Educating Health Professionals

Becoming a University Teacher

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This book is for health professionals who are becoming involved in the education of people entering their professions. It introduces many of the challenges that educators must engage with in the twenty-first century: challenges that will preoccupy our attention for many years to come. The world of professional practice in healthcare is changing and the education we provide to prepare people for that practice is also changing. How do we prepare professional practitioners for this changing world? How do we prepare them for the changes that are yet to come? What challenges and changes do they need to be aware of? How do we prepare educators – both academics and workplace educators – for these challenges? This volume opens up and articulates the issues we face in preparing people to enter the contemporary world of healthcare. Experienced educators should also find much of interest in these pages. Practice-based education provides an overarching framework for consideration of the issues involved.

There are five sections in the book:

- Section 1: Introduction
- Section 2: Health Professional Education in Context
- Section 3: Teaching and Research
- Section 4: Case Studies
- Section 5: Future Directions
PRACTICE, EDUCATION, WORK AND SOCIETY
Volume 8

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JOY HIGGS

SERIES INTRODUCTION

*Practice, Education, Work and Society*

This series examines research, theory and practice in the context of university education, professional practice, work and society. The series explores places where two or more of these arenas come together. Themes that are explored in the series include: university education of professions, society expectations of professional practice, professional practice workplaces and strategies for investigating each of these areas. There are many challenges facing researchers, educators, practitioners and students in today’s practice worlds. The authors in this series bring a wealth of practice wisdom and experience to examine these issues, share their practice knowledge, report research into strategies that address these challenges, share approaches to working and learning and raise yet more questions.

The conversations conducted in the series will contribute to expanding the discourse around the way people encounter and experience practice, education, work and society.

*Joy Higgs, Charles Sturt University, Australia*
FOREWORD

This book is intended for academics and for health professionals in workplace settings who are involved in educating health professionals. Some of these educators are scientists from outside the health professions, some have taken an academic path soon after graduating from the health professions and bring both a (sometimes distant) professional background as well as academic qualifications and experience to their role, some are practitioners newly entering academia and some are practitioners who take on the role of workplace educators for health professional students.

For each group there are many issues to deal with. These issues range from learning about teaching and learning strategies, learning to do research (often for the first time), managing workplace learning or interprofessional learning, learning to deal with assessment, engaging with issues of educational internationalisation, coping with the demands of standards and accreditation, to becoming involved in curriculum review and design. These issues cannot be dealt with superficially and they will seriously engage the attention of health professional educators. These are issues that are complex and have no easy answers but which are at the heart of higher education in general and health professional education, in particular.

There is a growing volume of literature on the education of health professionals. Many publications can be seen as ‘survival guides’ helping newcomers to survive their first few weeks in a university environment. This book is different. While there is much sound, practical advice in this book that can be applied quickly, its main intention is more long term, i.e. to introduce newcomers to the conversations and issues that will occupy a great deal of their time and attention as educators. We have endeavoured to provide an introduction to the major concerns that will confront health professional educators so that they will be informed and able to engage with the complexities that make up university and workplace teaching and learning in the health professions, today and for years to come.

There are several sections to this book:

1. **Introduction**: This section looks at what it means to be a health professional who is also an educator.

2. **Health professional education in context**: This section explores issues such as the personal and professional development of educators as well as the expectations that society has of our graduates.

3. **Teaching and research**: This section opens up a range of issues such as curriculum, standards, the student experience and interprofessional education among others.
FOREWORD

4. **Case studies**: In this section we take a close look at examples that include internationalisation, blended learning, workplace learning and the teaching of clinical reasoning.

5. **Future directions**: The final section takes a critical look at current trends and discusses how the future of health professional education could develop.

*Stephen Loftus*
SECTION 1: INTRODUCTION
1. BEING A HEALTH PROFESSIONAL EDUCATOR

Understanding the Context

The core purpose of health professional education is to prepare practitioners who can cope with the many demands of working in a range of health settings, not only as these settings exist today but also as they might exist tomorrow. This can include traditional clinical roles in metropolitan and regional hospitals, suburban and rural clinics, specialist centres and the many varieties of community care.

