HOW DO NON-ATTENDERS OF FACULTY DEVELOPMENT OFFERINGS PERCEIVE THEIR DEVELOPMENT AS EDUCATORS?

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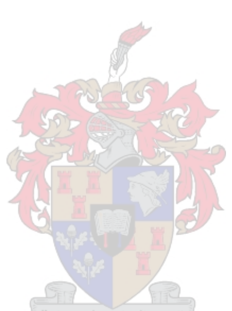

Research assignment presented in partial fulfilment of the requirements for the degree of Master of Philosophy in Health Professions Education at Stellenbosch University

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Date submitted: December 2019

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Acknowledgements

I would like to thank the following persons:

My supervisor Professor Julia Blitz

My colleagues and staff in the department of Health Professions Education at the University of Zimbabwe, College of Health Sciences for their encouragement, discussions and critical debates: Dr Walter Mangezi, Dr Shalote Chipamaunga, Dr Ida Nyawata, Mrs Tsitsi Goremsandu, Mr Lackson Mukavhi and Shale Kasambira.

The interviewees, who were all colleagues and gave up their time and shared some of their deep thoughts about teaching and education.

My colleagues at the Universities of Zimbabwe and Botswana who made my journey into Health Professions Education a very interesting one. May we live in interesting times !

My wife Sunanda Ray, our children, the Madzimbamuto-Rays: Nyasha Sulekha, Kiran Yoliswa and Tamsa Kabir, for their constant support, encouragement, critical discussion and physical exercise.

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Abstract

Background: Faculty Development, as a means of addressing the educational needs of health professionals entering undergraduate and postgraduate teaching, has been undergoing continuous change of definition and expanding its scope of activities. The research literature has tended to focus on those that participate or attend faculty development activities. The Department of Health Professions Education at the University of Zimbabwe College of Health Sciences has been offering faculty development activities for seven years. There are members of faculty who have not attended all or most of these. From the literature, those who attend in other countries, describe the same constraints to participation as non-attenders, and yet still manage to attend. In higher education, faculty are recruited for their content expertise and have to develop pedagogic expertise, and faculty development activities assist in this process. The aim of this study is to explore how faculty who do not attend perceive their development and identity as educators.

Methodology: This was a phenomenological study attempting to present, record, understand and be interpretive of the experience of faculty developing into teachers and educators. Non-attenders were defined as those who, in the last five years, have attended one or less faculty development offerings of the Department of Health Professions Education. Attendance registers were used to identify participants and purposive sampling was used to achieve a sample balanced for clinical and non-clinical roles, full and part-time, gender and years since appointment to the university. An interview schedule was used, with all the interviews recorded, transcribed, and member-checked before analysis commenced. Transcendental phenomenological analysis was used. Each subject's own words, phrases, sentences and narratives related to the research question were extracted. These 'moments of meaning' were then arranged in clusters and themes before being combined and subjected to interpretation.

Results and Discussion: Six faculty members were interviewed, and each transcript generated between 41-65 'moments of meaning', from which duplications and redundancies were removed. The themes that emerged were related to *becoming a teacher*, *professional identity* and *perception of personal development*. In *becoming a teacher*, there was a diversity of pathways into teaching, participants had mainly been

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identified as academic or bright and encouraged to join or participate in the academic activities of their discipline on completion of postgraduate training. Health professionals usually come into higher education with an identity as a clinician already formed, and they must negotiate developing or adding a new one as an educator. The departments and professional association provided a network for the source and dissemination of information about teaching, learning and education research. This networking played was a key enabler of informal learning.

Conclusion: The non-attenders were largely independent and organise their own learning opportunities, goals and objectives. Their drive and motivation can help other faculty, particularly in being able to articulate their learning needs, so that FD can be more purposive and needs directed.

Keywords: Tacit knowledge, Professional networks, informal learning, transcendental phenomenology, professional identity, experiential learning.

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Abstrak

Hoe ontwikkel nie-bywoners van Fakulteitsontwikkeling as opvoeders?

Agtergrond: Fakulteitsontwikkeling (FO), as 'n manier om die onderrigbehoeftes van gesondheidswerkers wat voorgraadse en nagraadse onderrig betree aan te spreek, is deurlopend besig om geherdefinieer te word en die omvang van aktiwiteite uit te brei. Die navorsingsliteratuur is geneig om op diegene te konsentreer wat deelneem aan fakulteitsontwikkelingsaktiwiteite. Die Departement van Gesondheidsberoepe-onderrig aan die Universiteit van Zimbabwe College van Gesondheidswetenskappe bied reeds die afgelope sewe jaar fakulteitsontwikkelingsaktiwiteite aan. Daar is fakulteitslede wat nog geen, of die meeste van hierdie geleenthede, nie bygewoon het nie. Volgens die literatuur, beskryf diegene wat in ander lande wel bywoon, dieselfde beperkings tot deelname as nie-bywonendes, alhoewel hulle tog daarin slaag om die aktiwiteite by te woon. In hoër onderrig word fakulteitslede gewerf vir hul inhoudskundigheid en moet hulle pedagogiese kundigheid en fakulteitsontwikkelingsaktiwiteite help met hierdie ontwikkelingsproses. Die doel van hierdie studie is om te ondersoek hoe fakulteit wat nie bywoon nie, hul ontwikkeling en identiteit as opvoeders ervaar.

Metodologie: Dit was 'n fenomenologiese studie wat gepoog het om die ervaring van fakulteitsontwikkeling van gesondheidsprofessionele opvoeders weer te gee, aan te teken, te begryp en te interpreteer. Nie-bywonendes is gedefinieer as diegene wat die afgelope vyf jaar een of minder fakulteitsontwikkelingsaanbiedinge van die Departement van Gesondheidsberoepe-onderrig bygewoon het. Bywoningsregisters is gebruik om deelnemers te identifiseer en doelgerigte steekproefnemings is gebruik om 'n steekproef te bereik wat gebalanseer is vir kliniese en nie-kliniese rolle, voltyds en deeltyds, geslag en jare sedert die aanstelling van die universiteit. 'n Onderhoudskedule is, tydens die opnames van al die onderhoude, wat getranskribeer en deur lede gekontroleer is, gebruik, voordat die ontleding begin het. Transendentale fenomenologiese analise is gebruik. Elke persoon of deelnemer se eie woorde, frases, sinne en vertellings wat met die navorsingsvraag verband gehou het, is aangehaal. Hierdie 'oomblikke van betekenis' is in groepe en temas gerangskik, voordat dit saamgevat en aan interpretasie onderwerp is.

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Resultate en bespreking: Ses fakulteitslede is ondervra, en elke transkripsie het tussen 41-65 'oomblikke van betekenis' gegenereer, waarvan duplikasies en onnodige inligting verwyder is. Die temas wat na vore gekom het, hou verband met die ontwikkeling van ŉ opvoeder, die professionele identiteit en die persepsie van persoonlike ontwikkeling. In die ontwikkeling van ŉ opvoeder, was daar 'n verskeidenheid van paaie na onderrig; deelnemers is hoofsaaklik as akademies of bekwaam geïdentifiseer en is aangemoedig om aan die akademiese aktiwiteite van hul vakgebiede deel te neem, na voltooiing van die nagraadse opleiding. Gesondheidswerkers sluit gewoonlik by hoër onderrig aan met 'n identiteit van 'n klinikus wat alreeds gevorm is, en hulle moet dan onderhandel oor die ontwikkeling hiervan of die byvoeging van 'n nuwe een as ‘n opvoeder. Die betrokke departemente en die professionele vereniging het 'n netwerk voorsien vir die bron en verspreiding van inligting oor onderrig, leer en onderrignavorsing. Hierdie netwerke wat uitgespeel het, was 'n belangrike faktor vir informele leer.

Gevolgtrekking: Die nie-bywoners was grootliks onafhanklik en organiseer hul eie doelwitte, doelstellings en leergeleenthede. Hul dryfkrag en motivering kan ander lede van fakulteit help, veral om hul leerbehoeftes te artikuleer, sodat FO meer doelgerig en behoefte gerig kan wees.

Sleutelwoorde: Ongesproke kennis, Professionele netwerke, informele leer, transendentale fenomenologie, professionele identiteit, ervaringsleer.

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Chapter 1: Overview

1.0 Background

In higher education generally, including health professions education, academics have historically been recruited for their content and discipline expertise, with the assumption that they can teach (Daly, 1994; M McLean, Cilliers, & van Wyk, 2009). Significant changes have taken place in higher education since the mid-20th century which have transformed the education landscape, both at school and tertiary levels. One of these changes was the development of new understanding of how learning takes place (Illeris, 2018), with new teaching approaches and curricula developed underpinned by these theories. In higher education, faculty needed to acquire new skills and develop an understanding of this teaching and learning paradigm, for which they had not usually been prepared in their discipline training. Training programmes and policies developed to meet this need, establishing faculty development (FD) in institutions, first in the United States in the 1960s and later in Europe (M McLean et al., 2009). Information and computer technologies that developed, such as the internet, entered the educational environment and further changed the teaching and learning resources, for students to develop more ownership of their learning (Ratheeswari, 2018).

The definition of FD used for this study was

> 'all activities health professionals pursue to improve their knowledge, skills and behaviours as teachers and educators, leaders and managers, and researchers and scholars, in both individual and group settings' (Steinert et al., 2016).

The literature on FD mainly documents those who participate in formal, often institutional activities such as workshops, seminars, conferences, and courses (Leslie, Baker, Egan-Lee, Esdaile, & Reeves, 2013; Steinert et al., 2016). There is increasing recognition that individuals may also engage in informal (Steinert et al., 2016) or discipline-based professional association FD independently of the institutions (Waters & Wall, 2007). There is little in the literature on the perspectives and practices of faculty who do not participate in institutional FD (Steinert et al., 2006, 2009).

Non-attenders of formal institutional FD are an important consideration because of resource and cost implications of organizing activities which may be poorly attended. If the

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education culture and practice do not change and improve, this translates into poorer quality of care and clinical outcomes (Kim, Hwang, Lee, & Shin, 2017; Kogan & Holmboe, 2014). In the University of Zimbabwe (UZ), formal FD programmes organized by the Department of Health Professions Education (DHPE) have existed in the College of Health Sciences (CHS) for seven years, consisting of half-day workshops, meetings, seminars, a journal club, an annual conference and a longitudinal course with an integrated project run over twelve months (Hakim *et al.*, 2018; Aagaard *et al.*, 2018; Matsika *et al.*, 2018). There is currently a review of the undergraduate medical (MBChB) curriculum in progress which has created an opportunity for wider discussion about education theory and practice.

HEALZ (**H**ealth **E**ducation and **A**dvanced **L**eadership for **Z**imbabwe) is the longitudinal course established with the assistance of University of Colorado, Denver, as part of the MEPI grant (Aagaard et al., 2018). It is for health professions faculty and runs over twelve months, part-time, with three contact sessions of a week each. The course has an annual intake of about 14 scholars and has enrolled from all three schools of medicine and faculties of health sciences in the country with over 70 trained at CHS alone. Most departments now have at least one HEALZ Fellow and is now on its eighth cohort of students.

In Zimbabwe, the Council for Higher Education and the Medical and Dental Professions' Council have not made FD a policy requirement for all tertiary education faculty, although UZ does have a process of appraisal for faculty annually, for promotion and for teaching awards. UZ was one of several African universities in 2011-15 to be awarded a five year medical education grant from the USA government (J. Hakim et al., 2018). The impact of the Medical Education and Partnership Initiative (MEPI) activities at CHS have been evaluated including the educators' experiences of FD (Aagaard et al., 2018; Connors et al., 2017). Connors *et al* used the "most significant change" technique (Davies & Dart, 2003), where the study focus was on the most positive aspects, similar to the Success Story method (Hogle & Moberg, 2015) and Appreciative Inquiry method (Cooperrinder & Whitney, 2001). Their findings showed that the most successful changes were demonstrated where individuals felt they became better teachers and clinicians as a result of FD; expanded their inter-professional networks and relationships; and became more confident and interested in teaching and research (Connors et al., 2017). Developing the

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attributes of good teaching in faculty is one, but not the only goal, of faculty development. Aagaard et al used Guskey's model of evaluation of professional development (Aagaard et al., 2018; Guskey, 2002) to evaluate the longitudinal FD course, reporting that there was a gain in competence in interpersonal skills and leadership, interprofessional relationships and impact on course teaching and organisation. Lack of protected time was reported as a major constraint in the program.

Ronaghy (2013) explains how education is 'an art with scientific foundations'. Before medicine or education developed their scientific bases, knowledge and skills were gained through apprenticeship alongside experienced clinicians, observing and emulating what they did (Ronaghy, 2013). Experience is fundamental to how we learn. Kolb's framework of experiential learning explains how thinking about an experience plays a central role in learning (Kolb & Kolb, 2005; Yardley, Teunissen, & Dornan, 2012). Experiential learning, as it is called, may explain the method by which FD non-attenders develop themselves as educators. Thinking about an experience or experiences, elaborating on it to derive meaning, understanding, and ideas or hypotheses is called reflection. It was first described by Dewey in 1910 (Rodgers, 202AD). Later formulations have attempted to frame this in a way that can make it useful as a tool. Reflection is a natural process which all humans do, consciously and unconsciously; in education, however, the goal is to fully grasp the learning possibilities inherent in the reflective process. In Kolb's framework, an experience must lead to reflection, and meaning emerges out of reflection in the form of abstract ideas, concepts or hypotheses, which can be tested or experimented with and become the individual person's gain in learning or fund of knowledge. When the process is carried on over a period of time, after an experience, past experiences are recalled and associations made with different other knowledge: it is a powerful learning tool (Sanders, 2009).

In health professions education (HPE), much of teaching and learning takes place in the clinical context, the workplace and in teaching departments, in proximity with colleagues whom we observe or observe us. Learning 'unconsciously' from others or in a specific context is very individual, is related to development of expertise through 'experience' and has been called tacit learning (Leonard & Insch, 2005). According to Kothari et al (2012) organisations embed within themselves cultural knowledge which has to be learned by individuals through being present in the workplace, to develop competence for the tasks

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they have to perform, the people they have to negotiate with and the structures they have to utilise. Developing as a health professions' educator requires developing tacit knowledge and competence at three levels: task performance, situational context and organisational context. Attenders of FD may acquire knowledge skill through additions pathways of explicit learning in various FD offerings while non-attenders of FD may be reliant on tacit learning as their pathway to teaching competence (Kothari, Rudman, Dobbins, Sibbald, & Edwards, 2012). Participating in academic departments, professional associations, other professional bodies such as regulatory councils, all provide an environment for tacit learning and developing networks.

Departments in general have been identified as places where individuals have the potential to develop relationships that are supportive, collaborative and influential to career growth (Borgatti, Mehra, Brass, & Labianca, 2009; Pifer, Baker, & Lunsford, 2015). They have examinations committees, curriculum committees, contact with external departments and external examiners and other experienced faculty members where pedagogical ideas can be shared, presented and discussed, both formally and informally. Participation in discipline-specific international or health professions education meetings and conferences, establishes networks and pathways for information transmission. In this way, FD non-attenders in the network have access to information and may adopt new practices, even though they may not consciously foreground education.

'A rising tide lifts all boats' (Anon) is an expression associated with the idea of benefit or gain for more people than those for whom it was initially targeted. The benefits of FD could be extending beyond those who attend, without being documented.

1.1 Study aim

This study attempts to explore how faculty at College of Health Sciences, University of Zimbabwe, who do not attend FD perceive their development as educators. It has been clear for some time that the model of FD that DHPE uses needs some revision, but to what extend non-attenders should targeted has been a point of intense discussion. The greater purpose of the study therefore is addressing this question and to inform future discussion and design of FD. One of the concerns is that non-attenders are read by other faculty as

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reflecting the hidden CHS curriculum of placing low priority on educational skills. With this study, the FD landscape in Zimbabwe is going to change significantly.

1.2 Delineations

The study was conducted at CHS, where formal FD has been offered by DHPE and has always been open to all faculty as well as health professionals in other universities teaching health sciences. Notices for FD are sent to other institutions with the DHPE programmes and to the professional associations for circulation to their members. However, for the study, only CHS faculty not attending FD activities organized by HPE were eligible.
Other units within the CHS and the UZ also conduct 'educating the teacher' seminars, workshops and other activities. The University Teaching and Learning Centre conducts a week-long course for newly appointed academic staff which covers teaching methods. The Institute of Continuing Health Education also conducts sessions on dissertation supervision, setting and marking examinations and others. The Research Support Centre runs courses in research methods and more recently, a MEPI successor health professions educations grant to the University of Zimbabwe, PETRA, also run education offerings that overlap with FD activities offered by DHPE.

1.3 Limitations

Non-participation in DHPE offered FD by large sections of the faculty body is a general experience of many HPE departments and units globally (Kim et al., 2017; PR Lowenthal, Wray, Bates, Switzer, & Stevens, 2013). Whether the experience of Zimbabwe has unique features due to its recent history of economic and political instability, and the impact this has had on its institutions is not clear. Individual faculty members interviewed gave a perspective that may resonate with others health professionals elsewhere.

1.4 Report Outline

Chapter 1 provides an outline of the study background and aim. Chapter 2 contains a definition, some background to the emergence of faculty development as a key activity in higher education institutions, an outline of different approaches to faculty development

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and some of the learning theories underlying it. Chapter 3 describes the methodology of this study, its theoretical basis and how the data was collected. Chapter 4 describes the nature of the data gathered, analytical process used and results from its analysis. Chapter 5, the discussion looks at the concepts that emerge from the data, their general implications and relation to the literature. Chapter 6, is the conclusion which provides the overall perspective with the author's reflections.

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Chapter 2: Literature Review

In this Chapter FD is defined and a brief background to the emergence of faculty development as a key activity in higher education institutions, an outline of different approaches to faculty development and some of the learning theories underlying it.

