

## Faculty Development: A Conversation

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This is the transcript of a recording made by Dr. Cee Boria (CB), a newly appointed trans-pedagogic faculty development officer working in the Trans-Relational University Student and Staff Education Support (TRUSSES) office, when she visited Professor Ligno Caine (LC), the head of surgery in the medical school at the University of Impecunia.

**Editor's Note: Dr Boria made this recording as part of her Academic Portfolio Enhancement programme and this transcript has been copied from the original tape with only minor editing.**

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- LC** 'What do you mean – you want to watch me? Are you in need of some kind of help? Anyway, who are you?
- CB** Professor Canings...
- LC** Caine not Canings.
- CB** I am so sorry Professor Caine. I got your details from HR and they told me you were Professor Canings, Head of Theoretical Surgery. My name is Dr. Cee Boria—but please call me Cee.
- LC** There's nothing theoretical about what I do young lady. I don't deal in theory—I operate on real people with real disease.
- CB** Professor, as part of the ongoing inclusive faculty development programme it has been decided that everyone is going to be watched and evaluated in their teaching and then given feedback.
- LC** Feedback! Feedback—what is this—some kind of food additive? I have been giving my series of lectures for 20 years. I know exactly what the students need to know. After all, when they qualify I decide which ones will work on my unit.
- CB** Has anyone ever seen you teach Professor Caine?
- LC** Of course they have—what do you think the students are doing when they are sitting in the lecture theatre?
- CB** No, I meant has any member of the staff of the university, such as from TRUSSES, like an educationalist, helped you reflect on your teaching? They may be able to offer really helpful advice.
- LC** Dr Boria, and incidentally what speciality of medicine are you in?
- CB** My doctorate is in applied social anthropology with particular reference to nested olfactory experiences.
- LC** Ye Gods!
- CB** I beg your pardon?
- LC** I see that the University is developing its widening access scheme in its usual challenging ways.

**CB** In medical education we are seeking to establish if there is a need to develop a metaphorian approach to faculty and student development.

**LC** A what approach?

**CB** An approach where we use new metaphors for developing solutions to the problems in medical education <sup>1</sup>. It's a method that gives us huge potential for creativity.

**LC** So the Hippocratic Oath falls at last—to be replaced by metaphorical medicine—this week's new faculty development paradigm. I think that you will find that the Hippocratic Oath, which had things to say about education, is still in use today.

**(Editors comment: There seemed to be a semi-erased part of the tape at this point where it is possible a voice was heard asking who Hippocrates is (sic).)**

**CB** In TRUSSES we help all members of the university develop their full potential in interactions with students and the institution.

**LC** The only thing I use a truss for is to support a rupture, usually in an old man. Maybe that's what you think I am.

**(There is a possibility that a wheezy laugh was heard at this point on the tape – Ed.)**

**CB** Certainly not Professor, and please call me Cee. In TRUSSES we pride ourselves in being able to work with all types of people. Have you attended any of our 'Teaching the Teachers' programmes?

**LC** Yes, but only once. Look, Cee . . . .

**CB** Thank you.

**LC** Over the last few years the way in which my colleagues and I have had to deliver clinical care for patients has changed <sup>2</sup>. We now have less time to teach students. Generating grant income for research and delivery of clinical service and meeting targets for seeing and treating patients are the new drivers. We have had to bring in many teachers for our students with only the scantiest medical background simply because we have run out of sufficient numbers of experienced clinical teachers. And remember, most of the teaching of medical students is by clinicians who are not university employees, they are employed by the National Health Service, and they are all trying to meet targets set by their hospitals or by the government—none of which relate to teaching.

**CB** But in sorting these issues out didn't you find going on the "Teaching the Teachers" course helpful Professor? We know that faculty development reaps big rewards and can have enormous and transforming effects for individuals and institutions.<sup>3,4</sup>

**LC** I'm not so sure. Most alleged benefits seem to have focussed on the career advance of participants with many taking on what they call leadership roles in education. I am an evidence-influenced practitioner. Where's the evidence that faculty development is of benefit to patients and their families? Even if you think that faculty development is based primarily on the needs of students there is little evidence anyway that students are actively engaged in the process <sup>5</sup>, which is rather odd, don't you think especially as the General Medical Council has a requirement that doctors should be able to teach.<sup>6</sup> The place to start is with the students.