Many health professionals will become involved in other responsibilities besides the purely clinical, such as management, research and education. This complex mixture of demands means that the education we provide must equip our new graduates with the knowledge, the skills and the resources of character that will enable them to cope with the uncertainty that arises out of such complexity.

However, we want our graduates to do more than just cope. We want them to flourish and thrive as health professionals who are not only competent technically, but who understand and embody the underlying values of their chosen profession. We want them to be health professionals who relate to patients/clients as human beings and who can integrate new knowledge and insights into their practice as these become available in the course of their careers. Preparing people for the health professions of the 21st century is therefore a formidable task and not to be taken lightly.

THE PROFESSIONAL PRACTICE OF HIGHER EDUCATION

Educating new practitioners for the health professions can be, and should be, a rewarding and interesting experience. For many practitioners a career in higher education offers the chance to combine an interest in their professional practice with the opportunity to prepare new practitioners who will themselves go on to be enthusiastic, well-prepared, and capable of carrying on the profession to high standards. Some might describe such a teaching career as a vocation rather than just a career, as it requires real commitment from those who undertake it.

There are challenges in becoming a professional teacher and academic which are not to be underestimated. Most prominent of these challenges is the state of seemingly never-ending change imposed by a range of parties and communities. Professional practice itself may be steadily changing in many ways, but our understanding of what university education is, and how to conduct it, is also undergoing rapid change and is likely to do so into the foreseeable future. New and prospective academics need to be fully aware of these challenges and ready and
willing to deal with them if they are ever to be successful university teachers. Perhaps the journey is best taken by those willing and prepared to cope with change as normal and expected.

Living in a World of Change

It is almost a cliché to say that we live in a world of change, but this is certainly true of academic life in the early 21st century. Change comes from many different directions, from educational technology, from new understandings of what professional education should entail, from educational policy change that might, for example, affect the balance between service, research and teaching activity. Society’s expectations of higher education are also changing, with more people being encouraged and expected to complete tertiary education. This means that higher education is no longer seen as a privilege reserved for an intellectual elite who are strongly motivated and need little support. The increased participation rate in higher education brings with it the requirement to provide greater support so that people from a wide variety of backgrounds can engage with tertiary education and graduate at the level required for professional practice.

To highlight the first example of change in higher education, the emergence and continued development of educational technology now allows us to provide much richer learning experiences for our students – but only if applied wisely. Educational technology allows us to offer open-source and mobile options including sophisticated simulations through which students can try out many scenarios and develop different kinds of expertise and, above all, make mistakes where patients will not be harmed if things go wrong. There is further discussion of educational technology and blended learning in Chapter 21. Mastering educational technology is just one aspect of the modern practice of higher education.

Research and Scholarship of Higher Education

One of the most exciting aspects of being involved in higher education today is that it has been and continues to be the subject of sustained and rigorous research and scholarship. This scholarly activity has raised our awareness of many issues and produced insights that are of real and practical use for university teachers seeking to offer a high-quality education. Some insights seem obvious. For example, the notion of constructive alignment in the curriculum is now widely accepted and consciously implemented.

In the past there have been many examples of courses that espoused noble aims, such as developing critical thinking in their students. Yet close examination of the enacted curricula often revealed that in many cases these lofty goals were rarely or poorly taught and might not even have been assessed. Research demonstrates that, for students, assessment drives what they learn and the choices they make in their learning habits. (For an introduction to this work see Biggs & Tang, 2011.) Therefore, careful attention to assessment and ensuring that it aligns with what we aspire to teach and what we actually teach (i.e. constructive alignment) is more
likely to bring about a course that achieves its aims. This may seem obvious, but it is remarkable how often it is still not realised in many courses. Chapter 20 provides further exploration of assessment. Assessment can also be linked to the ideas of self-assessment and metacognition. This creates yet another challenge for university teachers to address, in shared responsibility with students, students’ capacity for and commitment to lifelong learning.

