with faculty who facilitated small-group discussions around the social and behavioral sciences, in which she relied on the processes espoused by narrative medicine. Content typically covered in faculty development programs was not dismissed; alternatively, it emerged as conversations about effective teaching, education theory, and so forth were evoked by narrative medicine.

Narrative medicine refers to the practice of medicine with narrative competence, that is, the ability to acknowledge, absorb, interpret and act on the stories and plights of others.¹⁶ Engagement with text amplifies careful attention to, and reflection upon, one's work as a physician. The faculty development program used the processes of shared reading and guiding reflection that were espoused and informed by narrative medicine as a venue for clarifying and sharing beliefs, attitudes, opinions, and emotional reactions that make up meaning perspectives. The tension created by encountering different perspectives of trusted colleagues prompted reflection, questioning of assumptions, and ultimately learning from experiences so as to inform the next patient (or student) encounter.

DESCRIPTION

Participants

Participants were current or past small-group preceptors for the Foundations of Clinical Medicine (FCM) course at Columbia P&S. Beginning in the preclinical years and extending through medical school, FCM introduces students to core domains in the social and behavioral sciences identified by the Institute of Medicine (e.g., Physician–Patient Interactions, Social and Cultural Issues in Healthcare). Relevant participant demographics are displayed in Table 1. From 2006 to 2010, grant funding protected up to one half-day per week for FCM preceptors to lead their FCM small group and to attend a 90-minute seminar, the core of the faculty development program. As shown in Table 1, with the exception of 2007, new preceptors were recruited each year to fill in for faculty members no longer able to serve as FCM preceptors (but who continued as members in the faculty development program). These new recruits also joined and quickly became integrated into the faculty development program. For clarity, we refer to FCM preceptors, all of whom attended weekly seminars while leading a small group of medical students, as participants in the process-oriented faculty development program. Once part of the program, participants continued to attend when they were no longer precepting first-year students in FCM; of note, 9/11 in first cohort remained engaged as of the time of this writing.

Setting

In keeping with our ethnographic approach to evaluation, we recognized that the program did not occur in isolation but interacted with other systems within and beyond the institution. Locally, curriculum redesign at Columbia P&S, brought to fruition in 2009 with a new curriculum, created a period of flux and innovation. For example, the new curriculum was guided by inductively created school-wide learning objectives that elevated many of the same values embraced by the faculty development program (e.g., peer learning, teamwork, and self-awareness).¹⁷ At the same time, narrative medicine, a program birthed at Columbia

P&S, was gaining a national and international reputation and, as a result, gaining credibility within the research-oriented institution that Columbia is known to be.

Program Description

The program leader engaged faculty with the social and behavioral sciences using the processes of shared reading and guided reflection espoused by narrative medicine. The structure of the weekly faculty seminar evolved over the years. Initially, outside experts in the social and behavioral sciences were recruited to attend and to lead individual seminars. By the 2nd year, participants assumed this responsibility in an attempt to enhance their content-specific teaching skills. Time devoted to the narrative processes of reading and writing fluctuated from seminar to seminar, as did the nature of the readings and writings. However, narrative medicine remained a “keystone” to which the group consistently returned while the focus on behavioral and social science content remained secondary.

Participation in the weekly seminars was neither passive attendance nor absorption of content. Rather, participants actively engaged with text as a basis for meaningful conversations around issues related to teaching generally and to the social and behavioral sciences more specifically. They read stories written and published by others, wrote their own stories, and told stories about themselves and their students. For example, close reading of “another’s” story (e.g., John Berger’s short story “A Fortunate Man: The Story of a Country Doctor”)¹⁸ provided a safe venue for personal reflection about one’s personal experiences related to the narrative. Working from the premise that writing is making thinking manifest, participants also engaged in writing their own narratives. For instance, they wrote to prompts about patients that baffled them and about their fears as a teacher. They shared oral stories in the weekly “check in,” stories not only about their personal lives but also about students’ experiences with, and understanding of, the social and behavioral sciences.