**CB** Ah, but surely we must be aiming to ensure that all teaching faculty are performing at their best?

**LC** Absolutely right!

- CB** I'm so pleased that we're beginning to agree at last. Faculty development really will help you realise your aims and ambitions.
- LC** Poppycock – my aims and ambitions, as you call them, are to provide the best clinical care I can, to do my research and to help medical students become doctors. In this I am guided by the General Medical Council.<sup>7</sup> The only reason we have to have faculty development is because many of the teachers haven't the foggiest idea about the substance of what they're teaching. You don't have teachers anymore, you have facilitators. This is all part of some conspiracy designed to make teaching sound as if it's got some real substance when the stuffing is being knocked out of it by bureaucrats and managers forever changing the way they want healthcare delivered and making it increasingly difficult for us to be with students. Even with all your best faculty development in the world if it doesn't link with the service delivery of healthcare, we're sunk.
- CB** Professor, or may I call you Ligno? Faculty development does help you change organisations and that is exactly the point.<sup>3,4</sup> It really allows you understand education in terms of adult growth.<sup>8</sup>
- LC** Now you've spoilt it! Off you go with meaningless words. What on earth is adult growth?
- CB** It's about getting better at what you do.
- LC** Why not say that then? I can understand that. Let's get the language we use straight.
- CB** I thought it was.
- LC** Look, we are all busy people and if we have to have to learn a new language and new tricks as well, which are not necessarily transferable to the postgraduate arena, this may all be a step too far. Possibly this explains why in a survey of over 70% of US teaching hospitals only a minority support faculty development. Even in those places that faculty were supported the numbers involved were low.<sup>9</sup> Now there's a market economy that knows the value of everything. If they're not doing it, they must be not doing it for a very good reason. What I want to know is does any of this faculty development have any impact on the outcomes of patient care. What's the evidence? Do you know?
- CB** I'm sure that in the near future there will be much supporting evidence. After all, when you fly do you ask for such evidence about the pilots? You do not. You, quite reasonably believe that training and updating of the pilots will be to your benefit. What's the problem in doing the same with the teachers of future doctors?
- LC** OK, good point. Maybe there will be times when we don't have all the evidence but feel instinctively that there needs to be change. Why though does it appear that the change is being lead by people who are not necessarily close to medical practice? Won't this be detrimental to developing and inspiring students?
- CB** We don't know, but pragmatically feel that with changing clinical practice, and as you have said, the need for you to be more closely involved with patients than in the past and thus have less teaching time, we need to have others who are able to teach, lead and support students in a safe and protective environment – and they need training and support to do this.
- LC** Just a moment. Again, I was beginning to sympathise with you and your views. We don't want students to be alienated but why should we always be seeking a safe and protective environment for their learning experience? Children face enormous challenges in primary school playgrounds. They don't seem to suffer from this. Darwin would rather approve of this approach. Why should we then neutralise the experience that budding professionals get at medical school or indeed anywhere?

- CB** You can't get away with that. To develop the top officers in the armed forces they are sent to Staff College, a protected and supportive place, to develop their professional skills, knowledge and behaviours. All I am suggesting is that the same needs to occur in this medical school as regards teachers. And a starting point is that I come and watch you give a lecture and then give you feedback.
- LC** Well, you are very persuasive. But when I went on the 'Teaching the Teachers' course there were a number of young newly-appointed lecturers there, uncertain why they were there, or what they're supposed to be learning or how they're supposed to be studying being guided by a bunch of sandal-clad, hair-shirted individuals who don't know what the inside of a body looks like. How could that be a good learning environment? And do you know, I was reading a few days ago about something called a "Good Healing Environment"<sup>10</sup>. It's as if you have to spend your life getting the environments and the facilitators right before any learning can occur—I simply teach where the patients are. It seems that the world of education is being taken over by a bunch of people who are on a mission to encourage us to indulge in intense introspection, copious self-flagellation and develop an enhanced appreciation of our mystical sensibilities, using a language that only they understand—a neat ploy.
- CB** Many people need help and guidance to work optimally in institutions though. Both individuals and institutions need help as they change. How do you help them through this?
- LC** Well I don't start by running my clinical service by sitting everyone in a softly lit room holding hands reflecting on and testing assumptions of life and delving into the theories of organisation. My service is successful, why should I now use methods such as you suggest learning how to teach? How will I know that this will improve either my teaching performance or institutional performance? I don't want to become part of some homogenised, sanitised, monochrome approach to teaching. I want individuals who can inspire and enthuse students, who can show them shafts of light, who can agitate them and can challenge them but most of all who can make them into healthcare professionals with all the right skills, knowledge and behaviours.
- CB** This is just what you achieve by reflection. If you won't do it then let your juniors learn about it. It works!<sup>11</sup>
- LC** No, Dr. Boria, ...Cee, this is common sense. Curiously some of us have it even before going on a faculty development programme.
- CB** Maybe I should come and watch you in your clinical service too. Has anyone reviewed what you do in your operating theatre, clinics and wards?
- LC** Oh absolutely; I'm surrounded by bean-counters with clipboards and stopwatches who do nothing else other than measure the speed at which I can put a scalpel to the skin. But these people are just like folk in medical education, they're not measuring the quality of the end product—they're just describing processes. For goodness sake, some even get publications just by writing down quotations of what others have said in questionnaires. To accept conversations as publications is preposterous. I provide leadership to the students and to my junior faculty. Leadership is different from perpetual instruction, inspection and introspection. I don't go through life asking myself what I need to do or have to do to make me feel better. I don't need to undergo socio-psychological bombardments to make me a better teacher. I'm not ill. I don't need this form of healing you know. You can have all the correct, as you define them, approaches but unless you're an expert in your subject you're a nothing in the eyes of the students and indeed the patients.
- CB** But how do you know what you're supposed to be teaching and how best you can teach it?
- LC** What a preposterous question and if you don't mind me saying so, rather rude! I am merely the gateway for students in their encounters with patients.