There is now a renewed awareness of the importance of thinking about curriculum issues more deeply, beyond constructive alignment (refer to the discussion of curriculum theory in Chapter 11). For now, we simply note that simplistic understandings of what constitutes learning and teaching have led to unnecessary suffering for students in the past, because some university teachers in the past have thought of students as blank slates (tabula rasa) to be filled in and have followed a strategy of cramming as much material into a course as possible. We now realise that this led to superficial or surface learning, where students were required simply to memorise material in order to reproduce it in an exam, but without having the chance to truly understand what it was they were learning or how it might apply to practice. Students often struggled with such over-burdened courses. Poor learning outcomes were blamed on students rather than on courses deeply in need of “decompression”.

MODELS OF EDUCATION

There are reports going back to the mid-19th century (see General Medical Council, 1993) claiming that medical courses were too full, but because the underlying belief was that students had to be “filled up” with knowledge, the practice of cramming courses continued, and arguably became worse. As medical science advanced there was competition between different disciplines, with each believing that its disciplinary knowledge was crucial and had to be included in the educational program.

Another problem, for the education of doctors in particular, was that medical schools were able to point out that the doctors they graduated did, on the whole, become proficient practitioners. What was ignored was the fact that medical students tend to be bright and highly motivated, and that medical students were graduating from medical school and becoming good doctors not because of the educational experience provided but in spite of it.

Fortunately, this situation began changing in the latter half of the 20th century when newer models of education, such as those utilising problem-based learning, began to emerge. Instead of expecting students to simply know everything, there was recognition that it was possible to focus on a “core” body of knowledge and how it was to be used in practice. It began to be accepted that professional practitioners could never know everything upon graduation, or at any time in their careers, and they would need to become lifelong learners.

In light of such an approach, discovering an area of ignorance is now generally regarded as a prompt to go and find out, rather than as a fault that needs to be punished. Newer educational models make a conscious and explicit attempt to
foster lifelong learning. On a critical note, however, the question of whether the newer courses will truly encourage students to become lifelong learners is still contentious (Newman, 2003).

More recently, courses that are oriented around whole-of-course frameworks as opposed to collections of subjects have been widely adopted across health professional programs. A typical example of a whole-of-course framework, now widely accepted, is that of problem-based learning (PBL). In PBL the curriculum is founded on a series of clinical cases, based on real patients. In designing the cases, the curriculum team makes a conscious effort to integrate as many relevant subjects as possible. So, for example, a patient with heart disease will prompt students to study the anatomy, physiology and biochemistry of the heart and how they are relevant to the present case. The same case could be used to integrate the social sciences if it turns out that smoking, lack of exercise and poor diet have been contributing factors. Further subjects, such as ethics and medical economics, can be integrated into the case by creating a “patient” who is elderly, incapable of living alone, and occupying a bed in an acute ward that is desperately needed for other patients. The strength of the PBL approach is that the different subjects can be related to each other and to real-world practice in a relatively seamless manner.

In these courses, academics need to adopt a new mind-set in their teaching. In such courses, academics who are used to more old-fashioned pedagogy will need to exercise restraint and resist the temptation to impart as much information as possible, as quickly as possible, to their students. Becoming a facilitator of other people’s learning rather than a lecturer who simply dispenses knowledge is just one of the challenges to be met by anyone who aspires to be a professional and a university educator today. Beginning teachers need to educate themselves about the range of new educational models; problem-based learning just happens to be one of the most popular. How successful, or otherwise, teachers are in engaging with new educational models has not been widely investigated. The predominant focus of research is often on students rather than on teachers. There is much scope for research into how academics can become successful university teachers.

For university teachers in the health professions, the knowledge that needs to be learned includes what is relevant both to the professional practice of healthcare and the professional practice of university teaching. About the same time as the newer educational models began to emerge, education of other health professions began moving into universities and, unburdened with a long tradition of university education, these professions were willing to question and critique prevailing models of medical and dental education and to rethink how health professionals should be prepared for the world of professional practice.