2.0 *Definition*

FD has been an evolving term and has become an encompassing term that refers to activities health professionals pursue to improve their knowledge, skills and behaviours as educators, researchers and administrators (Steinert et al., 2016). It has assumed increasing importance because current trends in education theory and education technologies means today's educators can no longer model themselves on how they were taught themselves (Bilal, Guraya, & Chen, 2019; C Morris & Swanwick, 2018). Other far-reaching changes are emerging in the organisational structures of HPE, transforming FD into a 'multi-dimensional activity focused on learning environments and learning opportunities, providing space for trainers to examine, develop and innovate their educational practice' (C Morris & Swanwick, 2018). Workplace-based learning, including the clinical area, has become the focus of faculty development. It has been integrated into clinical practice and transformed to create an environment conductive to learning and educating, with the educator acting as facilitator of learning by designing and identifying learning opportunities for students and trainees. A variety of innovative teaching and learning "moments" have been introduced in many clinical environments, where the role of the faculty is to suggest questions, stimulate curiosity and reflection, exchange ideas on moral and ethical dilemmas, and encourage open exploratory communication between the educator and students, all within brief teaching clinical encounters (Kumagai, Richardson, Khan, & Kuper, 2018).

2.1 Non-attenders

There are few reports in the literature on the perspectives and practices of faculty who do not participate in FD (Steinert et al., 2006, 2009). In two systematic literature reviews of the literature on the effect of FD on knowledge, skills and attitudes among medical educators and the impact on their institutions, Steinert noted that the responses of FD

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attenders are well documented, but those of the FD facilitators and non-attenders are not. Among frequent attenders and non-attenders of FD, the same barriers to attendance were identified by both groups, which were lack of time and workload; lack of institutional recognition of teaching and logistical factors related to location of FD site and parking (Steinert et al., 2010, 2009). However, the question was not explored or explained how with these same factors affecting everyone, some attended and others did not. These same factors are often cited as reasons for non-attendance at the CHS as well. The structure of FD activities may be an area of alienation for faculty who have a strong discipline-specific identity and competing obligations on their limited time. Health professionals are adult self-directed, goal-oriented learners and choose their own learning activities (Taylor & Hamdy, 2013a). Combining continuing professional development (CPD) and FD has been used in attempts to address the needs of possible non-attenders (Green, Gross, Kernan, Wong, & Holmboe, 2003; Karg, Boendermaker, Brand, & Cohen-Schotanus, 2013). The hidden curriculum has been discussed as contributing to a climate (Lawrence et al., 2018) where faculty acquire a perception that developing educational excellence and skills is undervalued compared to service and research, and senior faculty take little interest in FD (Hafler et al., 2011). A teaching promotional track does not exist at the UZ. If the concept of scholarship of teaching was assimilated into clinical practice, research in teaching may replace or complement discipline research for some faculty members (Souter, 2016). When viewed from the perspective of education theory, faculty find themselves situated and learning in a social environment in which they co-develop with others. New ideas and skills learned through FD offerings do not necessarily produce a positive climate. A sense of conflict could emerge from the mismatch between the environment or context and the new knowledge and skills. Knight et al describes how participating in an event-based FD can lead to 'unlearning' because a tension emerges between current practice, regulations and assumptions within other colleagues on the one hand, and uncertainties about implementation, on the other (Knight, Tait, & Yorke, 2006). In the situated learning environment (Lave & Wenger, 1991; Machles, 2003), social relationship in the team, department or institution are important to how individuals participate in learning (Berkhout, Helmich, Teunissen, van de Vleuten, & Jaarsma, 2018). Where, in the past, FD was voluntary and event-based, several countries are now

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introducing policies to professionalise higher education and making FD a requirement that may form part of one's appraisal or promotion (Knight et al., 2006).

2.2 *Professionalising Higher Education*

External regulatory authorities in higher education (Monica McLean & Bullard, 2000) and institutional advocacy by HPE leaders in many countries (Sullivan, Buckle, Nicky, & Atkinson, 2012) have highlighted the need to professionalise and quality assure higher education teaching and develop new curricula. This has occurred alongside other developments in society such as expansion in secondary and tertiary education and student numbers, diversification of course content and structures, with calls by policy leaders for social accountability of higher education (M McLean et al., 2009; Monica McLean & Bullard, 2000). Navigation of the increasing dimensions to teaching and education and their different theoretical foundations requires formal understanding of education theory (Lueddeke, 2003). In the UK, the General Medical Council has required, since 2016, all medical schools to formally recognise and appraise trainers in undergraduate and postgraduate medical education (AoME, 2010; Patel, 2016). This has led to further development and uptake of longitudinal FD courses such as Postgraduate Certificate and Masters qualifications. Universities are also encouraged to establish more diverse training opportunities that faculty can embark on to increase their capabilities particularly with postgraduate training (Dilly, Carlos, Hoffmann-Longtin, Buckley, & Burgner, 2018). Where previously, only a small proportion of medical educators took university accredited courses or wanted to, this is now becoming essential (C Morris & Swanwick, 2018; Waters & Wall, 2007).

2.3 *Scope of Faculty Development*

Teaching and learning, research and (clinical) service in communities have become integral parts of the health professional role in the workplace, where FD may be formal or informal, and where the workplace maybe the clinical area or the academic institution (Clare Morris & Blaney, 2010; Spencer, 2014). The workplace-based teaching of specific skills is based on behaviourist concepts of learning by carrying out specific tasks and activities with frequent practice, having clarity of objectives for learners, and using reinforcement to motivate.

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However, it is now the cognitive model of apprenticeship that predominates. In this model the learning is individual and benefits from observing others who know or have more skill and what has been learnt can be expressed verbally or in writing. The workplace is a complex environment with service obligations, yet that is where learners are socialised and develop their professional identities within the social learning environment (Clare Morris & Blaney, 2010).

Colleagues in departments provide both formal and informal opportunities for development as educator (Andrews, Conaway, Zhao, & Dolan, 2016; van Roermund, Tromp, Scherpbier, Bottema, & Bueving, 2011). However, unless there is formal organisational practice of coaching and mentorship, these opportunities remain at a low level of efficacious interaction (Andrews et al., 2016; Knight et al., 2006). Faculty with specific interests, knowledge or experience in education exert a great influence through sharing their teaching materials, running journal clubs and publishing research. In institutions where there are Faculty Learning Groups or Community of Practice Groups dedicated to improving education, they also provide opportunities for learning (Andrews et al., 2016). New faculty members therein become part of a learning network.

Discipline-based professional associations are increasingly engaged in 'education CPD' and members can often access different types of material and platforms (RCoA, 2014) and through individual initiatives can find and select their own from elsewhere (Spencer, 2014). The benefits of combining discipline CPD and faculty development include embedding the educational concepts into the discipline practice, improving the quality of teaching and use of time (Green et al., 2003; Karg et al., 2013; Waters & Wall, 2007).

Teaching and learning may be conducted through role modelling, peer coaching, mentorship and in discipline-specific activities such as Train-the-Trainer courses, and on-line courses (Cook, 2014; Pearse et al., 2012).

Formal FD is structured and organized with a group or individual-focus and takes place within institutional structures such as the university and professional associations, while informal FD maybe spontaneous, unstructured and may take place anywhere (Fig 1), including such places as the workplace or solitarily online encounters (Crandall & Cacy, 1993; Evans, 2018; McDonald, 2016). The meaning and description of 'informal learning' is

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an active field of research (Evans, 2018; Clare Morris & Blaney, 2010), with Eraut suggesting that it should be considered on a continuum away from formal learning and characterised by being implicit, unintended, opportunistic and unstructured (Eraut, 2004). Informal learning has in the past been regarded in relation to formal learning, but current conceptualisations regard it as having its own pedagogy (Clare Morris & Blaney, 2010).

Table 1: A typology of informal learning (adapted from (Eraut, 2004))

Time of focus	**Implicit learning** (no conscious attempt to learn, no knowledge about what was learnt)	**Reactive learning** (intentional but during an action/task)	**Deliberative learning** (includes deliberate learning and preparation to learn)
Past episode(s)	Implicit linkage of past memories with current experience	Brief near-spontaneous reaction on past episodes, events, incidents, experiences	Discussion and review of past actions, communications, events, experiences
Current experience	A selection from experience enters episodic memory	Noting facts, ideas, opinions, impressions; asking questions; observing effects of actions	Engagement in decision making, problem solving, planned informal learning
Future behaviour	Unconscious expectations	Recognition of possible future learning opportunities	Planning learning opportunities; rehearsing for future events

Professional HPE associations have been established to strengthen and guide the development of HPE into a discipline setting standards to be attained by educators (AoME, 2014; SAAHE, 2004). This has also been reflected in alternative definitions of FD, moving away from the university as the locus of education (C Morris & Swanwick, 2018), and calling it 'education CPD' (Waters & Wall, 2008). Evans offers a definition of FD as professional development comprising:

> what practitioners do; how they do it; what they know and understand; where and how they acquire their knowledge and understanding; what kinds of attitudes they hold; what codes of behaviour they adhere to; what purpose(s) they perform; what

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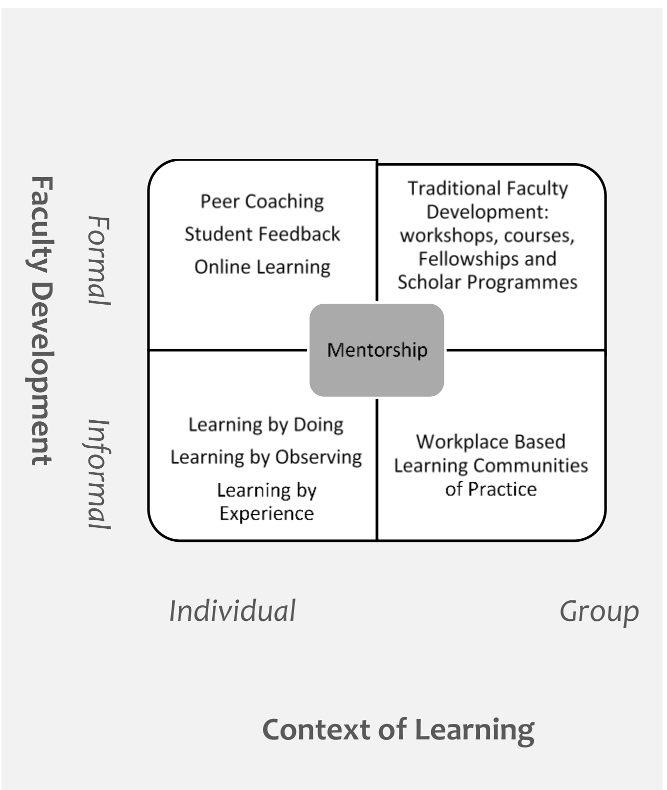
quality of service they provide; and, the level of consistency incorporated into the above list (Evans, 2019;p5).

In Zimbabwe, undergraduate HPE is carried out at the universities. Professional Colleges are being established under the East, Central and Southern Africa Health Authority, an intergovernmental agency based in Arusha Tanzania. Based on the model of the College of Surgeons of East Central and Southern Africa (COSECSA) (Lane, 2009), several others have been created and will be running training programmes using professionals inside and outside the universities.

Consequently, it can be argued that every health professional participates in FD explicitly through attending FD activities and implicitly through being in the workplace, where they experience FD learning informally. Identifying the 'non-participant', in a general sense, could therefore present challenges.

Figure 1: Approaches to Faculty Development (adapted from (Steinert et al., 2016))



FD activities generally focus on improving teaching and learning, although the roles of the higher education educator include research, administration and leadership (Steinert et al.,

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2016). A novice teacher has been described as one who perceives themselves as the 'knowledge expert' and their task as one of 'imparting knowledge' to the learner (Monica McLean & Bullard, 2000). In higher education, teachers are appointed for content and not teaching expertise. One of the goals of faculty development is to transition the novice to an expert teacher who perceives their role as 'facilitator of learning' to the student (Monica McLean & Bullard, 2000; O'Sullivan, Mkony, Beard, & Irby, 2016).

2.4 *Theories of Faculty Development*

FD development uses and teaches a range of instructional methods derived from different theories of learning. The theories include the core concepts of behaviourism, cognitivism and social learning. The teaching and learning of specific tasks, where there is a clear objective or learning outcome such as a drill or clinical skill, a correct way of performing it, repetitive practice and reinforcing with feedback, borrows significantly from behaviourism and it is used in course design for simulation-based training and e-learning (Torre, Daley, Sebastian, & Elnicki, 2006). Behaviourism, which emerged as a learning theory at the beginning of the 20th century, regards learning as behaviour, and structures the learning environment to maximise control of teaching and demonstration of new and desirable behaviour. Many tools in education research and practice such a Bloom's taxonomy, developed from behaviourist principles (Murtonen, Gruber, & Lehtinen, 2017). Behaviourism did not explore what learning or changes took place in the brain, which later cognitive theories focused on.

For cognitivism, the internal environment of the individual, including the cognitive structures in the brain such as perception and memory, is the site of learning. The individual experiences learning as thought processes and creation of meaning (Torre et al., 2006). The role of the teacher is to help the learner to learn and how to develop strategies for linking previous knowledge to current, so the learners acquires an understanding of the structure of knowledge (Taylor & Hamdy, 2013b; Torre et al., 2006; Yilmaz, 2011). Thinking is at the core of cognitivism, and experience is the substrate for reflecting on and developing critical reasoning, from where experiential learning models developed (Williams, 2009; Yardley et al., 2012). Teaching reflective practice and making connections with other knowledge are essential elements that have been associated with life-long

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learning skills and can be taught through development of concept maps, portfolios, recalling past or recording present experience, such as in diaries, for future reflection (Hargreaves, 2016; Torre et al., 2006). Cognitive learning theories emphasise the individual and their internal environment and personal development towards becoming self-directed and self-evaluative, yet individuals learn in a social context, with and from other people.

Social learning theories attempt to address this imbalance by retaining cognitivist constructs and building in social interactions so that the knowledge now is constructed through interactions with others, the context and the environment (Bleakley, 2010; Taylor & Hamdy, 2013b; Torre et al., 2006). Observation, participation, self-regulation and role modelling are ways in which social learning is conducted by both the educator and the learner (Bandura, 2005). In teaching a task, it must first be demonstrated with the learner observing, then the learner participates by carrying out the observed task, modelling themselves on the expert performance provided, followed by feedback and deliberate practice. The traditional apprenticeship approach, which is no longer congruent with modern medical education theory, has been re-packaged using social learning theory. It now begins with modelling, which is observation of educator practice; then coaching, the educators observes and gives feedback; in scaffolding the educators create additional opportunities to practice and learn; the learner must then articulate or talk through what they are doing and learning; reflection is when the learner now analyses their performance while comparing with the example; and finally exploration, where the learner can become independent (Clare Morris & Blaney, 2010). Situated learning in based within social learning theory and was developed by Lave and Wenger to describe the development of apprentice from being outside the group or community of practice, through being at the peripheries and gaining a place in the centre by active participation and learning from peers and experts (Lave & Wenger, 1991). It describes and models workplace-based learning, and how the learner builds their own knowledge through participation in a community with others. A community of practice is a group of people who share an area of interest, a domain, and learn how to do it better through their regular interactions with each other (Cruess, Cruess, & Steinert, 2018)

Constructivism borrows from both cognitive and social learning theories and conceptualises knowledge as something that is created by the learner and does not exist

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without them. It requires the learner's cognitive machinery and the social interactions to make it meaningful (P Lowenthal & Muth, 2008). It focuses teaching and learning on the learner rather than on knowledge itself, so that prior knowledge, learning through discovery, real or authentic problems, environments and assessments are important components of teaching (P Lowenthal & Muth, 2008; Taber, 2011; Torre et al., 2006).

2.5 *Reflection*

Discipline experts may not know these principles and concepts explicitly, but often pick them up as they gain experience and reflect on their practice (McLeod, Meagher, Steinert, Schuwirth, & McLeod, 2004).

2.5 *Problem Statement*

The vision of the Department of HPE is to create a vibrant, dynamic, collaborative and well-resourced community of teachers responsible for transforming faculty from novice to expert educators. Although FD has been well established at the CHS for many years, with a variety of activities, (Aagaard et al., 2018; J. Hakim et al., 2018; Matsika et al., 2018), there is a body of faculty that consistently do not attenders of FD events. The DPHE has debated how to respond to this non-attendance in line with its vision. Possible responses are to develop other forms of activities that would draw-in these non-attenders, identify specific needs or accept that there will always be a of non-attenders who find their own development path to becoming expert educators.

2.6 *Research Question*

How do non-attenders of faculty development (FD) offerings perceive their development as educators?

2.7 *Aim*

The aim of the study is to use a phenomenological approach to describe and interpret, from the perspective of non-attenders of faculty development offerings, how they perceive their development as teachers and educators in the College of Health Sciences, University of Zimbabwe.

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Chapter 3: Methodology

This section describes the methodology of this study, its theoretical basis and the nature of the data that was collected.

3.0 Research Design

The study is set in an interpretivist paradigm or worldview (Kivunja & Kuyini, 2017), based in phenomenology (Eddles-Hirsch, 2015; Groenewald, 2004). Phenomenology seeks to understand the meaning of the lived experience of individuals experiencing a particular phenomenon (Cresswell, 2007). This uses qualitative methods to explore and interpret multiple, diverse perspectives of individuals or groups (O'Sullivan & Irby, 2014). The purpose is to record, present, understand and be interpretive of the perspective of the participants as deeply as possible recognizing that the interpretation of the data is that of the researcher (Kivunja & Kuyini, 2017).

3.1 Ethical approval

Ethical approval for the study was obtained from the Health Research Ethics Committee, University of Stellenbosch (HREC: S19/03/54). Institutional approval was obtained from the Joint Research Ethics Committee for the University of Zimbabwe, College of Health Sciences and Parirenyatwa Group of Hospitals (JREC:124/19) and the Medical Research Council of Zimbabwe (MRCZ/B/1737).