Although all participants had a common purpose for participating in the seminars (i.e., all were, at the time of their entry into the program, serving as preceptors in FCM), this primary purpose for coming together did not limit the focus of discussions. Rather, participants were encouraged to draw upon and generalize lessons learned to all the educational venues and roles in which they were involved.

EVALUATION

Evaluation Methods

We took an ethnographic approach to evaluation, believing it to be most appropriate for evaluating this complex and emerging faculty development program. To facilitate observation, we joined the program as participant-observers; thus, we claim to know the program in ways that “outsiders” cannot. Research assistants captured near-verbatim notes on a laptop computer of weekly seminar discussions from June 2006 to March 2010 ($n = 91/110$; 83%). These notes supported our direct observation. In the spring of 2010, we conducted in-depth, open-ended interviews with a sample ($n = 8/25$; 32%) of participants who represented the larger group. An interview guide was constructed to solicit responses about faculty member’s experience with the program. All interviews were audio-recorded and transcribed verbatim. We obtained various documents (e.g., course websites, accreditation reports), created with input from program participants. We managed data from notes from the seminars with Microsoft Access 2007 and data from the interviews with Atlas.ti software (v. 6; Scientific Software Development).

In an iterative process, we tagged data from meeting notes and interviews with inductively derived codes (e.g., “student leadership,” “bonding”).¹⁹ We applied codes to segments of

data, revising the code list as patterns in the data became more apparent. In the final stages of analysis, we had “conversations” with the data, that is, we moved back and forth between the data sources, the codes, and two concepts from education: transformational learning and teaching as a social practice. These concepts address change at individual, interpersonal, and institutional or social levels and were helpful in understanding and in organizing our findings. With these concepts serving as interpretative lens, we iteratively formed assertions to capture the insights we gained from the data about the impact of the program on individuals, interpersonal relationships, and the institution. To build trustworthiness, we triangulated data sources and repeatedly checked our assertions with the program leader and the participants.²⁰

Impact on Participants: Teaching Skills and Personal Growth

Participants recognized growth in themselves as a result of engaging in the faculty development program. Growth occurred along different dimensions, including growth as teachers of social and behavioral sciences:

It's really enhanced my confidence and creativity as a teacher. I feel like I did better with the groups that I was leading.

Participants reported learning teaching strategies such as setting goals for small-group facilitation and using online resources to help students explore and scrutinize personal biases. Just as they had taken ownership of the weekly seminars, they came to value giving students the opportunity to lead FCM small-group discussion. One participant talked about empowering the students' voice this way:

Boy, it is so much smarter and so much better to let them [students] do the work instead of us like trying to be brilliant and show them how brilliant we are, you know?

Participants consistently identified student leadership as among the most powerful, and unanticipated, teaching strategy they learned and applied to other venues. One participant described extending this strategy to her work with other faculty members, thus making small but important inroads in the social practice of teaching:

I've been teaching this cultural competency workshop for seven years and there has been a growing number of faculty who are teaching cultural competence with me. This was the first year where I felt comfortable bowing out, partially because of this faculty development program. I gave faculty the tools to teach and then I just stepped back.

Process-oriented faculty development program also fostered personal growth. In developing narrative competence, participants acquired the wherewithal to see themselves from their own and other's perspectives, and to attend to multiple perspectives. One participant described his own transformation, or “recharging” as another participant said, like this:

I've seen an internal change for me. I came into medicine from anthropology, big picture, social and cultural aspects. Somewhere in there I knew I wanted to do primary care. I lost some of that joy during residency training. But these readings have really reconnected me to why I'm doing what I'm doing. It's been really powerful for me.

Impact on Interpersonal Relationships

Personal growth of individuals contributed to transformation in relationships. It was in participants' relationships with peers that they underwent a process of self-scrutiny that enabled them to become more critically reflective teachers. By developing narrative

competence, participants were better able to take on another's perspective, and thus truly know "another."

I feel like the program resonates with a lot of what I've learned in my training which is very collaborative: I am not the owner of the truth. Rather, it's mutual, sort of guided discovery, let's learn together and be transparent.