Nursing, for example, largely adopted a model of patient care. There was a conscious attempt to put an emphasis on the care of patients as human beings rather than as biological organisms that had pathology to be treated (Meerabeau, 2004). This was nursing care that, while informed by biomedical science, was quite different from the treatment of pathology that seemed to dominate the curricula of the older health professions that had participated in university education for many decades.
The emergence of higher education for other health professions highlighted the need to examine other aspects of healthcare besides the biomedical sciences, such as sociocultural aspects. The growing literature on clinical reasoning can be seen as an attempt to integrate all these aspects (Higgs, Jones, Loftus, & Christensen, 2008). This need for integration highlights another quality required by the professional who is also a teacher and an academic, which is the ability to access, interpret, value, apply and contribute to research and evidence-based practice, often of both their professional knowledge and their teaching. One response to this call has been research-based teaching.

Fish and Coles (2005) wrote of research-based teaching as one of three models that can be used to categorise the majority of courses provided to health professionals. The oldest model they called the product model, in which education was seen as a product to be passed on as efficiently as possible from teacher to student. This has been by far the most common model used in the education of health professionals. Some of the weaknesses of this model have been mentioned earlier, but can be summarised as assuming that the transmission of knowledge is simple and unproblematic. It is now clear that this is a simplistic view, even though there will be occasions where it is appropriate to use a transmission model. Many of the newer courses fit within what Fish and Coles described as a process model; case-based approaches such as problem-based learning fit within this model. Here, teachers are seen as facilitators, encouraging students to manage their own learning.

However, teachers are still very much in control of the process and provide strong direction as to what students should learn. Fish and Coles promoted a third model, which they called the research model. Here, the ideal is that students and teachers learn together and students use academics more as supervisors of their developing understanding than as learning facilitators. One particular version of the research model is research-led teaching, about which we say more below.

The emphasis in the research model of education is on the development of a critical understanding of knowledge, and especially a critical understanding of the underlying principles of professional practice that can contextualise knowledge in any setting. The implication is that in settings where practitioners do not hold all the necessary knowledge to deal with new professional problems they can still base their actions on underlying principles and make professional judgements that are considered and justifiable. Underpinning all this, there is an emphasis on professional values.

Fish and Coles (2005) claimed that when designing or reviewing a curriculum it is important to begin by articulating the professional values that would underpin the course and characterise the graduates who go out into the workplace. These values, such as being professional, being reflective, being critical or being ethical, must explicitly inform the course, and conscious attention should be given to making them explicit to staff and students, with the express intention that the students should come to accept and embody these values for themselves.

This raises the question of how we can teach these aspects of professional practice. The answer is that we must provide role models and we, the teachers,
must be those role models. Professional practitioners who are also university teachers must embody these qualities in their own practice so that students can see the qualities being enacted. Students have to see that we behave professionally, reflectively, critically and ethically.

A well-designed curriculum is likely to produce many occasions when these values can be enacted, and at key points a perceptive practitioner/teacher can point out to students how and when these values are playing an important role. It is also important to encourage students to engage with these values and become familiar with discussing them. This explicit engagement with values can bring a degree of authenticity to education. It is said that students have a strong resonance with education and careers that support their plans for an authentic quality to their lives; this is a dimension to be considered when a practitioner is a role model (Osipow, 1990). For example, many cases in a problem-based learning course can be designed to raise ethical and social issues for staff and students to explore together.

RESEARCH-ENHANCED LEARNING AND TEACHING

Among the central goals of any university is the continued development of its intellectual environment. Research-enhanced learning and teaching attempts to capture this goal by describing teaching that is directly informed by research conducted or interpreted by the teacher and sometimes by the student as well. The term “research-enhanced learning and teaching” is also referred to in the literature and other knowledge avenues as “research-led learning and teaching” but “enhanced” may be more fitting to the concept for discussion here.

Research-enhanced learning and teaching include the integration of disciplinary research findings into courses and curricula such that students are both an audience for research and are engaged in research activity. Equally important is the provision of opportunities for students to experience and conduct research, learn about research throughout their courses, develop the skills of research and inquiry and contribute to the university’s research effort.