3.2 Setting

The University of Zimbabwe, College of Health Sciences (CHS) is the largest public tertiary health sciences education institution in Zimbabwe, which is a low-middle income country (World Bank, 2019). The CHS runs several undergraduate and postgraduate programmes, the largest of which are in medicine and pharmacy. The student body is over 2,000 with over 340 fulltime faculty. The names of part-time faculty staff were obtained from the Human Resources department lists and verified with the individual departments. The Basic Science and clinical teaching are on separate sites, while the clinical teaching is centralized in two 1, 000 bed teaching hospitals. The community of faculty consists of CHS full and part-time faculty as well as government staff in the clinical service division. The student body has increased rapidly in recent years with the MBChB intake now approximating 240 per year.

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3.3 Data Generation

FD non-attenders (FD-NA) were defined as those who have never participated or attended only once an offering in FD by the Department of Health Professions Education (DHPE) in the last 5 years for which the department has attendance records. Non-attenders (FD-NA) were identified through searching the attendance registers, and academic department staff lists and verified through asking them directly if they had attended any DHPE faculty development offering. Written letters, emails, or telephone messages were sent, and calls made to invite potential participates to an interview. Those agreeing to participate were allocated to a group (Table 1) based on their length of time teaching in the institution, type of service (clinical or non-clinical), whether part-time or full-time and gender. One person was selected from each group for the interview, if that person could not be interviewed, then another person was picked from the same group. All interviews were conducted in English, the only language of teaching and learning in CHS, with no translations into indigenous languages. Consent was signed by three participants before coming for the interview while the other three signed before interview commencement.

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Table 2: Interview Schedule

Research Question	Key concepts	Questions
How do non-attenders of Faculty Development offerings perceive their development as educators?	background	Do you recall how and why you became a teacher? For you, is being a 'teacher' the same or different from being an 'educator'? In what ways have you changed since you have been in education? How do you feel about your experiences so far ?
	opinions	what do you understand by Faculty Development? [Prompt: how did you come to this understanding?] Do you think colleagues have the same understanding of FD?
	behaviours	Are there activities you participate in to develop yourself as an educator? [Prompt: through your professional association for example?] How do you choose which ones to engage with and which not? If not, are there any reasons? [Prompt: would you have an interest in participating in any activities? what sort?]
	educator	How did you see a career in education developing separate from one as a discipline professional? Can you talk me through how you see yourself as an educator in the CHS now?
	development as educators	What differences do you think your colleagues would notice in your teaching or in you as an educator?

The groups are based on that pre-tenured faculty are new to teaching and are still trying to be secure in a faculty position, while junior faculty are settled but beginning to gain some responsibility; established faculty are usually older and have had several roles in the institution. Time is cited as a major determinant of participation which may be influenced by presence or absence of clinical load, time commitment and gender.

Purposive sampling was used to select potential interview participants so that if the first selected participant in one group was female, the next for the following group was male and so on, with a similar process for full-time vs part-time faculty in order to achieve balanced heterogeneity between the different groups. Invitation was by a letter, email, phone message or oral, and an information leaflet with a consent form were given to 29

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potential participants explaining the study and requesting their consent to participate in the study.

Table 3: Interview cells and those interviewed

		Clinical Fulltime	Clinical Part-time	Non-clinical Full-time	Non-clinical Part-time
♀	Pre-tenure 0-3 years	2 years			
	Junior 3+ to 5 years	5 years			
	Senior 5+ years		13 years	6 years	
♂	Pre-tenure 0-3 years		3 years		
	Junior 3+ to 5 years				
	Senior 5+ years			10 years	

The phenomenon being studied was the self-perception of non-FD as educators, so it is important for those interviewed to be heterogenous set to get as rich and detailed a description of their experiences as possible, free from the hierarchy of the institution (Eddles-Hirsch, 2015). The interview schedule was developed by the researcher (FDM) and reviewed by two HPE department members and amended.

Interviewing as a research tool seeks to reveal the individual's narrative of their personal experience, their descriptions and what it means to them and how they relate to others (Kvale, 1996: p124). In doing so the interview attempts to cover some relevant background facts, life experiences, opinions and emotional reactions and the resulting actions or behaviours related to the topic of interest (Kvale, 1996: p131). An interview schedule was developed to touch on these areas and pilot interviews with two faculty members prior to commencing the formal study were conducted. One interview was conducted by the researcher (FDM), and the other by a colleague in DHPE.

Nine cells had been designed in which the selection for three of these was based on gender, in the event of an imbalance. Everyone who was asked to be interviewed, based

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on records of FD attendance, agreed initially, were given the information sheet and the consent form. Later, three possible participants could not be interviewed because of 'time constraints', and two would not be recorded but were willing to discuss and to put forward their point of view. These discussions are not part of the presentation here. Non-clinical part-time staff were difficult to contact and follow-up because in many departments their appointments were of limited duration, and they often busy outside CHS.

Six interviews were recorded (SONY ICD-PX240 Digital Voice Recorder) between May 29th and June 24th, out of nine that had been planned. Four women and two men, four were clinicians and one a clinical scientist and one biostatistician. Five of the interviews were conducted in the Department of Health Professions Education and one was in the participants office. These were downloaded to a using computer software (Sound Organizer V1.6.2) to a laptop and transcribed. The transcribed copy was sent to interviewee for verification (Birt, Scott, Cavers, Campbell, & Walter, 2016). It is important that the interviewee verifies the statements that will be attributed to them, as this reduces errors of misrepresentation but is also an opportunity to generate addition data from the corrections (Elo et al., 2014; Mays, 2000). Each interview was listened to before the next one was conducted and any ideas not originally considered by the researcher and not sufficiently captured were used to inform further interviews (Eddles-Hirsch, 2015; Groenewald, 2004). Transcription was done in the Department of Health Professions Education and printed documents kept securely in locked cupboards while the electronic version was stored on a password locked computer.

3.5 Epoche

In natural sciences, the phenomenon under study is assumed to be real, and present even in the absence of an observer, and the observer cannot influence its behaviour. In other words, the speed of light will be 300 million metres per second whether the observer is present or not, and the observer cannot influence that. Yet we do know from the Doppler shift that the measured wavelength of light is influenced by the observer. Transcendental phenomenology treats its material of study much the same way as natural science, as objective phenomena, and attempts to strip away the effect of the observer, to transcend the observer, through a process of called epoche (Groenewald, 2004; Moustakas, 1994),

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also called bracketing. During epoche, the researcher attempts to suspend their preconceptions and biases, by allowing the subject's voice only to speak for them. It differs from descriptive phenomenology which acknowledges the influences the observer brings to the data collection. As a visible faculty member and chairperson of the department of HPE which organizes the FD offerings and member of several committees in the university, the Medical and Dental Professions Council and the Anaesthetic Association, my role and advocacy in DHPE was well known. In addition, I am in regular interaction with many colleagues who are FD non-attenders and have myself developed perspectives on this. While that experience is useful for the analysis of the data, it was important that it played as little a part in the data gathering as possible (Bednall, 2006). This was done first by recording an interview of myself conducted by a colleague, and in recognising, during interviews, when I began to form opinions about what was being said by interviewee. This was difficult, especially when a follow-up question was necessary to achieve clarity.

3.6 Reflexivity

I had thought, like many of my interviewees that most faculty members who were non-attenders did not value teaching.

3.7 Data Analysis

The first step in the analysis, following the verification of the transcripts, is phenomenological reduction (Bednall, 2006; Groenewald, 2004; Moerer-Urdahl & Cresswell, 2004). This is a complex process involving two 'actions' or 'movements': the epoche and the reduction (Fig 2). In this study of the phenomenon of perception of non-attenders of faculty development, the interview transcripts were 'reduced' gradually through identifying key statements representing a 'moment of experience', a process called horizontalization, which are then abstracted, labelled and categorised. Eventually everything in the whole transcript was represented by a selection of the interviewee's own words, called invariant horizons. These are then gathered into clusters and themes. These were synthesised into a descriptive text to portray the worldview or life-world of the interviewee, so that any differences in perspective of the subjects remain, and will still be apparent, maintaining fairness (Mays, 2000). The six life-worlds were then combined into one or more portrayals, called composite texts, which were then subjected to interpretation. (Bednall, 2006; Eddles-Hirsch, 2015; Groenewald, 2004; Moustakas, 1994)

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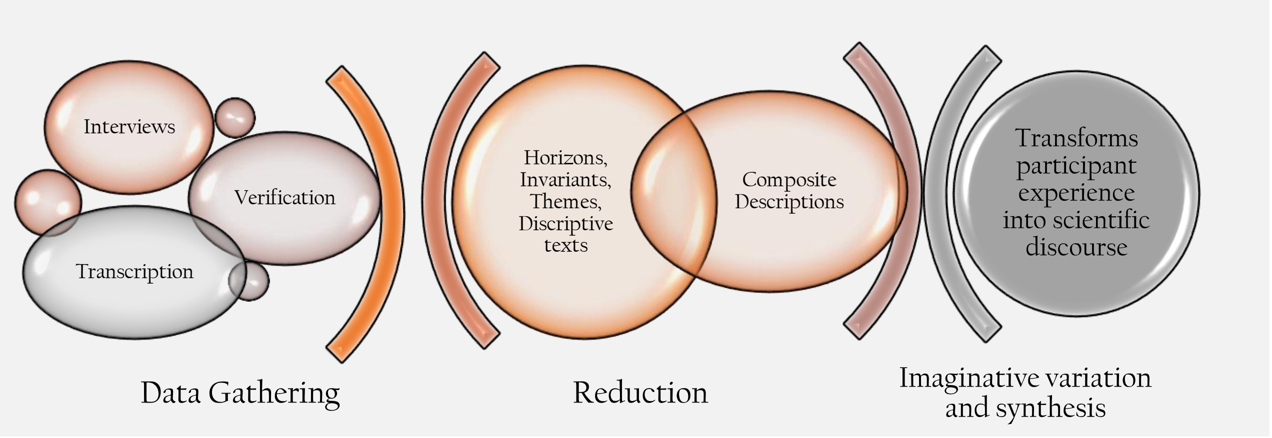
Figure 2: The Phenomenological Research Process (developed by the author).



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Chapter 4: Findings and Discussion

4.1 *Participants*

The narratives of five of the six participants were broadly similar. The duration of each interview ranged from 28min 30 sec for the shortest to 44min 22 sec. Four women and two men were interviewed. Non-clinical part-time staff were more difficult to track down, as they tended to come in only for specific activities, while clinical staff would tend to be in the hospital even if they are not in the academic department.

Table 3: Interview cells and those interviewed

		Clinical Fulltime	Clinical Part-time	Non-clinical Full-time	Non-clinical Part-time
♀	Pre-tenure 0-3 years	2 years			
	Junior 3+ to 5 years	5 years			
	Senior 5+ years		13 years	6 years	
♂	Pre-tenure 0-3 years		3 years		
	Junior 3+ to 5 years				
	Senior 5+ years			10 years	

4.2 *Moments of experience*

A table was generated with significant statements and key words used by each interview participant, the text was examined again to ensure all important topics had been identified. 'Meaning of experience' units were generated from each interview and tabulated, producing between 41-65 items per interviewee, which were then put into clusters before combining the separate texts and removing duplications and redundancies. They all remained the words of the interviewees. Other points that arose from the text but not thematized were set aside for later review or put in miscellaneous if they seemed relevant to the aim of the study.

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Figure 3: Process of data analysis (developed by author)

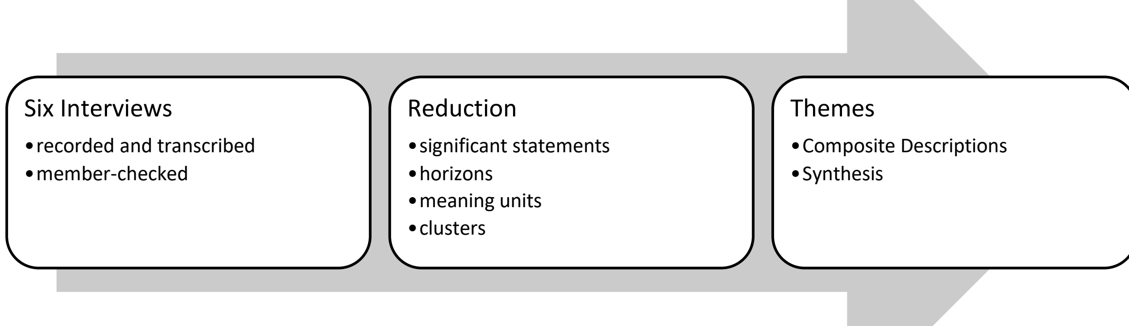

Table 4 : Example of 'significant statements' from one interview, The full length of statements can be found in Appendix F).

1.	I became a part-time lecturer straight out of training
2.	full-time was not going to work for me
3.	I was identified
4.	because I was a 'reasonable', maybe 'responsible
5.	I had been reasonable in terms of my academics
6.	they felt maybe they could use some of my talents
7.	I was literally thrown in at the deep end
8.	with no teaching experience at all.
9.	I did go for sessions at the main campus
10.	went through the whole induction course (for new staff)
11.	learnt different teaching methods, examining students, the whole hog
12.	a teacher, at the university, somebody who, apart from teaching students, does a lot of research, publishing, other things such as inter-departmental activities
13.	For me, [being] a clinician, its more that my passion is anaesthesia and imparting that to the students is the teaching aspect
14.	being an rather than getting involved in what is perceived as a teacher at a university
15.	I have acquired skills of teaching I did not have when I started off.
16.	With the few seminars at the main campus I also learnt about how to teach, what it entails, and what is expected of the student, which I did not know at the beginning when I started off
17.	I have become more wiser in what is expected of me as a teacher and what is expected of student as well
18.	For a long time, I felt that if a student failed it was the student's problem, but then I have realized, with growth, that it is actually my problem as well.
19.	the student can have a problem, but as a teacher I must find ways to make sure that students, do the best they can
20.	I suppose I have learnt skills as well that I did not have before.
21.	obviously input from other teachers, you always learn from others as well.
22.	discussing with other senior teachers, senior as in yourself

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The following three themes emerged from the cluster formed by 'moments of meaning' statements: *Becoming a teacher*, from the point of entering academia, the induction into the university system their recognition of having little or no prior experience. *Professional identity* was a second theme and spoke to current identity, self-perception as teacher/educator and possible future identity or identities. Finally, was their own *Perception of Development* which began an awareness of their own change, how they have developed that change through informal learning and formal faculty development.

Table 4: Composite Meaning units, clusters and theme: becoming a teacher

Theme	Cluster	Meaning units
Becoming a teacher	**Entering academia**: Academic, talented, responsible, reasonable, always wanted to teach, strategically acquiring teaching qualifications Straight out of training	• I was identified; I was a 'reasonable' [academically]; maybe 'responsible'. They felt maybe they could use some of my talents. I was quite academic. I knew very early on I was academic. • Departmental Chair . . was encouraging people to come and join the department full time and teach. Since you are going to be a government specialist doing clinical work on the wards, join the department part-time and we will give you lectures you can prepare and you will have students anyway. It seemed a good compromise • I feel I have always wanted to teach • Academia is not something I wanted to do . . but they needed my skills [because the only other person with similar training left]. • It was strategic ... getting a professional qualification • I was a Staff Development Fellow
	Prior experience: no teaching experience, part of postgraduate training,	• I was literally thrown in at the deep end . . with no teaching experience at all. • Teaching. . . and supervision. . are some of the key competencies Registrars assessed on in department • Part of our postgraduate training . . . we had to teach . . (our faculty) were also saying they want to teach you how to teach . . , but they did not focus on how to teach. • I am a qualified classroom practitioner.
	Induction: attended and benefited from university induction course	• I did go for sessions at the main campus • went through the whole induction course (for new staff) • learnt different teaching methods, examining students . . .
Bright, responsible, promising, recent trainees with self-drive, vocation, opportunity already part of the team. Experienced 'pull' or encouragement from colleagues, but unprepared by their undergraduate or postgraduate training. UZ induction course and offerings by other departments		

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At this point, epoche could be suspended, and my own experience and insight could be used to understand and interpret the results.

4.3 Theme 1: Becoming at teacher

Even though health professions institutions of higher learning educate and train the next generation, it is the clinical service and research roles that have clear pathways of entry, and development (Bartle & Thistlethwaite, 2014). There is more emphasis in modern health professional curricula on the competency of scholarship. In this context scholarship includes teaching of others, continuous learning, evaluation of evidence and contribution to scholarship (RCPSC, 2018). For the future, the role of an educator will be distinct with attributes of service, such as teaching, research in education and leadership. This has the potential to make being an educator as attractive as being a clinician or a researcher in academia.

Joining Faculty: The interviewees used the terms '*academic*', '*talented*', '*responsible*' to describe themselves, or how they were seen, when they were trainees. It was their '*self-drive*', desire '*to further themselves*' or '*always wanted to teach*', and proximity to the department and faculty that meant they were noticed and integrated into its activities. Expectations and encouragement, particularly when staffing needs were acute, led to them being invited to join the faculty.

> *I was identified at that time because I was a 'reasonable' … maybe 'responsible' and they felt maybe they could use some of my talents* (Int 6)

> *I feel I have always wanted to teach . . . I just used to talk to [Prof] . . And then just through talking to him he said you must be a teacher, so he affirmed and just through interaction I thought I was on the right path. (Int 4)*

Three were actively recruited by the departments straight from its own postgraduate programme. One had trained abroad and had not planned to join the department but wanted to have a relationship. Positions became available or were facilitated when the special skills they possessed through training or had demonstrated were not be covered by anyone else. Those with a non-medical background joined the CHS as staff development fellows and went for further academic training to PhD level before joining.

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Prior Experience: The MEPI programme (2011-15) in Zimbabwe was called NECTAR (**N**ovel **E**ducation **C**linical **T**rainees **a**nd **R**esearchers). One of its outcome goals was developing faculty from among the postgraduate trainees, one of whom was interviewed.