Three things were remarkable about this relationship building and perspective taking. First, participants came to a new recognition of their need to be supported in relationships. For them, teaching was a collective and communal activity.

What surprised me about this faculty development program was to recognize that there's a universal need for this kind of venue. I'm not alone in that feeling. I really benefit from meeting with colleagues who teach medical students on a regular basis in a productive but also informal setting. Gosh, there's such a need for this in all of academics. There really is such a huge need for this.

Second, the relationships built in the program were not so much "opportunistic" but were "affiliations" wherein participants could speak openly about values and practices that mattered to them.

I like having colleagues outside of my own department that I feel very close to, affiliated with in terms of our goals and the teaching. That helps maintain my perspective in my other work. I haven't had such a close group of colleagues working on a project together with such positive intentions.

Third, the relationships reflected a rich connectedness. The program was not about individual faculty members coming together once a week, or about a collection of a few special teachers. It was about the inclusive community these faculty members formed, a community that gave thoughtful attention to why, and how, they taught.

I'm participating in this cohesive, smart, wonderful, caring, group, shared a lot of common agendas vis-à-vis medical education and wanting to introduce the knowledge, skills, attitudes, related especially to doctor/patient communication and professionalism, and so it's nice to have that aspect of life, feel really supported and be part of a community experience.

Impact on the Institution

Just as the growth of individuals transformed relationships, transformed relationships influenced the institution in which they occurred. Because the faculty development program was implemented during a critical period of curriculum reform, and because most participants had key roles in this reform process, they had frequent opportunities to help shape the norms and practices around teaching in the new curriculum, as revealed in this comment:

Hopefully this is something that is infusing through the institution. So many participants are involved in many parts of the curriculum at all different levels. This curriculum changed, and even coming up with the new curricular goals [school-wide learning objectives]—we were very involved in that.

Most faculty entered the program with multiple educational roles in the institution. Many assumed additional roles after the program begun, often as a result of their involvement in the program. In the spring of 2010, as part of program evaluation, participants were asked to list their current roles as educational leaders (members of curriculum committees or directors of courses), participants in ongoing educational projects (designing new courses, creating reflective writing tools), or teachers in the courses or clerkships (lecturer,

attending). On average, faculty reported six roles ($SD = 0.95$; range = 3–11). Seven faculty reported eight or more roles, whereas four had fewer than five roles.

As evident in these numbers, the “infusion” of ideas from the process-oriented program was not tied to the efforts of a few well-positioned or highly motivated faculty members in a few venues. Rather, participants collectively contributed broadly to transformation across many venues, as illustrated in these examples:

- 13 of 25 participants collaborated to create the P&S Questions, a series of questions that serve as a guide to the development of reflective clinical practice. For example, “Who am I to this patient; what is my role? What is at stake for this patient; what is at stake for me? What do I choose to listen for, and why?” The P&S Questions are part of the medical student handbook and core to the FCM curriculum.
- 11 of 25 participants played a pivotal role in constructing new school-wide learning objectives for Columbia P&S, a framework for thinking about what it means to be a medical students at this particular institution.¹⁷ As a result, the new curriculum is now guided by a set of objectives that includes statements such as, “Understand patients deeply, as evidenced by listening, bearing witness and building and maintaining authentic relationship and healing affiliations.”
- 7 of 25 participants serve on the medical student curriculum committees. Of these, three chair the committee.
- 5 of 25 participants worked together with administration to break down the silo between the skills and science of physical diagnosis and art of medical interviewing. These elements of clinical practice are now blended in the FCM course, reinforcing much of what students learn about social and behavioral sciences.
- 5 of 25 participants have been integral to efforts to including and legitimizing reflective writing in the formal curriculum. This includes writing to prompts in the FCM course and in anatomy, narrative medicine selectives, and reflection on clinical scenarios in core clerkships.
- 13 of 25 participants are actively engaged in aspects of medicine beyond the traditional walls of medical education, for example, student health and wellness, community pediatrics, and interprofessional education.
- Although their formal role in the clinical curriculum varies, each participant, by virtue of being a practicing clinician, has the opportunity to interface with medical students and other trainees.