A further matter of interest is research on learning and teaching itself as opposed to research into basic medical sciences or clinical practice, which is what most students and practitioners think of when they consider research. Research on learning and teaching itself might be better thought of in terms of the scholarship of learning and teaching. This is because “scholarship” is a wider term that includes other activities besides what is conventionally seen as pure research. Scholarship can include the critique and integration of existing knowledge from disparate sources. When both teachers and students engage in scholarship and/or research on learning and teaching it is argued that there is great promise of improving education (Boyer, 1990). This is because there is considerable motivation to students to engage with an activity that directly concerns them and can enrich their experience of education. Research-enhanced learning and teaching can also encourage students to see teachers as colleagues and collaborators in a joint enterprise rather than merely as the transmitters of knowledge.
An important aim of research-enhanced teaching and learning, therefore, is to engage students in the discovery, engagement and elaboration of new knowledge in collaboration with academics. To start, the objective is to make teachers’ research interests transparent to students. The curriculum captures this endeavour in student–teacher learning activities and in assessments that are clearly valued and linked to such research. The world of research, often a realm exclusive to researchers and postgraduate students, is opened to both teachers and undergraduate students and thus expands students’ horizons. This may be the real purpose of research-enhanced teaching and learning.

How well such teaching and learning achieves deep learning and its objectives is contested. Debate continues about the objective of effectively combining the strands of research and teaching into a cohesive educational experience (Brew, 2003; Jenkins, Healey, & Zetter, 2007). Positions range from a positive view that teaching and research fit naturally together (e.g. Sullivan, 1996) to a negative view that such a combination is a waste of an academic’s time and resources (e.g. Ramsden & Moses, 1992). It may be that the divergence of opinion reflects perceptions of what research-led teaching is understood to be. It can be as simple as presenting research to students, or as complex as engaging students in conducting their own research.

Whether academics believe that research can or cannot be integrated with undergraduate teaching seems to be related to how one understands knowledge and its relation to research (Robertson & Bond, 2001, 2005). It can be argued that students are most likely to gain the greatest depth of learning from research when they are actually engaged in doing some research. However, there has been little evaluation of students’ experiences of learning from research and how they develop research-related understanding and skills. The few studies that have focused on students’ experiences and perceptions of the relevance of academic research to their learning are mixed (e.g. Volkwein & Carbone, 1994).

Higher education, along with professional practice, faces the challenge of establishing richer vocabularies and discourses to conceptualise what we do. There is, for example, a growing body of literature on practice-based education that is changing the way we visualise much of what we now do in higher education. The two authors of this chapter happen to be dentists. We can both testify that dentistry education has been practice-based for decades. There have also been dental simulations for many years, although these were for many decades admittedly “low-tech”. The bulk of a dental course takes place in clinics with students treating real patients, doing exactly what they will do in practice after graduation.

What has changed is that we now have a new vocabulary and discourse that allows us to articulate and conceptualise professional practice and its education in ways that can deepen our understanding of what it is our students learn and how it is learned (Higgs, Loftus, & Trede, 2010). Also emerging from this new vocabulary and discourse is the growth of new approaches to educational practices.
that exist outside the classroom. Two such pedagogies are research-enhanced learning and teaching and work-integrated learning, both of which have particular significance in health professional education and are part of practice-based education.

Courses that emphasise the role of regular and frequent practice can help students bring theory and its application together. There is now a growing realisation of the importance of practice-based education. This is a whole-of-curriculum approach that emphasises the importance of integrating theory with practice throughout a course (Higgs et al., 2010). Such integration occurs through work-integrated learning (WIL) which is a common aspect of courses that are practice-based. Problem-based learning is another example of practice-based education, which makes an explicit effort to regularly and consciously integrate theory into practice, as well as integrating different subjects as described above. For instance, a medical student with a previous degree in biomedical sciences had this to say about his experience of a course founded on problem-based learning.

I’ve gone through my old notes and progressively thrown them out as I’ve rewritten them into a different format … now I approach learning the diseases in the same way that I would … a patient. (Loftus, 2009, p. 100)

In other words, the scientific knowledge this student already had was being reformatted to make it applicable to his emerging experience of professional practice. It can be argued that the student was reformatting his knowledge into the narratives that comprise the case-based knowledge so important to medical practice as opposed to the straightforward factual knowledge of medical science.

**Critical and Narrative Thinking**

As our understanding of what constitutes professional education develops there are now moves to borrow ideas from other disciplines such as those of the humanities and social sciences (Loftus, 2011). The example referred to just above is one instance where narrative knowing, a construct from the humanities, is utilised to understand how health professionals formulate their practice knowledge. There is a growing and informative literature around the importance of narrative in the health professions (Charon, 2006; Frank, 2004; Loftus & Greenhalgh, 2010).