> *I recall, almost quarterly there were workshops on teaching, research, communication skills and I know we had structured sessions on character-types, how to teach people in different ways, how do you look at people's personality types, and how to effectively communicate with people even across different character types.* (Int 1)

One interviewee with a non-medical background had acquired a teaching diploma after their basic degree and taught in the university before transferring to CHS, while another had been a teaching assistant before embarking on their PhD. The experience of starting their teaching career was described by one as like '*being thrown into the deep end*', but the others had some extended involvement in their departments. Being exposed to be a teacher as an undergraduate or postgraduate, does not equate with being able to teach, because it is a skill that needs acquiring and nurturing (Bartle and Thistlethwaite, 2014).

Being 'taught to teach' was described in the following way by one of the interviewees:

> *Whenever we had a conference . . .[or] there was any journal (we also had a journal club) we had to present because they (our faculty) were also saying they want to teach you how to teach. You had to get comfortable with teaching the subject, but they did not focus on how to teach. They just expected [you] to be able to stand in front and teach on a subject, whatever it was, or the topic was we were talking about during that journal club. But they never really taught you how to actually do it, so you had to learn it by yourself.* (Int 4)

Induction: The induction courses were very beneficial, are offered by the University Teaching and Learning Centre, and teaching being discussed in this way was a new experience. The principal induction course combines several faculties and is run over one week. In the CHS another unit responsible for the administration of postgraduate programmes, runs seminars on various aspects of assessment and supervision.

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Table 5: Composite Meaning units, clusters and theme: teacher identity

Theme	Cluster	Meaning units
Professional Identity	**Identity:** *Principally a clinician who teaches.*	• I see myself as a physician who teaches while [working]. • [I see myself as. .] probably the clinician who is keeping up with the trends globally, improving themselves, and teaching along the way. • For me, [being] a clinician, that is my passion and imparting that to the students is the teaching aspect • being [a clinician] rather than getting involved in what is perceived as a teacher at a university. You really actually have to do both.
	Self-perception as teacher-educator: *Principally a clinician who teaches. A teacher imparts information an educator ensures learning has taken place.*	• the teaching I do is bed-side, in the clinic, on rounds, that sort of thing. . .the teaching that I do, not much of it didactic. • you have to excel at teaching as well as excel at your profession . . . • I think I am still becoming [a teacher] I am becoming because I am learning • I do like what I do, I do enjoy teaching actually, and what it also helps me is it helps me to keep researching. When you teach you have to look for the information. • Teaching is a profession I already have. Teaching someone is a skill that is acquired, not a natural skill
	Future development: *association with university, being a clinical teacher but delicate balancing act of clinician-educator-academic, developing the specialty in the country, running a programme*	• I think my association with the university is a mutually beneficial thing. The university needs teachers, boots on the ground doing the leg work . . . At the same time, for anyone . . . association with an academic institution is important. I would like to continue with that • What do I see myself as after ten years, if I stay with the department . . . probably my educator-teacher side might end up overshadowing my clinical side, but if I leave the university, the other side will flourish. I actually enjoy both, but sometimes I feel a bit strained . . The balance for me is quite delicate and quite . . • what I want is to be able to see . . . in ten years' time is where [my discipline] is a recognized entity within the College and maybe . . (Hospital) • in the next ten years, in the next five years I will be ready to run a department, I am trying to see myself running a department and producing the product I would actually want to produce. • To me, my role there [as educator]is zero. at the moment one would stay put focused on the primary purpose, which is teaching, then if there is something to do, I can at a personal level. • I wouldn't want to put myself out there and say I want to be . . . .[this or that] I think we have a good graduate . . Could they be better ? Could I be involved in that ? Yes, but in the trenches rather than heading it up.

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4.1 Theme 2: Professional Identity

Health professionals usually come to academia with an already established professional identity, from years of undergraduate and postgraduate training and socialisation. Browne et al in discussing professional identity describe the difference between 'change' and 'transition'; change refers to what you do, being in a different situation, while transition is a psychological progression to the new situation (Browne, Webb and Bullock, 2017). 'Unless transition happens, change won't work, because it doesn't take' (Bridges, W. reference 11 quoted in (Browne, Webb and Bullock, 2017). In addition, transition is a process developing over time as one grows into the new role and acquires the knowledge and skill to be comfortable in it. While university teachers from a professional background hold-on to their professional identity, especially in the early years of university appointment, they experience significant stress from self-doubt and feelings of inadequacy (van Lankveld et al., 2017).

Current Identity: Three of the clinicians described themselves emphatically and emotionally as '*clinicians who teach*', irrespective of how long they have been in associated with the university. Two interviewees also emphasised their having dual identities but also being conflicted, especially if this was going to threaten their future competence in either role. From their systematic review, van Lankveld et al (2017) reported that those with PhD backgrounds were comfortable with just being intellectuals or researchers who teach, without commitment to their previous background, but health professionals struggled for several years with which identity to protect. The institutional culture in CHS generally values service (even though promotion is based on publications) and clinical faculty generally are '*clinicians who teach*'. One person interviewed already possessed a teaching diploma and described themselves as '*classroom practitioner*' and '*what I acquired during my training as a teacher is sufficient, and it will not go away*'. (Int 5) Smith and Boyd, in their study, cite other literatures to support the concept of identity as a process of continuous negotiation and reconciliation between the individual and the 'communities' they belong to, so that identity is always 'becoming' and not fixed, and the informal and formal 'learning architecture' shape the trajectories of the identity formation (C. Smith & Boyd, 2012).

Self-perception as teacher-educator: There was general understanding that the roles of a university teacher went beyond just transmitting information, that there were other

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responsibilities with teaching and learning, such as assessments, supervision, mentoring, and university administration, clinical service and research. The university administration, or 'politics', was negatively commented upon, including by full-time faculty with terms like:

> *'[would rather be teaching] than getting involved in what is perceived as a teacher at a university'*. (Int 6)
>
> *'there are also frustrations with the university and renumeration and all that stuff'. (Int 2)*
>
> *'I don't really think I want to be attending Dean's meetings, Vice-Chancellor's meetings, and meetings on main campus. I don't want the politics and business of the university side, I am not interested in that.'* (Int 1)

A common sentiment was: *'I see myself as a [clinician] who teaches while doing (my) work'*. (Int 1). One of the clinicians accompanied this with an anecdote:

> *I remember, say, going on rural attachment or on electives as an undergraduate, and you would be attached to a district medical officer and they are doing their job they end up teaching you, you know, it's by virtue of the job. If you know something and you have people rotating* or *following you are going to end up teaching. That is one of my earliest memories, on rural attachment the GMO would call us and say, guys, this is how you do an evacuation, this is how to do a caesarean delivery, this is why we are doing this, this how it is, just teach the little that you know.(Int 1)*

Several interviewees wanted their '*passion*' for their discipline to reach through to the students, to motivate and inspire them to specialise in it. Another reason was an intrinsic attraction to the discourse of teaching, the '*back and forth talking*' or '*getting more information always progressing*'. (Int 4) Finally, there was the developmental process of education, transforming a novice into a capable practitioner.

> *'being involved in the business of taking students from the positions of being infants (as far as medical knowledge is concerned) to being people you can confidently leave to see patients by themselves'*. (Int 1)

Future Developments: Imagining a future trajectory in the profession is an important psychological factor in development of teacher identity (van Lankveld, Schoonenboom, Volman, Croiset, & Beishuizen, 2017). Reflection on practice includes looking ahead at future practice and of establishing a vision and goal to shape current identity and its development (Beauchamp & Thomas, 2009). There was such a diversity

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of expressions of the future with only one person having a vision which was clear, explicit and progressive in education, to become the head of a department.

> '.. *in the next ten years, in the next five years I will be ready to run a department, I am trying to see myself running a department and producing the product I would actually want to produce. The type of [clinician] I would want [to look after me], is the one I would want to produce.*' (Int 2)

One was conflicted about which identity would be sacrificed,

> '*It's a difficult question for me because that is exactly what I have been asking myself this whole year. That what exactly is it that I actually want. … The balance for me is quite delicate . . .*' (Int 3)

while two had hopes but no concrete plan of action:

> '*I want is to be able to see [my field], in ten years' time, having developed [in this country, this hospital].*' (Int 4)

And

> '*Lately I have been trying to advance myself in [my] field . .. just to solidify myself. I am studying [at] MSc level, just to solidify myself.*' (Int 5)

The last was modest in expectation, without making commitments

> '*You know what: I wouldn't want to put myself out there and say I want to be . . . .[this or that] …*' (Int 6)

As well as being a process, identity is a product of one's self-image and is shaped in and by practice. It may be an identity one holds internally and presents to one's self; or one presented to the institution, society or authority; or to specific groups or communities such as professional association or other (Beauchamp & Thomas, 2009). Over time the internal and the institutional identities should be on a converging path. Work-place experience and faculty development have an enormous influence in shaping the stories or narratives individuals play and replay for themselves and for others that express their desires and give meaning to the identities they assume(Beauchamp & Thomas, 2009).

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Table 6: Composite Meaning units, clusters and theme: Perception of development

Theme	Cluster	Meaning units
Perception of Development	**Change :** *Confident, better organises, grown, knowledgeable, wiser, self-aware, better the more you do it, simplify, broaden, make things practical, being relevant, use and take questions, how much to information to deliver*	• [I am ..] more confident. . I would say I am more confident and knowledgeable. • Teaching requires time. A lot of it requires you to be self-aware. I also realise that as a teacher, you become better the more you do it. • I have developed, when I listen to myself, I realise that I have changed. I have noticed that I have tried to simplify, I have broadened and tried to make it as practical and as simple as possible. I have noticed myself gradually changed. My methods have changed,. . . before I never used to ask them to ask me any questions, now each time before I leave, I ask them to ask me questions, so that I also get a feel of whether they understood anything, whether there is something . . . I could have completely omitted. I think I have changed and developed in that regard. No idea [how that happened]. I don't know. . • [I have grown] in terms of knowing how much to deliver and the things that are important to deliver. • I feel somebody could say that being better organized and not wanting to talk too much but giving the relevant • I think I have changed immensely. Definitely, my confidence has changed. I've also learnt to be a better person as far as examining. other things [which have changed] are: before every lecture did not have clear objectives. • But now, I go through the objectives of why the course is important and what I expect the student to know at the end, and how does that help them to be a better clinician. My powerpoints have definitely changed from being wordy to being more illustrative. • I have acquired skills of teaching I did not have when I started off. I have become more wiser in what is expected of me as a teacher and what is expected of student as well. For a long time, I felt that if a student failed it was the student's problem, but then I have realized, with growth, that it is actually my problem as well. . .the student can have a problem, but as a teacher I must find ways to make sure that students, do the best they can • what I acquired during my training as a teacher is sufficient, and it will not go away.
	Informal learning: *Supposedly learnt new skills, benefited from other teachers, from international professional meetings, colleagues sharing education journal articles, recognising failures in teaching, reflection, feedback, teaching helps to keep discipline knowledge up to*	• I suppose I have learnt skills as well that I did not have before. • obviously input from other teachers, you always learn from others as well. • discussing with other senior teachers, senior as in yourself • I found that what I had tried to gather, through going to those international conferences definitely had a place here. We started doing our own workshops here. We would use the same model. • For me if I have any teaching problems I go to [colleague], • I am beginning to read because [Professor ...] will read a good article and then forward to the group, before I just focused on the professional journals [Professor . . .] is also actively involved in health education, that is his passion • In terms of getting additional guidance, in terms of teaching per se, I have not had anything formal, • You learn to recognize areas of weakness or problem areas, so the students you teach in the rotation at the end of the block you end up examining them and you realise they have certain weaknesses and make you [think about] the way we teach certain clinical skills • I use the exams as a way of reflecting back on how well I well I taught • As feedback: do they have an interest in answering my questions and how are they answering my questions • I have learnt that there are many ways in which people learn, and different students learn differently and I have learnt to embrace that without necessarily telling the student that they are lazy or they are not performing

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	date, use curriculum as guide to teaching, and improving examining skills	• I have had to learn to know the type of student I am dealing with, and what works better for them: is it illustrations, is it . . . some can read on their own, but not every student can. I have developed the ability to be able to pick out which student needs more visual or more illustrations. • on the clinical, I think that is where I learn the most because I feel that my students get more from me when I am on the floor with patient and the student. • I have also taught at [Association] meetings all the time and give lectures at annual conferences I give lectures in .... all the time, that has strengthened that skill which I thought I did not have. • I keep revising for myself which I can now talk from the top of my head. So it has helped me as much as it has helped the students. • now, I go through the objectives of why the course is important and what I expect the student to know at the end, and how does that help them to be a better clinician and then I go into the topic, so that the student has a clear understanding and I have a clear understanding based on the curriculum. So I did not really take the curriculum into context, I just knew that they needed to know what a cyst of the jaw-bone was and they need to understand what it is because they will meet it in the clinic but I didn't actually marry the objective and have the student understand exactly what it is they really needed to know before they leave the class and how that is going to help them. • going on-line, looking at teaching methods, examination methods that are different from before.
	Formal Faculty Development: *teaching incorporated into postgraduate teaching but not generally explicitly taught or assessed, university induction course, specifically targeting workshops such as exam, dissertation supervision, departmental student surveys of teaching,*	• Postgraduate training incorporating teaching skills • Induction course for new university faculty • exam workshops are the ones I have attended . . . I have always wanted to sit on a board of examiners, and so those are the workshops I have attended • For me . . . once I see 'Faculty Development' . .. I kind of look at it and like 'maybe it's for the full-time' lecturers. • I used to have a very difficult time marking essays, when I attended an exam workshop I learnt that you actually have to devise a marking scheme • My multiple-choice question also, how I can assess the different levels of learning through a multipl- choice question. I always considered myself very good at that but I learnt much more when I took time to review every question and see what level I wanted them and what level of learning I wanted, so in that I have changed • I also have a survey, we also have a survey in the department, which I try to do every single time after a few lectures. When I begin a lecture series, I do maybe after three or four lectures, I give the students a survey which evaluates how my teaching is.
Change: Confident, better organises, grown, knowledgeable, wiser, self-aware, better the more you do it, simplify, broaden, make things practical, being relevant, use and take questions, how much to information to deliver. **Informal learning**: Supposedly learnt new skills, benefited from other teachers, from international professional meetings, colleagues sharing education journal articles, recognising failures in teaching, reflection, feedback, teaching helps to keep discipline knowledge up to date, use curriculum as guide to teaching, and improving examining skills. Formal Faculty Development: teaching incorporated into postgraduate teaching but not generally explicitly taught or assessed, university induction course, specifically targeting workshops such as exam, dissertation supervision, departmental student surveys of teaching,		

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4.4 Theme 3: Perception of Personal Development

Even though the subjects interviewed were non-attenders of FD offerings by DHPE, they were highly selective in what they participated in, picking from other activities in the University and externally, such as '*the exam workshops are the ones I have attended*' (Int 4) or '*more specific to dissertations, the supervision, the marking and things like that . .*' (Int 3)

Five of the six felt they had changed while one expressed in the following words:

> '*what I acquired during my training as a teacher is sufficient, and it will not go away*.' (Int 5)

This view does not resonate with the literature, for example in teacher education, where trained teachers from school level enter higher education to teach, and they experience the same dilemma of being content experts, but need to develop a specific pedagogical repertoire to teach a specific subject at that level, while holding an image of the teacher they would want to be, the ideal teacher in their minds (Beauchamp & Thomas, 2009; C. Smith & Boyd, 2012).

Change: Even though all explained or defined teaching as transmitting information to the students, a number used a narrative style to show how they have changed:

> '*Back then, you would be thinking teaching is letting them know that the causes or the risk factors . . . , list them, remember them, and the next thing is how does it cause this, tell me the nitty-gritties of how the HPV incorporates itself in the body and ends up with cancer and tell me how do you manage it : one, two, three . . . now remember that. . .* '(Int 3)

> '*Now it's more interaction with the students, very laid back, the students are free to come to me, and happy to actually, and good relationship with the students but at the same time teacher-student relationship but colleague relationship as well, us being doctors, you know having the same passion . . . .*' (Int 6)

Conceptions of teaching had changed, through a combination of formal and informal learning (Light & Calkins, 2008), but suggesting that the underlying structure of the knowledge about teaching and education was not systematic. Many will not have been explicitly prepared by their undergraduate or postgraduate training to teach. As a result, they dig deep into their own experience as students, sift through and reflect for lessons while also putting themselves in their students' shoes. This is the Kolb's cycle of experiential learning originally published in 1985 (Kolb & Kolb, 2005; Williams, 2009; Yardley et al., 2012), in which concrete experience is reflected on, abstract concepts developed and action taken. This model of learning was further elaborated on by Andresen (Andresen, Boud and Cohen, 1999) who argued that the goal of experience-based learning involves something personally significant or meaningful to the learner;

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includes personal emotional engagement; and reflective thought and opportunities to discuss their experiences. This immersion in the experience is in fact what the interviewees described as their experience of becoming teachers. It is turned into personal narratives or biographies that shape their personal image. Stories from the past are used to link different events together and to explain current actions, making them both the stories and what they are explaining meaningful (Flanagan, 2015). For example, the story of the experience during the rural hospital attachment is used to explain why being a clinical teacher is simply '*teaching while you do your work*'.

Informal Learning: There is growing recognition that informal or non-formal learning is just as important as 'formal' learning and should be regarded as having its own theoretical structure or pedagogy. With increasing attention being given to work-based learning, the study of non-formal learning is increasing (Eraut, 2004; Evans, 2018). There are a range of terms describing informal learning including tacit, implicit, non-formal and other all of which convey the idea of unstructured acquisition of knowledge and skills.