**CB** So you are a facilitator then?

**LC** Yes all right, but I'm an expert facilitator because I'm an expert in my field. I don't tell the students when they encounter a problem to push off and find the answer to it. They're at the bedside with me with the patient because they want to know the answer to it there and then, not as a result of a half hour walk to a library thumbing through some dusty old books or electronic vapours and then coming back with a confused understanding of the situation. Yes, I facilitate but I facilitate because I'm an expert. I give the students the right context for their learning. When they're with me they're not thinking about the best way to learn, they're thinking about the problems in front of them, the clinical realities.

**CB** But how do you deal with your students and the hidden or informal curriculum? How do you know that they will have not just the knowledge and technical skills but the professional behaviours doctors must have? Some regard this as core in faculty development.<sup>12</sup>

**LC** When I teach nothing is hidden and certainly nothing is informal. Thinking and learning with me is extremely formal, it has to be; if it isn't patients suffer. There are no educational games here you know. If you have to teach people how to build relationships and understand themselves you shouldn't have employed them in the first place or taken them on as students. No wonder education has got such a bad name if it takes on a group of such deadbeats.

As far as professional behaviours are concerned I would bang a few heads together within the education system so that students who enter professional roles on graduation have been enabled to develop as professionals. And if they don't or can't then they are shown the door. That would be a good outcome from faculty development.

**CB** Professor Caine, ...Ligno, some of your teaching sessions sound as though they are using the principles of problem-based learning. Did you get trained to do this?

**LC** I teach because I like students not because I like an educational method. I don't need developing to make me an expert facilitator. The students need to be nurtured by experts in their field not by experts in facilitation. You don't find expert facilitators in the front line of a battle, you find expert soldiers. I am an expert in medicine. If you were ill you would come to me not to your facilitator.

**CB** This doesn't sound to be a very corporate approach in view of what the university is trying to achieve in faculty development.

**LC** My patients aren't interested in a corporate approach, they want to get better.

**CB** We know that teaching and learning fares best in environments that are safe for the learner. Does this resonate with you?

**LC** How can you educate our future practitioners and leaders if you wrap them up in politically correct educational cotton wool? In the United States surgery residency training hasn't changed much in a hundred years. The country produces excellent surgeons. It seems that even the august American Surgical Association, despite having an excellent system of education in its hands, now wishes to consider how it might change its educational structures<sup>13</sup> – for reasons that escape me.

**CB** But the great reforming impetus started by Flexner has had hugely beneficial effects, don't you think? Almost all medical schools in the world seem to be doing something about refining and revising their curricula. This has to be a good thing and needs to be supported.

**LC** Since Flexner the world has been deluged with new approaches to medical education. They can't all be right. The danger of 'reform without change' is a well identified hindrance to medical education.<sup>14</sup> Look, we are still asking the wrong questions as regards the outcomes of medical

education.<sup>15, 16</sup> If you do a search looking for links between either faculty or staff development and healthcare improvement or outcomes how many hits do you think you get?

**CB** I guess not many.

**LC** Dead right! It's zero.

**CB** Well OK; things might be changing. There may be some data that suggest linking faculty development to healthcare delivery may improve the latter.<sup>17</sup>

**LC** That's encouraging.

**CB** And there are real challenges getting the institution on board with some of the things we want to do and need to do. Some of the faculty we wish to work with have no protected time for teaching or for personal development and no obvious reward for being a good teacher. Even with the best made plans national faculty development programs have resulted in only a 50% success rate—the major reasons for failure being faculty having no protected time and there being insufficient financial support for the work.<sup>18</sup>

**LC** And even when you have trained attending physicians and residents to teach better it seems to have only a small if any effect on students' knowledge.<sup>19</sup> Faculty development leading to curricular change is also fraught with problems - you need to have eyes and ears everywhere to sort out the academic and financial conflicts that need resolving to sustain the changes.<sup>20</sup>

**CB** I started by asking you if I could come and watch you teach. May I do this please?

**LC** I'm afraid not.

**CB** Could we work together to take forward some of the ideas that we've discussed?

**LC** There would be no sitting around in incense-filled rooms holding hands?

**CB** No.

**LC** There would be no use of words that were modernistic contrivances?

**CB** No.

**LC** No squidgy philosophies?

**CB** No.....Are you going to get involved?

**LC** No, I can't. I retire today. You have made my last hour quite wonderful. I have not had a conversation here like this with anyone before. Thank you.

**CB** No, thank you, Ligno.

**Professor Nigel Bax is Head of the Academic Unit of Medical Education at the University of Sheffield. He was awarded his National Teaching Fellowship in 2003.**

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