CONCLUSION

Findings from this in-depth case study point to the influence of process-oriented faculty development for teachers not only at the individual and relational but also at the institutional level. Institutions are highly complex and culturally situated; thus, we do not presume our findings are generalizable. Rather, by reporting findings with the aid of conceptual lens, we hope to provide a scaffold upon which we, and others, might build understanding of a collective problem in medical education: how to develop and support teachers.²¹ Although each lens has merit and could stand alone, neither could sufficiently capture the different aspects of the program.

Transformational learning is, broadly defined, a process of effecting change in one’s habits of mind and points of view.²² Although transformational learning is initiated at an individual

level, it progresses along a continuum toward collective learning. Stages, or arenas, of transformative learning include invitation, participation, engagement, commitment, collaboration, and learning community.²³ The concept of teaching as social practice builds on transformational learning and sheds light on how groups of educators change the norms that regulate the practice of teaching at a local and institutional level.²⁴

In this case study, the process of guided reflection as espoused by narrative medicine fostered transformation and positive change at an individual level, which in turn seeped into relationships, and then started to spread throughout the institution. The web of relationships among participants in the process-oriented faculty development program created the opportunity, and the means, to address and reshape powerful norms of institutions, as for example, expressed in the school-wide learning objectives. Teaching practices started to change, not because of a “top-down” prescription, but because the collective, “bottom-up” understanding of what matters started to change the norms that regulate teaching practices.

Our findings have implications for the practice of medical education. The tendency for faculty members may be to “just survive” during periods of curriculum reform, especially those not directly responsible for planning or implementing the changes. However, the potential to impact an institution may be greater in times of curricular change, when norms are in flux and new ideas accepted more readily. Consequently, a program focused on processes that promote relationships and transformation has the potential to become powerful catalysts for influencing the reforms and shaping the direction and momentum to ensure their success. Faculty development programs that target groups of faculty members with a similar teaching role and a direct link to context, versus individual faculty members with diverse roles, may have an advantage in promoting transformational learning, because they may be more likely to form a community with shared interests and the capacity to influence norms that regulate teaching.^{24,25}

We encourage readers to keep several considerations in mind, not only because they limit generalizable conclusions but also because they point to areas for future research. None of the participants were from the surgical specialties. We suspect that time, rather than interest, is the constraining factor for these faculty. This evaluation was not designed to assess the impact of an “intervention” on individual faculty, nor was it designed to assess learning outcomes at a student level. Instead, we were struck, early on, by the almost insidious spread of influence on the interpersonal relationships and on the institutional. We believe evaluating impact at this level is best accomplished with methods of inquiry such as ethnography, which provide perspective rather than truth, and context-bound extrapolations rather than generalizations.^{19,26}

Providing faculty members with the resources to dialogue and reflect on what they do is foundational to their personal and professional development and may be essential to changing norms that, for the most part, regulate teaching practice. For programs oriented around process, the return on investment may exceed personal and professional growth of the participants and influence the institution. Future research might explore the sustainability of process-oriented faculty development programs as an alternative to content-oriented programs and build on efforts to link faculty development to student learning.

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TABLE 1

Participant demographics

Department/Division	M:F	No. of Participants			
		2006	2007 ^a	2008	2009
Family Medicine	0:2	1		1	
Internal medicine					
General	2:4	4		1	1
Hospitalist	0:3	1		1	1
Subspecialty (Oncology)	0:1			1	
Pediatrics					
General	3:3	2		1	3
Subspecialty (Adolescent, Cardiology)	0:2			2	
Psychiatry					
Adult	3:0	2		1	
Child	0:2	1		1	

Note. M:F = male-to-female ratio.

^aIn 2007, all faculty members opted to accommodate another group of 1st-year students as well as continue with the group of students moving into 2nd year; thus no new Foundations of Clinical Medicine preceptors were recruited.