Tacit knowledge has been defined as that which is acquired individually, relies on personal experience and while it is the individual who decides what is meaningful in the experience, it is also action or practice based (Gourlay, 2004; McLeod et al., 2004). Each of the interviewees had very personal path of experience and emergence in the process of teaching. In answering the question 'How do clinicians acquire tacit knowledge', McLeod et al argued that it was when '*faculty members begin to seek explanations for their success or failure*' (McLeod et al., 2004; p25). All the interviewees described how they used student feedback, assessment results or students' choice of topic to reflect and evaluate their own teaching. During this time, they seek explanations and talk to other colleagues, search the internet or literature, or look for training. None could explain the change they observed in themselves, other than as a process of growth and experience, both personal and shared with colleagues.

Tacit knowledge itself has been described as multi-dimensional, involving mental processes of self-organisation, motivation and self-belief; task knowledge which is about the skills to perform a task, the process and procedures associate with it; and finally social skills to navigate the organisation and its culture, and its members (Leonard & Insch, 2005). Who to turn to for specific knowledge about, support for and help with a specific

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task is as important as knowing the institutional people who work in it, what they do and how they relate to the overall objectives (Leonard & Insch, 2005).

Networks: Networks are part of the tacit knowledge infrastructure. At teaching department level, all faculty are in a community of professional practice. Although teaching is a key function, it is not the professional practice that gives the faculty their professional identity. Within the departments, assessment or curriculum committees were central to focusing discussion on teaching and learning, although there was no formal drive to explore and incorporate educational theory. The non-attenders interviewed were all in departments that had colleagues who do attend faculty development, but some departments had more engagement than others. The impact of faculty development in an institution, such as UZCHS, is carried into the department by the members who do attend. Their changed behaviour, their increased contribution, especially to discussions on assessment, teaching behaviours and students' learning, is observed by other faculty.

> '*There are people that I recognized that take it seriously and they are growing within their field, and my chairperson is one such person I have seen grow. Yes, as a result of FD and I really respect that*' (Int 3).

> '*What I know about it is like people who have gone through it have changed, for the better I think . .*' (Int 6).

This diffusion may influence others or raise interest in pedagogical ideas. The attenders become key nodes in the network through which education information becomes diffused and transmitted in the department.

However, having faculty with specific training in health professions education provides a deeper resource in that these colleagues provided relevant and probably timely literature to colleagues through circulating journal articles in the network.

> '*before, I just focused on the professional journals . . . the person who has been feeding [us] some journals to us is Professor . . . he is also actively involved in health education, that is his passion . . . I am beginning to read [education journals] because he will read a good article and then forward to the group and we read those . .*' (Int 2)

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Although only one of the interviewees had mentors or 'go to' colleagues for guidance on teaching and learning, they did participate in informal networks with their colleagues, usually from the same discipline or department but also across disciplines. The Professional associations, or at least association members, also overlapped with the departments in their participation in teaching, assessment and regulation through the health professions authority. This created a community of practice for the discipline and profession, and its regulation but not for education. There is a certain irony in that health professionals generally regard themselves as teachers of their profession, the pedagogy of it is not part of continuing professional development. This maybe partly because of institutionalisation in universities and colleges and regulation by health professions authorities. Nevertheless, professional associations do assimilate training and teaching methods with little explanation of the theoretical underpinnings.

> '*I found that what I had tried to gather, through going to those international conferences definitely had a place here. We started doing our own workshops here. We would use the same model*.' (Int 4).

Professional associations are an ideal locus for combining faculty development with professional development because they are at the centre of their discipline national and global networks and drive change in practice without the institutional limitations of universities and colleges.

A social network is individuals who are connected to each other, forming a mesh representing people with whom an individual interacts within a network, at the same time an individual's position in that network shows how that person acts as a vector of information across it (Borgatti et al., 2009). Professional social networks tend to include colleagues whose opinions they value and with whom they have a positive rapport. Individuals may change their behaviour if significant others in the network change, and these are classed as early adopters, and early or late majority, but others resist till the last, the laggards (Mirriahi, Dawson, & Hoven, 2012). Within the network, there are key individuals who control the flow and quality of information, influencing how it is perceived and utilized. Consciously establishing communities of practice with focus on HPE is another way of re-directing FD to be focused at department or discipline level. The non-attenders, far from being laggards, seemed to be those who wanted to be independent within the

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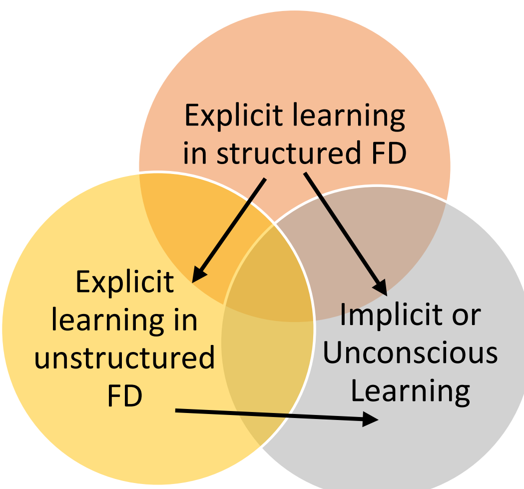
network, and found their own resources for learning. In short, the situation with FD is not binary, with attenders and non-attenders, but people who are on a spectrum from structured to unstructured FD, conscious to unconscious learning.

Figure 4: Structured learning in Faculty Development, unstructured learning and unconscious learning (developed by the author)



Theme 4: Mining of experience through story telling

In answering the question 'How do non-attenders of faculty development offerings perceive their development as educators?' a complex picture emerges of bright students who gravitate towards an academic career in their discipline and find themselves carrying a teaching responsibility. Many will not have been explicitly prepared by their undergraduate or postgraduate training to teach. As a result, they dig deep into their own experience as students, develop personal stories or narratives (Fig 8), sift through and reflect for lessons while also putting themselves in their students' shoes.

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Table 7: Composite Meaning units, experience interpreted through the lens of story telling

Personal Narratives		• You learn to recognize areas of weakness or problem areas, so the students you teach in the rotation at the end of the block you end up examining them and you realise they have certain weaknesses and make you [think about] the way we teach certain clinical skills, • I put myself in the student's shoes. I remembered myself first as a student and what I thought was missing. Then when I look at these guys now I realise that now OK, its still the same. And now I am thinking trends have gone so far away, so just think that probably what we were doing ten-twenty years ago is still what we are doing. So I saw the gap • Back then, you would be thinking teaching is letting them know that the causes or the risk factors . . . list them, remember them, and the next thing is how does it cause this, tell me the nitty-gritties of .... and tell me how do you manage it : one, two, three . . . now remember that. Now I have broadened • I find that very useful, using my own experience, the fact that I have walked the road, especially within the College, initially as a lecturer then as a student and now I am teaching the same students. I know what they go through it, how they go through it and I think I kind of understand how to approach topics and subjects based on my experience in the hospital as a student • One thing that has humbled me during my time as a teacher, is, when you have taught something and you review it, or you are assessed by the students, and the student actually tell you that they did not understand anything you just said, and you think you have done the best job and explained in the best way

This immersion in the experience (Table 8) is in fact what the interviewees described as their experience of becoming teachers. Each has a 'founding' story, of how they became teachers, and what being a teacher or educator means to them.

> '*At that time as a graduate it was difficult to get a job elsewhere, so it was strategic to say, 'I have finished a raw BSc, now I need a professional qualification.' Teaching was an additional qualification*'. (Int 5)

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> ‘*Straight out of training, I was identified at that time because they felt maybe they could use some of my talents, I was literally thrown in at the deep end. I had been reasonable in terms of my academics, because they didn’t have teachers, they then asked me to take on teaching (a group) students, but with no teaching experience at all.*’ (Int 6)

In the process they have developed ways of making that experience guide them currently, such as the following,

> ‘*For a long time, I felt that if a student failed it was the student’s problem, but then I have realized, with growth, that it is actually my problem as well. Yes the student can have a problem, but as a teacher I must find ways to make sure that students . . do the best they can in the programme which I specifically teach on.*’ (Int 6)

> ‘*and Academia is not something I wanted to do . . . surprisingly I did, and actually I enjoy it . . It is quite interesting because I have never taken a course related to teaching, but I always delve back into the courses I did not like when I was a student, so I try to use that as a guide during my teaching. I think, there are certain things I remember, certain professors or lecturers, their teaching methods I did not appreciate during that time, so I feel that during my particular teaching, I try to incorporate things that I felt could have been done during my training*’ (Int 4).

Gibbs Reflective Cycle and Moon’s Reflection in Action combine the tools of reflection with internal storytelling to underline the meaning of an experience. ‘*I put myself in the student’s shoes. I remembered myself first as a student . .*’ is both reflection and personal narrative (Oluwatoyin, 2015; Finlay, 2008; Moon, 2008). It is being able to describe for one’s self the experience and emotions, and relate these to what students may go through, then analyse it to look for and notice patterns that may be applied and made meaningful for the students. Stories from the past also help to link different events together and to explain current actions, making them both the stories and what they are explaining meaningful (Flanagan, 2015). For example, the story of the experience during the rural hospital attachment is used to explain why being a clinical teacher is simply ‘teaching while you do your work’.

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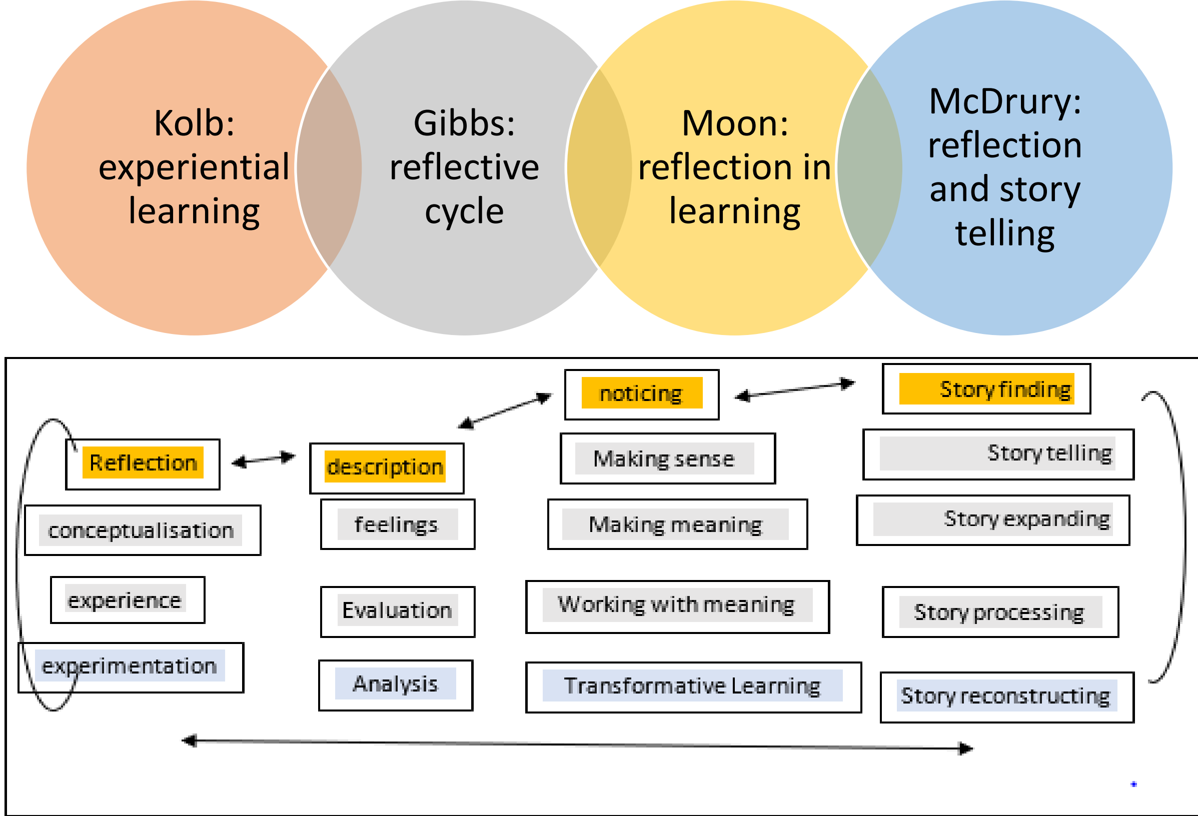
Figure 5: Reflection in experiential learning (developed by the author)



This study explored how non-attenders of faculty development perceived their development as educators in the UZCHS. An interpretivist approach within a phenomenological study was conducted. It was based on six interviews with faculty members identified through purposive sampling to achieve balance between length of service, clinical and non-clinical service, gender and part-time as against full-time faculty. All experienced immersion in the teaching at the start, with variable prior exposure to their roles, but dug deep into their own experience as students and imagined themselves in the position of their current students. At the same time, they received little pedagogical guidance from senior colleagues, who assumed that, as content experts, they could teach. The study participants revealed how they spent time thinking during an educational event (reflection in action) and after it (reflection on action) and how that helped them develop their understanding of and skill at teaching, some of which was became shared experience with specific colleagues. By selectively accessing FD from several different departments in

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the university or professional association meetings abroad, they were able to build themselves up.

Departments and professional associations act as networks through which participants learn about developments but themselves do not create professional identities of educators. Faculty development attenders, on the other hand, at department level, act as network nodes, from whom non-attenders learn from within their professional network. So, health professionals who do not attend faculty development perceive themselves to be teacher-educators largely developing themselves through their own selective choice of activities within and outside the network. However, some of the knowledge so acquired is unstructured. Whereas, the definition or explanation of what a teacher or teaching was in the behavioural theoretical model, what they described themselves to be practicing was more in the constructivist language.

Clinical full-time and part-time faculty all had very strong professional identities that exist in tension with their educator roles. The position of teaching as less recognised and credited within the universities makes it difficult to fully embrace the identity of a teacher-educator. The current curriculum developments in health professions educations are shifting teaching to the workplace and this is placing the clinical teachers at the forefront of different conceptions of FD and scholarship of learning.

What I found was that for many teaching as a profession did not have clear goals or identity. Participants preferred to solve what difficulties they had with pedagogy by looking for the solutions themselves through their networks and by selectively identifying and attending courses. It also means the value or profile of DHPE was not yet visible to them. Those who ended up on the college faculty, by whatever route, were probably among the brightest, most motivated of their cohort and had been ‘pulled in’ by their teachers. I have been involved in the same methods to grow the Department of Anaesthesia from three to eleven members. It seems, consciously establishing a ‘community of practice’ and also individually targeting some of the non-attenders to facilitate the learning of others, while being mentored or coached, in the areas in which they feel confident and capable, would be a way of bringing them from the periphery into the middle. The experience of the project has really challenged some of my own conceptions about non-attenders.

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Chapter 5: Conclusion

5.0 *Now What ?*

How educators develop within higher education and in the health professions is becoming an important area of research although still viewed as distinct from discipline professional development. This view is ripe for change, particularly as teaching in higher education becomes professionalised, and teaching was cited by the interviewees as strengthening their discipline competence.

In the first place, this study shows that many by-pass the formal FD system. Within DHPE there is no system for training and retaining faculty developers who can support, mentor or coach individuals or groups of faculty members. Having trained a significant number of HEALZ Fellows, most of whom are in departments and presumably share roles with colleagues without formal FD, there is a potential pool of facilitators to draw on. The role of 'faculty developer' has not been visible in CHS, and maybe that is one area where the FD gaze should face.

A faculty developer would be a faculty member, preferably of a different department from the target department, who would be able to work with a single and specific individual, unit or department to address perceived or assessed needs, establish longitudinal developmental tasks and methods for achieving them. Such a process would develop into a 'road map' with achievement milestones (Sorcinelli, 2007). The developmental process would be documented, shared with staff and students, generalised to the institution and evaluated for effect (Kirkpatrick Levels I and II) and impact (Kirkpatrick Levels III and IV) (Stanley, 2001). This would allow others not part of the process to learn and benefit from both formal and non-formal methods (Yee & Hargis, 2012) . Modern teaching and learning methods focus on behaviour change, the apex of the Miller pyramid, in addition to knowledge and skill acquisition (Sandhu, 2018). Methods that engage learner commitment and participation such as games (Abdulmajed, Park, & Tekian, 2015; Biehle & Jeffres, 2018) and narrative story-telling also change the learning environment (Milota, van Thiel, & van Delden, 2019; W, 2014). Ideal FD, therefore, would consist of a combination of institutional, even country-wide, programmes that are longitudinal (such as Modules, Certificate, Diploma and Masters programmes), plus tailored courses at individual, department and professional association level.

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The new CHS competence-based curriculum identifies ‘educator’ as a key outcome and graduate attribute, but how the student gains this competence is still being debated. DHPE can use the results of this study to advocate for and highlight the value of this competence and have its place in the curriculum secure and implemented. Postgraduate trainees should qualify with a strong understanding and identity of their role as educators to themselves, their colleagues, peers and community.

This study also demonstrates the potential for conducting education research in CHS, and the benefits in supporting education, teaching and learning development.

DHPE should now view its faculty development remit as serving the whole profession in Zimbabwe, and not just the CHS, and should now plan to participate and support ‘education CPD’ programmes of all health professional associations.

5.1 Strengths and Limitations

This study adds to the literature on FD, particularly with reference to non-attenders of FD who are not reported on in the health professions education literature. The definition of ‘non-attenders’ was specific to those not attending DHPE offerings in the UZCHS and found that, in fact, they appear to attend structured FD from a variety of sources, but on a highly selective basis. This is consistent with, and confirms, the current definition by Steinert et al (2016) above that FD is *any activity* the individual engages in to improve themselves as educators.

The study was developed and undertaken over a time-limited period, which made it difficult to accommodate the time constraints some of the eligible interviewees had. As a result, two of the male subjects could not be interviewed. A study of this nature carried out over a longer period could have more deliberately addressed that.

The term ‘non-attenders’ raised some comment. Although no-one said it was stigmatising, it was felt it labelled individuals in a negative way and one person protested over the term spiritedly. When someone was approached as a ‘non-attender’, they always responded with a chuckle and a laugh, like they had been ‘found-out’. Although this was not communicated, it may have been associated with the withdrawal of one other eligible participant. The term itself is not generally accurate as it refers to formally organised FD events or activities, but it was useful for the purposes of this study. One group that is

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missing from the study was those who have been in the college for twenty or thirty years. A longer study would have been able to recruit them to share their experiences.

5.2 *Recommendations*

Until recently, both undergraduate and postgraduate medical training were confined within the universities. The establishment of Colleges of Medicine for the postgraduate training in the various disciplines is establishing 'educators' outside the university who have a clear 'clinical' identity of themselves, those who '*teaching while they do their work*'. They are unlikely to use the university FD system, and it is up to the DHPE to motivate for taking FD out of the university into the professional associations and establishing an interprofessional health professions education forum such as SAAHE in Zimbabwe.

About one third of all UZCHS faculty have undertaken the longitudinal course, HEALZ, and every department has at least one HEALZ fellow, there is a need for more targeted and individualised FD at both personal and department level to support those who have FD experience and those managing their own development. The use and development of personal development plans (PDP), portfolio of teaching and peer observation of teaching (POT), would put DHPE in a position to be the 'go to' place for those looking for support with their development. Facilitators could be recruited from the current HEALZ Fellows.

The HEALZ course is going to be a pre-tenure mandatory requirement in the CHS for new faculty and CHS is also offering it to other universities. It should be offered to the associations as well and 'education CPD' points made mandatory for annual renewal of license to practice. A similar requirement is in existence in other countries with 'ethics CPD' point.

DHPE should now view its faculty development remit as developing a community or communities of practice across the CHS and HPE community in Zimbabwe through which educators can share experiences and drive their own development and bring these into contact with other HPE educators regionally and internationally, for example through being part of SAAHE network.

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Chapter 6: References

Aagaard, E., Connors, S., Challender, A., Gandari, J., Nathoo, K., Borok, M., … Hakim, J. (2018). Health Education Advanced Leadership for Zimbabwe (Healz): Developing the Infrastructure to Support Curriculum Reform. *Annals of Global Health*, *84*(1), 176–182.

Abdulmajed, H., Park, Y. S., & Tekian, A. (2015). Assessment of educational games for health professions: A systematic review of trends and outcomes. *Medical Teacher*, *37*(Supplement 1), S27–S32.

Andresen, L., Boud, D., & Cohen, R. (n.d.). Experience-based learning. In G. Foley (Ed.), *Understanding Adult Education and Training* (2nd ed., pp. 225–239). Sydney: Allen & Unwin.

Andrews, T., Conaway, E., Zhao, J., & Dolan, E. (2016). Colleagues as Change Agents: How Department Networks and Opinion Leaders Influence Teaching at a Single Research University. *CBE—Life Sciences Education*, *15*, 1–17.

AoME. (2010). *A Framework for the Professional Development of Postgraduate Medical Supervisors: Guidance for deaneries, commissioners and providers of postgraduate medical education*. London. Retrieved from www.medicaleducators.org

AoME. (2014). *Professional Standards for medical, dental and veterinary educators* (3rd ed.). Cardiff: Academy of Medical Educators. Retrieved from www.medicaleducators.org

Bandura, A. (2005). The Evolution of Social Cognitive Theory. In K. G. Smith & M. A. Hitt (Eds.), *Great Minds in Management: The process of theory development* (1st ed., pp. 9–35). oxford: Oxford University Press.

Bartle, E., & Thistlethwaite, J. (2014). Becoming a medical educator: motivation, socialisation and navigation. *BMC Medical Education*, *14*, 110.

Beauchamp, C., & Thomas, L. (2009). Understanding teacher identity: an overview of issues in the literature and implications for teacher education. *Cambridge Journal of Education*, *39*(2), 175–189.

Bednall, J. (2006). Epoche and bracketing within the phenomenological paradigm. *Issues in Educational Research*, *16*(2), 123–138.

Berkhout, J., Helmich, E., Teunissen, P., van de Vleuten, C., & Jaarsma, A. (2018). Context matters when striving to promote active and lifelong learning in medical education. *Medical Education*, *52*, 34–44.

Biehle, L., & Jeffres, M. (2018). Play games and score points with students. *Clinical Teacher*, *15*(1), 445–450.

Bilal, Guraya, S., & Chen, S. (2019). The impact and effectiveness of faculty development program in fostering the faculty's knowledge, skills, and professional competence: A systematic review and meta-analysis. *Saudi Journal of Biological Sciences*, *26*, 688–697.

Birt, L., Scott, S., Cavers, D., Campbell, C., & Walter, F. (2016). Member Checking: A Tool to Enhance Trustworthiness or Merely a Nod to Validation? *Qualitative Health Research*, *26*, 1802–1811.

Bleakley, A. (2010). Blunting Occam's razor: aligning medical education with studies of complexity. *Journal of Evaluation in Clinical Practice*, *16*, 849–855.

Borgatti, S., Mehra, A., Brass, D., & Labianca, G. (2009). Network Analysis in the Social Sciences. *Science*, *323*, 892–895.

Stellenbosch University https://scholar.sun.ac.za

Connors, S. C., Nyaude, S., Challender, A., Aagaard, E., Velez, C., & Hakim, J. (2017). Evaluating the Impact of the Medical Education Partnership Initiative at the University of Zimbabwe College of Health Sciences Using the Most Significant Change Technique. *Academic Medicine*, 92, 1262–1268.

Cook, D. (2014). Faculty Development online. In Y. Steinert (Ed.), *Faculty Development in the Health Professions: a focus on Research and Practice* (1st ed., pp. 217–241). Dordrecht: Springer.

Cooperrinder, D., & Whitney, D. (2001). A positive revolution in change: appreciative inquiry. *Administration and Public Policy*, *87*(611–630).

Crandall, S. J., & Cacy, D. S. (1993). Faculty development: An individualized approach. *Journal of Continuing Education in the Health Professions*, *13*(4), 261–272.

Cresswell, J. (2007). *Qualitative Inquiry and Research Design: Choosing among Five Approaches.* (3rd ed.). Thousand Oaks: Sage.

Cruess, R. L., Cruess, S. R., & Steinert, Y. (2018). Medicine as a Community of Practice: Implications for Medical Education. *Academic Medicine*, *93*(2), 185–191.

Daly, W. (1994). Teaching and Scholarship: adapting American higher education to hard tomes. *The Journal of Higher Education*, *65*(1), 45–57.

Davies, R., & Dart, J. (2003). A Dialogical, Story-Based Evaluation Tool: The Most Significant Change Technique. *American Journal of Evaluation*, *24*, 137–155. https://doi.org/10.1177/109821400302400202

Dilly, C., Carlos, W., Hoffmann-Longtin, K., Buckley, J., & Burgner, A. (2018). Bridging the gap for future clinician- educators. *The Clinical Teacher*, *15*, 488–493.

Eddles-Hirsch, K. (2015). Phenomenology and Educational Research. *INTERNATIONAL JOURNAL OF ADVANCED RESEARCH*, *3*(8), 251–260.

Elo, S., Kaariainen, M., Kanste, O., Polkki, T., Utriainen, K., & Kyngas, H. (2014). Qualitative Content Analysis: A Focus on Trustworthiness. *Sage Open*, (1–10). https://doi.org/10.1177/2158244014522633

Eraut, M. (2004). Informal learning in the workplace. *Studies in Continuing Education*, *26*(2), 247–273.

Evans, L. (2019). Implicit and informal professional development: what it ‘looks like’, how it occurs, and why we need to research it. *Professional Development in Education*, *45*(1), 3–15.

Finlay. (3008). Reflecting on reflective practice. *PBPL: Practice Based Professional Learning Paper*, (52), 1–27. Retrieved from www.open.ac.uk/pbpl

Flanagan, S. (2015). How does storytelling within higher education contribute to the learning experience of early years students? *J. of Practice Teaching & Learning*, *13*(2–3), 146–169.

Gourlay, S. (2004). ‘Tacit Knowledge’: The Variety of Meanings in Empirical Research. *SSRN Electronic Journal*. https://doi.org/10.2139/ssrn.676466

Green, M. L., Gross, C. P., Kernan, W. N., Wong, J. G., & Holmboe, E. S. (2003). Integrating teaching skills and clinical content in a Faculty Development workshop. *Journal of General Internal Medicine*, *18*, 468–474.

Groenewald, T. (2004). A Phenomenological Research Design Illustrated. *International Journal of Qualitative Methods*, *3*(1), 42–55.

Stellenbosch University https://scholar.sun.ac.za

Guskey, T. (2002). Does It Make a Difference? Evaluating Professional Development. *Educational Leadership*, *59*(6), 45–51.

Hafler, J., Ownby, A., Thompson, B., Fasser, C., Grigsby, K., Haidet, P., … Hafferty, F. (2011). Decoding the Learning Environment of Medical Education: A Hidden Curriculum Perspective for Faculty Development. *Academic Medicine*, *86*, 440–444.

Hakim, J., Chidzonga, M., Borok, M., KJ, N., Matenga, J., Havranek, E., … Campbell, T. (2018). Medical Education Partnership Initiative (MEPI) in Zimbabwe: Outcomes and Challenges. *Global Health: Science and Practice*, *6*(1), 82–92.

Hargreaves, K. (2016). Reflection in Medical Education. *Journal of University Teaching and Learning Practice*, *13*(2). Retrieved from https://ro.uow.edu.au/jutlp/vol13/iss2/6

Hogle, J. A., & Moberg, P. D. (2015). Success Case Studies Contribute to Evaluation of Complex Research Infrastructure. *Evaluation and the Health Professions*, *37*(1), 98–113. https://doi.org/10.1177/0163278713500140.

Illeris, K. (2018). An overview of the history of learning theory. *European Journal of Education*, *53*, 86–101.

Karg, A., Boendermaker, P., Brand, P., & Cohen-Schotanus, J. (2013). Integrating continuing medical education and faculty development into a single course: Effects on participants' behaviour. *Medical Teacher*, *35*, e1594–e1597.

Kim, D.-H., Hwang, J., Lee, S., & Shin, J.-S. (2017). Institutional factors affecting participation in national faculty development programs: a nation-wide investigation of medical schools. *BMC Medical Education*, *17*(48). https://doi.org/10.1186/s12909-017-0888-1

Kivunja, C., & Kuyini, A. B. (2017). Understanding and Applying Research Paradigms in Educational Contexts. *International Journal of Higher Education*, *6*(5), 26–41. https://doi.org/10.5430/ijhe.v6n5p26

Knight, P., Tait, J., & Yorke, M. (2006). The professional learning of teachers in higher education. *Studies in Higher Education*, *31*(3), 319–339.

Kogan, J., & Holmboe, E. (2014). Preparing Residents for Practice in New Systems of Care by Preparing Their Teachers. *Academic Medicine*, *89*(11), 1436–1437.

Kolb, A., & Kolb, D. (2005). Learning Styles and Learning Spaces: Enhancing Experiential Learning in Higher Education. *Academy of Management Learning & Education*, *4*(2), 193–212.

Kothari, A., Rudman, D., Dobbins, M., Sibbald, S., & Edwards, N. (2012). The use of tacit and explicit knowledge in public health: a qualitative study. *Implementation Science*, *7*(20). https://doi.org/10.1186/1748-5908-7-20

Kumagai, A. K., Richardson, L., Khan, S., & Kuper, A. (2018). Dialogues on the Threshold: Dialogical Learning for Humanism and Justice. *Academic Medicine*, *93*(12), 1778–1783.

Kvale, S. (1996). *Interviews: an introduction to qualitative research interviewing*. Sage.

Lane, R. (2009). Surgical Education & Training in the COSECSA Region. *East and Central African Journal of Surgery*, *1*(March/April), 1–12. Retrieved from http://www.bioline.org.br/js

Lave, J., & Wenger, E. (1991). *Situated Learning: Legitimate Peripheral Participation*. Cambridge: Cambridge University Press.

Lawrence, C., Mhlaba, T., Stewart, K. A., Molestane, R., Gaede, B., & Moshabela, M. (2018). The

Stellenbosch University https://scholar.sun.ac.za

Hidden Curricula of Medical Education: A Scoping Review. *Academic Medicine*, *93*, 648–656.

Leonard, N., & Insch, G. S. (2005). Tacit knowledge in academia: A proposed model and measurement scale. *Journal of Psychology: Interdisciplinary and Applied*, *139*(6), 495–512. https://doi.org/10.3200/JRLP.139.6.495-512

Leslie, K., Baker, L., Egan-Lee, E., Esdaile, M., & Reeves, S. (2013). Advancing Faculty Development in Medical Education: A Systematic Review. *Academic Medicine*, *88*, 1038–1045.

Light, G., & Calkins, S. (2008). The experience of faculty development: patterns of variation in conceptions of teaching, *13*(1), 27–40.

Lowenthal, P, & Muth, R. (2008). Constructivism. In E. Provenzo (Ed.), *Encyclopedia of the social and cultural foundations of education* (pp. 177–179). Thousand Oaks: SAGE.

Lowenthal, PR, Wray, M., Bates, B., Switzer, T., & Stevens, E. (2013). Examining Faculty Motivation to Participate in Faculty Development. *International Journal of University Teaching and Faculty Development*, *3*(3), 149–164.

Lueddeke, G. R. (2003). Professionalising Teaching Practice in Higher Education: A study of disciplinary variation and 'teaching-scholarship'. *Studies in Higher Education*, *28*(2), 213–228.

Machles, D. (2003). Situated Learning. *Professional Safety*, (September), 22–28.

Matsika, A., Nathoo, K., Borok, M, Mashaah, T, Madya, F., Connors, S., Campbell, T., & Hakim, J. (2018). Role of Faculty Development Programs in Medical Education at the University of Zimbabwe College of Health Sciences, Zimbabwe. *Annals of Global Health*, *84*(1), 183–189.

Mays, N. (2000). Qualitative research in health care: Assessing quality in qualitative research. *British Medical Journal*, *320*, 50–52. https://doi.org/10.1136/bmj.320.7226.50

McDonald, B. (2016). Individualised Professional Development in Higher Education. In *Research in Humanities, Sociology and Education* (pp. 73–77). https://doi.org/10.15242/ICEHM>ED1116067

McLean, M, Cilliers, F., & van Wyk, J. (2009). Faculty development: Yesterday, today and tomorrow. *Medical Teacher*, *30*(6), 555–584. https://doi.org/10.1080/01421590802109834

McLean, Monica, & Bullard, J. E. (2000). Becoming a University Teacher: evidence from teaching portfolios (how academics learn to teach). *Teacher Development*, *4*(1), 79–101. https://doi.org/10.1080/13664530000200104

McLeod, P. J., Meagher, T., Steinert, Y., Schuwirth, L., & McLeod, A. H. (2004). Clinical teachers' tacit knowledge of basic pedagogic principles. *Medical Teacher*. https://doi.org/10.1080/01421590310001643154

Milota, M., van Thiel, G., & van Delden, J. (2019). Narrative medicine as a medical education tool: A systematic review. *Medical Teacher*, *41*(7), 802–810.

Mirriahi, N., Dawson, S., & Hoven, D. (2012). Identifying key actors for technology adoption in higher education: A social network approach. In *ASCILITE 2012: Future Challenges: Sustainable Futures*.

Moerer-Urdahl, T., & Cresswell, J. (2004). Using Transcendental Phenomenology to Explore the "Ripple Effect" in a Leadership Mentoring Program. *International Journal of Qualitative Methods*, *3*(2), 19–35.

Moon, J. (3008). 'There is a story to be told...'; A framework for the conception of story in higher education and professional development. *Nurse Education Today*, *28*, 232–239.

Stellenbosch University https://scholar.sun.ac.za

Morris, C, & Swanwick, T. (2018). From the workshop to the workplace: Relocating faculty development in postgraduate medical education. *Medical Teacher*, *40*(6), 622–626.

Morris, Clare, & Blaney, D. (2010). Work-based learning. In T. Swanwick (Ed.), *Understanding Medical Education: Evidence, Theory and Practice* (pp. 69–82). London: Association for the Study of Medical Education.

Moustakas, C. (1994). *Phenomenological research methods*. London: Sage.

Murtonen, M., Gruber, H., & Lehtinen, E. (2017). The return of behaviourist epistemology: A review of learning outcomes studies. *Education Research Review*, *22*, 114–128.

O'Sullivan, P., & Irby, D. M. (2014). *Ch 18. Promoting Scholarship in Faculty Development: Relevant Research Paradigms and Methodologies*. (Y. Steinert, Ed.). Dordrecht: Springer.

O'Sullivan, P., Mkony, C., Beard, J., & Irby, D. M. (2016). Identity formation and motivation of new faculty developers: A replication study in a resource constrained university. *Medical Teacher*, *38*(9), 879–885. https://doi.org/10.3109/0142159X.2015.1132409

Oluwatoyin, F. (2015). Reflective Practice: Implication for Nurses. *Journal of Nursing and Health Science*, *4*(4), 28–33.

Patel, M. (2016). Changes to postgraduate medical education in the 21st century. *Clinical Medicine*, *16*(4), 311–314.

Pearse, J., Mann, M. K., Jones, C., van Buschbach, S., Olff, M., & Bisson, J. (2012). The Most Effective Way of Delivering a Train-the-Trainers Program: A Systematic Review. *Journal of Continuing Education in the Health Professions*, *32*(3), 215–226.

Pifer, M., Baker, V., & Lunsford, L. (2015). Academic departments as networks of informal learning: faculty development at liberal arts colleges. *Internal Journal for Academic Development*, *20*(2), 178–192.

Ratheeswari, K. (2018). Information Communication Technology in Education. In *Recent Trend of Teaching Methods in Education* (pp. S45-47).

RCoA. (n.d.). Anaesthetists as Educators (AaE) Programme. Retrieved 25 September 2019, from https://www.rcoa.ac.uk/anaesthetists-educators-aae

RCPSC, R. C. of P. and S. of C. (2018). CanMEDS 2015 Physician Competency Framework. Retrieved from http://canmeds.royalcollege.ca/en/framework

Rodgers, C. (2002). Defining Reflection: another look at John Dewey and Reflective thinking. *Teachers College Record*, *104*(4), 842–866.

Ronaghy, R. (2013). Philosophy of medical education. *Journal of Advances in Medical Education and Professionalism*, *1*(2), 43–45.

SAAHE. (2004). South African Association of Health Educationists. Retrieved 2 February 2019, from http://saahe.org.za/

Sanders, J. (2009). The use of reflection in medical education: AMEE Guide No. 44. *Medical Teacher*, *31*(8), 685–695.

Sandhu, D. (2018). Postgraduate medical education – Challenges and innovative solutions. *Medical Teacher*, *40*(6), 607–609.

Smith, C., & Boyd, P. (2012). Becoming an academic: the reconstruction of identity by recently appointed lecturers in nursing, midwifery and the allied health professions. *Innovations in*

Stellenbosch University https://scholar.sun.ac.za

Education and Teaching International, *49*(1), 63–72.

Sorcinelli, M. D. (2007). Faculty Development: The challenge going forward. *Peer Review*, *9*(4), 4–8.

Souter, J. (2016). What is Faculty Development. *International Anesthesiology Clinics*, *54*(3), 1–17.

Spencer, J. (2014). Faculty Development Research: the 'State of the Art' and future trends. In Y. Steinert (Ed.), *Faculty Development in the Health Professions: a focus on Research and Practice* (pp. 353–374). Dordrecht: Springer.

Stanley, C. A. (2001). The Faculty Development Portfolio: A Framework for Documenting the Professional Development of Faculty Developers. *Innovative Higher Education*, *26*(1), 23–36.

Steinert, Y., MacDonald, M. E., Boillat, M., Elizov, M., Meterissian, S., Razack, S., … McLeod, P. J. (2010). Faculty Development: if you build, they will come. *Medical Education*, *44*, 900–907. https://doi.org/10.1111/j.1365-2923.2010.03746.x

Steinert, Y., Mann, K., Anderson, B., Barnett, B. M., Centeno, A., Naismith, L., … Dolmans, D. (2016). A systematic review of faculty development initiatives designed to enhance teaching effectiveness: A 10-year update: BEME Guide No. 40. *Medical Teacher*. https://doi.org/10.1080/0142159X.2016.1181851

Steinert, Y., Mann, K., Centeno, A., Dolmans, D., Spencer, J., Gelula, M., & Prideaux, D. (2006). A systematic review of faculty development initiatives designed to improve teaching effectiveness in medical education: BEME Guide No. 8 Mark Gelula & David Prideaux (2006) A systematic review of faculty development initiatives designed to improve teachin. *Medical Teacher*, *8*(6), 497–526. https://doi.org/10.1080/01421590600902976

Steinert, Y., McLeod, P. J., Boillat, M., Meterissian, S., Elizov, M., & MacDonald, M. E. (2009). Faculty Development: a 'Field of Dreams' ? *Medical Education*, *43*, 42–49. https://doi.org/10.1111/j.1365-2923.2008.03246.x

Sullivan, P. B., Buckle, A., Nicky, G., & Atkinson, S. H. (2012). Peer observation of teaching as a faculty development tool. *BMC Medical Education*, *12*(26). https://doi.org/10.1186/1472-6920-12-26

Taber, K. S. (2011). Constructivism as educational theory: Contingency in learning, and optimally guided instruction. *Educational Theory*, 39–61. https://doi.org/10.5785/21-2-73

Taylor, D., & Hamdy, H. (2013a). Adult learning theories: Implications for learning and teaching in medical education: AMEE Guide No. 83. *Medical Teacher*, *35*(11), e1561–e1572. https://doi.org/10.3109/0142159X.2013.828153

Taylor, D., & Hamdy, H. (2013b). Adult learning theories: Implications for learning and teaching in medical education: AMEE Guide No. 83. *Medical Teacher*, *35*(11), e1561–e1572.

Torre, D., Daley, B., Sebastian, J., & Elnicki, D. (2006). Overview of Current Learning Theories for Medical Educators. *American Journal of Medicine*, *119*(10), 903–907.

van Lankveld, T., Schoonenboom, J., Volman, M., Croiset, G., & Beishuizen, J. (2017). Developing a teacher identity in the university context: a systematic review of the literature. *Higher Education Research & Development*, *36*(2), 325–342.

van Roermund, T. C., Tromp, F., Scherpbier, A. J., Bottema, B. J., & Bueving, H. J. (2011). Teachers' ideas versus experts' descriptions of 'the good teacher' in postgraduate medical education: implications for implementation. A qualitative study. *BMC Medical Education*, *11*. https://doi.org/doi:10.1186/1472-6920-11-42

Stellenbosch University https://scholar.sun.ac.za

W, F. A. (2014). Narrative Ethics as dialogical story-telling. *Hastings Center Report*, *44*(1), S16–S20.

Waters, M., & Wall, D. (2007). Educational CPD: how UK GP trainers develop themselves as teachers. *Medical Teacher*, *29*(6), e160–e169.

Waters, M., & Wall, D. (2008). Educational CPD: An exploration of the attitudes of UK GP trainers using focus groups and an activity theory framework. *Medical Teacher*, *30*(8), e250–e259.

Williams, D. (2009). Applying Kolb's Experiential Learning Style to an MIS Class. *Journal of Learning in Higher Education*, *5*(2), 1–4.

Yardley, S., Teunissen, P. W., & Dornan, T. (2012). Experiential learning: AMEE Guide No. 63. *Medical Teacher*, *32*(2), e102–e115. https://doi.org/10.3109/0142159X.2012.650741

Yee, K., & Hargis, J. (2012). Indirect Faculty Development and the Role of Sociability. *Journal on Centers for Teaching and Learning*, *4*(61–78).

Yilmaz, K. (2011). The Cognitive Perspective on Learning: Its Theoretical Underpinnings and Implications for Classroom Practices. *The Clearing House: A Journal of Educational Strategies, Issues and Ideas*, *84*(5), 204–212. https://doi.org/10.1080/00098655.2011.568989

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Appendices:

A Letter of invitation to a faculty member eligible to be interviewed

B Participant Information Leaflet and Consent form University of Stellenbosch, Cape Town South Africa

C Participant Information Leaflet and Consent form University of Zimbabwe College of Health Sciences

D Ethics approval Stellenbosch University Human Research Ethics Committee

E Ethics approval of Zimbabwe College of Health Sciences Institutional Review Committee

F Ethics approval of Medical Research Council, Zimbabwe

G Example: Significant statements

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A. Letter of invitation to a faculty member eligible to be interviewed

Thank you [redacted] for being willing to be interviewed.
Attached are the information sheet and consent form.
They are identical. One is UZ and the other in Stellenbosch.
It's a study I am doing with Stellenbosch for my MPhil. [The aim was to start a Masters in Health Professions Education (what used to be called Medical Education) and we needed local faculty].

I would be grateful if you read them carefully and we can discuss anything arising from it.

The interview would last about one hour approx.
I will have an interview guide, so it's not a Q+A. It is more a discussion.
So, in the meantime if can think around the topic (I know I am not giving much away!) but we can discuss in-depth with some spontaneity later.

The interview will be recorded and transcribed.
you will get a copy of the transcript to review and approve.
the approved version is the one we use. Identifiers will be removed from it.

Farai

Dr Farai D Madzimbamuto
MBChB, MMed, FRCA, *SAFRI Fellow*
University of Zimbabwe College of Health Sciences
Associate Professor
Department of Anaesthesia and Critical Care Medicine
Department of Health Professions Education
Tel: 00 263 (0) 777 289 219
00 263 (0) 77 471 8953

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B. *Participant Information Leaflet and Consent form University of Stellenbosch, Stellenbosch South Africa*

PARTICIPANT INFORMATION LEAFLET AND CONSENT FORM

Please see Section 8 of our Health Research Ethics Committee (HREC) Standard Operating Procedures (SOPs) for more detailed information about requirements for Informed Consent (IC). You will find the SOPs here: http://www.sun.ac.za/english/faculty/healthsciences/rdsd/Pages/Ethics/SOP.aspx. (Please delete this paragraph before submitting your Informed Consent Form (ICF) to the HREC)

TITLE OF RESEARCH PROJECT:	
How do non-attenders of Faculty Development offerings perceive their development as educators?	
DETAILS OF PRINCIPAL INVESTIGATOR (PI):	
Title, first name, surname: Dr Farai D Madzimbamuto	**Ethics reference number:** **HREC9083; JREC 124/19** **MRCZ /B/ 1737**
Full postal address: **Mazowe Street, Belgravia, Harare, Zimbabwe**	**PI Contact number:** **+263777289219 [mobile]** **+2638644217884 [office]**

We would like to invite you to take part in a research project. Please take some time to read the information presented here, which will explain the details of this project. Please ask the study staff or doctor any questions about any part of this project that you do not fully understand. It is very important that you are completely satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is **entirely voluntary** and you are free to decline to participate. In other words, you may choose to take part, or you may choose not to take part. Nothing bad will come of it if you say no: it will not affect you negatively in any way whatsoever. Refusal to participate will involve no penalty or loss of benefits or reduction in the level of care to which you are otherwise entitled to. You are also free to withdraw from the study at any point, even if you do agree to take part initially.

This study has been approved by the **Health Research Ethics Committee at Stellenbosch University.** The study will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki, the South African Guidelines for Good Clinical Practice (2006), the Medical Research Council (MRC) Ethical Guidelines for Research (2002), and the Department of Health Ethics in Health Research: Principles, Processes and Studies (2015).

This study has been approved by the Joint Research and Ethics Committee of Parirenyatwa Hospital and the University of Zimbabwe College of Health Sciences (JREC).

What you should know about this research study:

- We give you this consent so that you may read about the purpose, risks, and benefits of this research study.

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- The main goal of research studies is to gain knowledge that may be of help in the future.
- We cannot promise that this research will benefit you. Just like all research there may be some risks.
- You have the right to refuse to take part or agree to take part now and change your mind later.
- Whatever you decide, it will not affect the way you are regarded by colleagues or any others.
- Please review this consent form carefully. Ask any questions before you make a decision.
- Your participation is voluntary.

PURPOSE

The Department of Health Professions Education (DHPE) organises Faculty Development (FD) activities such as workshops and the Health Education and Advanced Leadership course for Zimbabwe (HEALZ). This year (2019) will be the fifth year of such activities. While many UZCHS faculty do attend such activities, there is a sizable proportion that do not. This has also been reported in the literature in other countries.

The challenge is whether to accept that there will always be a proportion that do not engage in FD or to find forms of FD that allow for all faculty to participate in one way or another. FD arose as a way of helping academics to become expert educators. They may be experts in their field of practice or study but are not trained to be teachers and educators.

PROCEDURE

In this study we will have detailed interviews with those who are not on our registers of attendance to understand how they develop as educators. A letter will be sent with a few questions to check what we know. If you are receiving this form, you have been found to be suitable to interview and have been selected out of a group of others equally suitable.

The interview will be recorded, a written report of the interview will be prepared, and you will be asked to read it and check that you stand by what was recorded. You will be able to add somethings which you may feel are not clear or you realised after that could have said.

The recording will then be deleted at the end of the study, and the written document will have anything that identifies you removed. This will then be used for analysis.

RISKS

There are minimal risks. Interviews will be conducted at your convenience in the College of Health Sciences or place of your regular work, to avoid inconvenience and unnecessary travel to place of interview.

CONFIDENTIALITY

Only the researchers will have access to your interviews. The electronic recordings will be stored on a password-locked computer in the Department of Health Professions Education. The transcribed record will be kept for up to 5 years. Possible risks may be related to leakage or loss of stored information.

BENEFITS AND/OR COMPENSATION

There is no personal benefit to you. This study is part of an MPhil study in Health Professions Education being undertaken with University of Stellenbosch. This will help to build capacity to

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establish HPE courses such as a Diploma and Masters in HPE in Zimbabwe. There will be refreshments during the interviews.
VOLUNTARY PARTICIPATION
Participation in this study is voluntary. If you decide not to participate in this study, your decision will not affect your future relations with the Department of Health Professions Education in the University of Zimbabwe, its personnel, and nay associated institutions in Zimbabwe or elswhere. If you decide to participate, you are free to withdraw your consent and to discontinue participation at any time without penalty.

Declaration by participant

By signing below, I …………………………………..………. agree to take part in a research study entitled (insert title of study here).

I declare that:

• I have read this information and consent form, or it was read to me, and it is written in a language in which I am fluent and with which I am comfortable.
• I have had a chance to ask questions and I am satisfied that all my questions have been answered.
• I understand that taking part in this study is voluntary, and I have not been pressurised to take part.
• I may choose to leave the study at any time and nothing bad will come of it – I will not be penalised or prejudiced in any way.

Signed at (place) ....…........…………….. on (date) …………....……….. 2019.

Signature of participant   Signature of witness

Declaration by investigator

I (name) ……………………………………………………..……… declare that:

• I explained the information in this document in a simple and clear manner to

……………………………………………..……………………………………..
• I encouraged him/her to ask questions and took enough time to answer them.
• I am satisfied that he/she completely understands all aspects of the research, as discussed above.
• I did/did not use an interpreter. (If an interpreter is used then the interpreter must sign the declaration below.)

Signed at (place) ....…........…………….. on (date) …………....……….. 2015.

Signature of investigator   Signature of witness

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The study has the approval of the Joint Ethics Committee of the University of Zimbabwe College of Health Sciences and Parirenyatwa Group of Hospitals (JREC) and the Medical Research Council of Zimbabwe (MRCZ). They can be contacted for any complains, clarifications or incidents you wish to discuss.

If you have any questions concerning this study or consent form beyond those answered by the investigator, including questions about the research, your rights as a research participant or research-related injuries; or if you feel that you have been treated unfairly and would like to talk to someone other than a member of the research team, please feel free to contact the Medical Research Council of Zimbabwe (MRCZ) on telephone (04)791792 or (04) 791193 and cell phone lines 0772 433 166 or 0779 439 564. The MRCZ Offices are located at the National Institute of Health Research premises at Corner Josiah Tongogara and Mazowe Avenue in Harare.

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C. *Participant Information Leaflet and Consent form, University of Zimbabwe College of Health Sciences*

DEPARTMENT OF HEALTH PROFESSIONS EDUCATION
COLLEGE OF HEALTH SCIENCES **UNIVERSITY OF ZIMBABWE**
Mazowe Street, PO Box A 178
Avondale, HARARE,
Zimbabwe

Telephone:263-4-791631
Fax: 263-
724912/791995/795019

Chairman
Farai D Madzimbamuto *MBCHB, MMed(Anaes), FRCA, FCA(ECSA), SAFRI Fellow*

PARTICIPANT INFORMATION LEAFLET AND CONSENT FORM

Please see Section 8 of our Health Research Ethics Committee (HREC) Standard Operating Procedures (SOPs) for more detailed information about requirements for Informed Consent (IC). You will find the SOPs here: http://www.sun.ac.za/english/faculty/healthsciences/rdsd/Pages/Ethics/SOP.aspx. (Please delete this paragraph before submitting your Informed Consent Form (ICF) to the HREC)

TITLE OF RESEARCH PROJECT:	
How do non-attenders of Faculty Development offerings perceive their development as educators?	
DETAILS OF PRINCIPAL INVESTIGATOR (PI):	
Title, first name, surname: Dr Farai D Madzimbamuto	**Ethics reference number:** **HREC 9083 Stellenbosch: JREC 124/19; MRCZ /B/ 1737**
Full postal address: **Mazowe Street, Belgravia, Harare, Zimbabwe**	**PI Contact number:** **+263777289219 [mobile]** **+2638644217884 [office]**

We would like to invite you to take part in a research project. Please take some time to read the information presented here, which will explain the details of this project. Please ask the study staff or doctor any questions about any part of this project that you do not fully understand. It is very important that you are completely satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is **entirely voluntary** and you are free to decline to participate. In other words, you may choose to take part, or you may choose not to take part. Nothing bad will come of it if you say no: it will not affect you negatively in any way whatsoever. Refusal to participate will involve no penalty or loss of benefits or reduction in the level of care to

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which you are otherwise entitled to. You are also free to withdraw from the study at any point, even if you do agree to take part initially.

This study has been approved by the **Health Research Ethics Committee at Stellenbosch University.** The study will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki, the South African Guidelines for Good Clinical Practice (2006), the Medical Research Council (MRC) Ethical Guidelines for Research (2002), and the Department of Health Ethics in Health Research: Principles, Processes and Studies (2015).

This study has been approved by the Joint Research and Ethics Committee of Parirenyatwa Hospital and the University of Zimbabwe College of Health Sciences (JREC).

What you should know about this research study:

- We give you this consent so that you may read about the purpose, risks, and benefits of this research study.
- The main goal of research studies is to gain knowledge that may be of help in the future.
- We cannot promise that this research will benefit you. Just like all research there may be some risks.
- You have the right to refuse to take part or agree to take part now and change your mind later.
- Whatever you decide, it will not affect the way you are regarded by colleagues or any others.
- Please review this consent form carefully. Ask any questions before you make a decision.
- Your participation is voluntary.

PURPOSE

The Department of Health Professions Education (DHPE) organises Faculty Development (FD) activities such as workshops and the Health Education and Advanced Leadership course for Zimbabwe (HEALZ). This year (2019) will be the fifth year of such activities. While many UZCHS faculty do attend such activities, there is a sizable proportion that do not. This has also been reported in the literature in other countries.
The challenge is whether to accept that there will always be a proportion that do not engage in FD or to find forms of FD that allow for all faculty to participate in one way or another. FD arose as a way of helping academics to become expert educators. They may be experts in their field of practice or study but are not trained to be teachers and educators.

PROCEDURE

In this study we will have detailed interviews with those who are not on our registers of attendance to understand how they develop as educators. A letter will be sent with a few questions to check what we know. If you are receiving this form, you have been found to be suitable to interview and have been selected out of a group of others equally suitable.
The interview will be recorded, a written report of the interview will be prepared, and you will be asked to read it and check that you stand by what was recorded. You will be able to add somethings which you may feel are not clear or you realised after that could have said.

The recording will then be deleted at the end of the study, and the written document will have anything that identifies you removed. This will then be used for analysis.

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RISKS

There are minimal risks. Interviews will be conducted at your convenience in the College of Health Sciences or place of your regular work, to avoid unnecessary travel to place of interview.

CONFIDENTIALITY

Only the researchers will have access to your interviews. The electronic recordings will be stored on a password-locked computer in the Department of Health Professions Education. The transcribed record will be kept for up to 5 years. Possible risks may be related to leakage or loss of stored information.

BENEFITS AND/OR COMPENSATION

There is no personal benefit to you. This study is part of an MPhil study in Health Professions Education being undertaken with University of Stellenbosch. This will help to build capacity to establish HPE courses such as a Diploma and Masters in HPE in Zimbabwe. There will be refreshments during the interviews.

VOLUNTARY PARTICIPATION

Participation in this study is voluntary. If you decide not to participate in this study, your decision will not affect your future relations with the Department of Health Professions Education in the University of Zimbabwe, its personnel, and nay associated institutions in Zimbabwe or elswhere. If you decide to participate, you are free to withdraw your consent and to discontinue participation at any time without penalty.

Declaration by participant

By signing below, I …………………………………..………. agree to take part in a research study entitled (insert title of study here).

I declare that:

- I have read this information and consent form, or it was read to me, and it is written in a language in which I am fluent and with which I am comfortable.
- I have had a chance to ask questions and I am satisfied that all my questions have been answered.
- I understand that taking part in this study is voluntary, and I have not been pressurised to take part.
- I may choose to leave the study at any time and nothing bad will come of it – I will not be penalised or prejudiced in any way.

Signed at (place) ....…......…………….. on (date) …………....……….. 2019.

Signature of participant   Signature of witness

Declaration by investigator

I (name) ……………………………………………………..……… declare that:

- I explained the information in this document in a simple and clear manner to

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……………………………………………...………………………………..

- I encouraged him/her to ask questions and took enough time to answer them.
- I am satisfied that he/she completely understands all aspects of the research, as discussed above.
- I did/did not use an interpreter. (If an interpreter is used then the interpreter must sign the declaration below.)

Signed at (place) ....……......…………….. on (date) ……………......……….. 2015.

Signature of investigator Signature of witness

The study has the approval of the Joint Ethics Committee of the University of Zimbabwe College of Health Sciences and Parirenyatwa Group of Hospitals (JREC) and the Medical Research Council of Zimbabwe (MRCZ). They can be contacted for any complains, clarifications or incidents you wish to discuss.

If you have any questions concerning this study or consent form beyond those answered by the investigator, including questions about the research, your rights as a research participant or research-related injuries; or if you feel that you have been treated unfairly and would like to talk to someone other than a member of the research team, please feel free to contact the Medical Research Council of Zimbabwe (MRCZ) on telephone (04)791792 or (04) 791193 and cell phone lines 0772 433 166 or 0779 439 564. The MRCZ Offices are located at the National Institute of Health Research premises at Corner Josiah Tongogara and Mazowe Avenue in Harare.

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D. *Ethics approval, Stellenbosch University Human Research Ethics Committee*

UNIVERSITEIT STELLENBOSCH UNIVERSITY

Approval Notice

New Application

02/05/2019

Project ID :9083

HREC Reference # S19/03/054

Title: How do non-attenders of Faculty Development offerings perceive their development as educators?

Dear Dr Farai Madzimbamuto

The **New Application** received on 05/03/2019 was reviewed by members of **Health Research Ethics Committee** via **expedited** review procedures on 02/05/2019 and was **approved**.

Please note the following information about your approved research protocol:

Protocol Approval Period: 02 May 2019 to 01 May 2020

Please remember to use your project ID (9083)on any documents or correspondence with the HREC concerning your research protocol.

Please note that the HREC has the prerogative and authority to ask further questions, seek additional information, require further modifications, or monitor the conduct of your research and the consent process.

After Ethical Review

Translation of the informed consent document(s) to the language(s) applicable to your study participants should now be submitted to the HREC.

Please note you can submit your progress report through the online ethics application process, available at: Links Application Form Direct Link and the application should be submitted to the HREC before the year has expired. Please see *Forms and Instructions* on our HREC website (www.sun.ac.za/healthresearchethics) for guidance on how to submit a progress report.

The HREC will then consider the continuation of the project for a further year (if necessary). Annually a number of projects may be selected randomly for an external audit.

Provincial and City of Cape Town Approval

Please note that for research at a primary or secondary healthcare facility, permission must still be obtained from the relevant authorities (Western Cape Department of Health and/or City Health) to conduct the research as stated in the protocol. Please consult the Western Cape Government website for access to the online Health Research Approval Process, see: https://www.westerncape.gov.za/general-publication/health-research-approval-process. Research that will be conducted at any tertiary academic institution requires approval from the relevant hospital manager. Ethics approval is required BEFORE approval can be obtained from these health authorities.

We wish you the best as you conduct your research.

For standard HREC forms and instructions, please visit: Forms and Instructions on our HREC website https://applyethics.sun.ac.za/ProjectView/Index/9083

If you have any questions or need further assistance, please contact the HREC office at 021 938 9677.

Yours sincerely,

Mrs. Melody Shana ,

Coordinator,

HREC1

National Health Research Ethics Council (NHREC) Registration Number:

Page 1 of 2

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REC-130408-012 (HREC1)•REC-230208-010 (HREC2)

Federal Wide Assurance Number: 00001372
Office of Human Research Protections (OHRP) Institutional Review Board (IRB) Number:
IRB0005240 (HREC1)•IRB0005239 (HREC2)

The Health Research Ethics Committee (HREC) complies with the SA National Health Act No. 61 of 2003 as it pertains to health research. The HREC abides by the ethical norms and principles for research, established by the World Medical Association (2013). Declaration of Helsinki: Ethical Principles for Medical Research Involving Human Subjects; the South African Department of Health (2006). Guidelines for Good Practice in the Conduct of Clinical Trials with Human Participants in South Africa (2nd edition); as well as the Department of Health (2015). Ethics in Health Research: Principles, Processes and Structures (2nd edition).

The Health Research Ethics Committee reviews research involving human subjects conducted or supported by the Department of Health and Human Services, or other federal departments or agencies that apply the Federal Policy for the Protection of Human Subjects to such research (United States Code of Federal Regulations Title 45 Part 46); and/or clinical investigations regulated by the Food and Drug Administration (FDA) of the Department of Health and Human Services.

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E. Ethics Approval, University of Zimbabwe College of Health Sciences Institutional Review Committee

University of Zimbabwe
College of Health Sciences

Joint Research Ethics Committee For The University of Zimbabwe, College of Health Sciences and Parirenyatwa Group of Hospitals

JREC Office No. 4, 5th Floor College of Health Sciences Building
Telephone: +263 4 708140/ 791631 Exts 2241/2242
Email:jrec.office@gmail.com/jrec@medsch.uz.ac.zw, website:www.jrec.uz.ac.zw

Parirenyatwa
Group of Hospitals

APPROVAL LETTER

Date: 10 June 2019 **JREC Ref: 124/19**

Names of Researcher Professor F D Madzimbamuto
Address: Department of Health Professions Education

RE: HOW DO NON-ATTENDERS OF FACULTY DEVELOPMENT OFFERINGS PERCEIVE THEIR DEVELOPMENT AS EDUCATORS?

Thank you for your application for ethical review of the above mentioned research to the Joint Research Ethics Committee. Please be advised that the Joint Research Ethics Committee has reviewed and approved your application to conduct the above named study. You are still required to obtain MRCZ and RCZ approval before you commence the study if required by the nature of your study.

- **APPROVAL NUMBER:** **JREC/124/19**
- **APPROVAL DATE:** **10 June 2019**
- **EXPIRY DATE:** **9 June 2020**

This approval is based on the review and approval of the following documents that were submitted to the Joint Ethics Committee:

a) Completed Application Form
b) Full Study Protocol
c) Informed Consent in English and/or appropriate local language

After this date the study may only continue upon renewal. For purposes of renewal please submit a completed renewal form (obtainable from the JREC office) and the following documents before the expiry date:

a. Progress report
b. A Summary of adverse events
c. A DSMB report

Advancing Healthcare Training, Research, Innovation and Service Page 1

OHRP IRB Number: IORG 00008914
PARIRENYATWA GROUP OF HOSPITALS FWA: 00019350

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- **MODIFICATIONS:**

Prior approval is required before implementing any changes in the protocol including changes in the informed consent.

- **TERMINATION OF STUDY:**

On termination of the study you are required to submit a completed request for termination form and a summary of the research findings/ results.

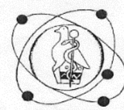
Yours sincerely,

Professor Rangarirai Masanganise
JREC Chairman
RM/llm/uh

Stellenbosch University https://scholar.sun.ac.za

F. *Ethics approval, Medical Research Council, Zimbabwe*

Telephone: 791792/791193
Telefax: (263) - 4 - 790715
E-mail: mrcz@mrcz.org.zw
Website: http://www.mrcz.org.zw



Medical Research Council of Zimbabwe
Josiah Tongogara / Mazoe Street
P. O. Box CY 573
Causeway
Harare

APPROVAL

MRCZ/B/1737 **17 June, 2019**

Dr. F. D. Madzimbamuto
UZCHS
Department of Health Professions Education
P.O. Box A178
Avondale
Harare

RE: - How do non-attenders of Faculty Development offerings perceive their development as educators?

Thank you for the application for review of Research Activity that you submitted to the Medical Research Council of Zimbabwe (MRCZ). Please be advised that the Medical Research Council of Zimbabwe has **reviewed** and **approved** your application to conduct the above titled study.

This approval is based on the review and approval of the following documents that were submitted to MRCZ for review:-

a) Study Proposal
b) Participant Information leaf and Consent Form
c) Interview Guide

APPROVAL NUMBER : **MRCZ/B/1737**

This number should be used on all correspondence, consent forms and documents as appropriate.

- **TYPE OF MEETING** : **Expedited**
- **APPROVAL DATE** : **14 June, 2019**
- **EXPIRATION DATE** : **13 June, 2020**

After this date, this project may only continue upon renewal. For purposes of renewal, a progress report on a standard form obtainable from the MRCZ Offices should be submitted three months before the expiration date for continuing review.

- **SERIOUS ADVERSE EVENT REPORTING**: All serious problems having to do with subject safety must be reported to the Institutional Ethical Review Committee (IERC) as well as the MRCZ within 3 working days using standard forms obtainable from the MRCZ Offices or website.
- **MODIFICATIONS**: Prior MRCZ and IERC approval using standard forms obtainable from the MRCZ Offices is required before implementing any changes in the Protocol (including changes in the consent documents).
- **TERMINATION OF STUDY**: On termination of a study, a report has to be submitted to the MRCZ using standard forms obtainable from the MRCZ Offices or website.
- **QUESTIONS**: Please contact the MRCZ on Telephone No. (04) 791792, 791193 or by e-mail on mrcz@mrcz.org.zw

Other

- Please be reminded to send in copies of your research results for our records as well as for Health Research Database.
- You're also encouraged to submit electronic copies of your publications in peer-reviewed journals that may emanate from this study.
- In addition to this approval, all clinical trials involving drugs, devices and biologics (including other studies focusing on registered drugs) require approval of Medicines Control Authority of Zimbabwe (MCAZ) before commencement.

Yours Faithfully

....

MRCZ SECRETARIAT
FOR CHAIRPERSON
MEDICAL RESEARCH COUNCIL OF ZIMBABWE

MEDICAL RESEARCH COUNCIL OF ZIMBABWE
2019 -06- 14
APPROVED
P.O. BOX CY 573 CAUSEWAY, HARARE

PROMOTING THE ETHICAL CONDUCT OF HEALTH RESEARCH

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G. Horizons: Significant Statements

1. I became a part-time lecturer straight out of training
2. full-time was not going to work for me
3. I was identified
4. because I was a ‘reasonable’, maybe ‘responsible
5. I had been reasonable in terms of my academics
6. they felt maybe they could use some of my talents
7. I was literally thrown in at the deep end
8. with no teaching experience at all.
9. I did go for sessions at the main campus
10. went through the whole induction course (for new staff)
11. learnt different teaching methods, examining students, the whole hog
12. a teacher, at the university, somebody who, apart from teaching students, does a lot of research, publishing, other things such as inter-departmental activities
13. For me, [being] a clinician, its more that my passion is anaesthesia and imparting that to the students is the teaching aspect
14. being an anaesthetist rather than getting involved in what is perceived as a teacher at a university
15. I have acquired skills of teaching I did not have when I started off.
16. With the few seminars at the main campus I also learnt about how to teach, what it entails, and what is expected of the student, which I did not know at the beginning when I started off
17. I have become more wiser in what is expected of me as a teacher and what is expected of student as well
18. For a long time, I felt that if a student failed it was the student’s problem, but then I have realized, with growth, that it is actually my problem as well.
19. the student can have a problem, but as a teacher I must find ways to make sure that students, do the best they can
20. I suppose I have learnt skills as well that I did not have before.
21. obviously input from other teachers, you always learn from others as well.
22. discussing with other senior teachers, senior as in yourself

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23. You have a problem with a particular topic, they tell this could possibly help in order for the kids to understand it better and or has worked
24. Because of their experience they also give you input as to how they have twicked their teaching over the years and how they have seen better results with that
25. When .... came and started telling us about health education (even though I am a non-attender), in the department what is expected, what is new these days
26. obviously I also do some reading on the topic. That has also impacted on my teaching. Mostly its what are the new things concerning teaching nowadays.
27. long long ago, it would be me teaching the students. Then it changed to 'we are a group', we all participate .... we all contribute towards the topic.
28. So you are going on line, looking at teaching methods, examination methods that are different from before. That sort of thing
29. No I have not attended any [international] meetings ... In Zim I have, ... I do attend the things that interest me !
30. When I started off I used to be very intense with the students, intense as in expectations, my expectations were very high, if I didn't get my way, it was my way or no way !
31. Now its more interaction with the students, very laid back, the students are free to come to me, and happy to actually, and good relationship with the students but at the same time teacher-student relationship but colleague relationship as well, us being doctors, you know having the same passion for anaesthesia.
32. With the [teaching] undergraduates its fun. ... with the undergraduates, the element of wonder
33. With them [undergraduates] its just teaching them the basics. Yes, again it has changed because, with age, I think again I am less intense in that regard. Its about them enjoying. What you want from the undergraduate to enjoy the wonderment of
34. the other thrust is to encourage them to do anaesthesia, even for the four months.
35. You are always telling them anecdotal stories like how you chanced upon some accident and you asked for gloves, and everyone is looking at you, and the emergency ambulance technicians are like 'Wow!' because you are an anaesthetist . . Everybody else cannot do this sort of thing
36. story which I am always telling them is about getting stuck on a plane or rather flying off and you are in a plane, and they ask for doctor on board (which has happened to me twice). Each time you hope there is someone else on board, then suddenly the steward

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comes along and says 'Are you a doctor ?'. You have to say 'Yes. . .' And you have to rise to the occasion.

37. With them its kind of a scenario where you want to encourage them to do the anaesthesia just because you feel it completes them as doctors, once they do their training.

38. That has obviously changed from the time when I started teaching undergraduates. Then it was a means to an end: they had a logbook and it was 'what have you done?' 'what needs to be done ?' That's it. But now there is a lot more personal interaction as well as the academic.

39. I have never really looked at what the faculty offers. I mean, yes you have sent out stuff and I have never really looked at it. Once I see 'Faculty Development', if I am perfectly honest, I kind of look at it and like 'maybe its for the full-time' lecturers. You must remember I am part-time I kind of look at it like it's expected of full-time lectures

40. I do attend some of the stuff that UZ does that are linked to education and teaching .. I attended the IT course . . At the beginning of the year when they have their induction, I have attended several of those over the years. Just because I can. I have always found them good refresher courses.

41. I know about it [HEALZ]. I have thought about it [doing it]. What I know about it is like people who have gone through it have changed, for the better I think

42. you must do the best that you can to make sure that they can pass. That is what he is always going on about. I have always thought that at some point I should do HEALZ

43. I have seen other faculty members going through it, although there are still a couple to are still to go through with it. It's something I have thought, well, at some point I will go

44. but somehow, the year starts and there is always a mad rush for so many other things something

45. I wouldn't do it [HPE qualification] in a hurry. A diploma, possibly, but it would be the way it is structured. A Masters . . . tricky.

46. I want to be an educator but I think I am still a teacher ! I don't want to put myself up there ! After all I am a non-attender ! So I cannot perceive myself as an educator. . For me a teacher is someone who just imparts knowledge, whether or not it's received in the same vein is another thing. An educator is someone who is imparting skills, those skills are assimilated, and are used appropriately. The way you have educated that

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particular person, allows them to impart that same knowledge to somebody else. I think that is what makes a very good educator, I would think

47. You know what: I wouldn't want to put myself out there and say I want to be . . . . The graduate we are getting now in terms of the DA, I think we can only do better, we haven't reached where I would probably . . . I think we have a good graduate. We have a good graduate for Zimbabwe population or according to standards. Could they be better ? there is always room for betterment. Could I be involved in that ? Yes, but in the trenches rather than heading it up. I don't know, I haven't really thought about it that way.. . . .

48. I suppose yes but I suppose that would entail a lot more education for me to get there. Am I willing to get that, 'yes', as long as it is flexible with whatever else I am doing

49. For me, the 'educator' bit is not core, its about getting that clinician who is able to put me to sleep safely and wake me up and do a good job. I feel at the moment that is what I am delivering, although I think I could do better with more knowledge or education

50. I would read it, I would use it. I would take on board in my own teaching with my students.