Other ideas borrowed from the humanities include the importance of critical thinking. Sullivan and Rosin (2008) claimed that integrating insights and skills (such as critical thinking) from the humanities into professional education could foster what they called “practical reasoning”. This is reasoning aimed at working out what is to be done in a particular situation, in other words, contextualised thinking for this particular patient, in this particular time and setting with all its limitations. They contrasted this with theoretical reasoning or scientific thinking which is aimed at working out knowledge that is context-free and true in all times and places. Professional reasoning is primarily the former, practical reasoning, although it is informed by the latter, scientific knowledge. A key aspect of such practical reasoning is criticality.
Real-world Experience

It has long been assumed, ever since the Flexner Report (1910), that the education of most health professionals needs to occur in tertiary teaching hospitals in large metropolitan centres where there is a concentration of specialties and extreme cases in need of specialised treatment. This means that the practitioners who provide the role models for students, in these early and impressionable years, are the specialists in such tertiary centres.

Most graduates, not surprisingly, want to continue working in such metropolitan centres and are reluctant to work in rural environments that are very different from the environments that have formed them as early career professionals. Because of this, many countries which have a sharp division between rural and metropolitan living, Australia and Canada in particular, have long experienced significant shortages of health professionals, particularly doctors, willing to work in rural settings. In recent years there have been attempts to move some portion of education into remote and rural settings. However, attempts to move most of the education into remote and rural clinics have generally met with fiscal and cultural resistance.

Despite this resistance there are now examples where medical schools have made a deliberate attempt to provide the bulk of their education in rural clinics. Some such schools make a point of being predominantly rural. In these rural settings, the role models who provide the examples of what it is to be a health professional are the practitioners in the rural clinics who take on the teaching and supervision of such students. The result is that many of the graduates from these institutions are happy to pursue careers in rural settings and are just as capable and competent as their peers schooled in the cities (Tesson, Hudson, Strasser, & Hunt, 2009). Some graduates drift back to seeking city practice, perhaps seeking a different quality of life, while strongly valuing their rural experience. A key aspect of education in both rural and metropolitan settings is the direct experience of actual professional practice.

For too long, many university courses assumed that (scientific) theory comes first and that practice, as applied scientific theory, will simply follow on naturally. This naivety resulted in generations of newly graduated practitioners who struggled to cope with real-world practice, knowing that they had learned relevant scientific knowledge but being unsure as to how to use it with real patients.

This problem can range from simply trying to apply textbook knowledge of diabetes to the individual patient to trying to integrate that same textbook knowledge with the complex sociocultural issues that many patients bring to the clinical encounter. For example, how closely can a well-educated medical graduate raised in a comfortable middle-class environment understand the complexities of the situation faced by an Indigenous patient, living in poverty, who may, for a large number of reasons, have difficulty complying with a medical plan? We now realise that direct involvement in supervised practice is probably the most important learning experience of all. As Davey (2006, p. 245) wrote:
What makes a practice a practice rather than a method is precisely the fact that it is based upon acquired and accumulated experience. The acquisition of discernment, judgment, and insight is based not so much upon what comes to us in a given experience but what comes upon us by involvement and participation in a whole number of experiences.

Work-Integrated Learning (WIL)

WIL describes educational programs that integrate classroom learning and workplace experience. Other terms are also in common use, such as workplace learning, and this subject is dealt with in more detail elsewhere in this book. WIL is now a serious topic of interest in academic circles (e.g. Atchison, Pollock, Reeders, & Rizzetti, 1999) and has become a distinctive pedagogy (Boud, Solomon, & Symes, 2001). Boud (2001, pp. 44-58) has outlined the characteristics of work-based learning programs as those that:

− are established in a partnership between an organisation and an educational institution
− are where learners enrolled on the program work in the partner-organisation
− are developed out of the needs of the workplace and of the learner
− have a starting point that often involves accreditation of prior learning or work experience
− have learning projects that are undertaken in the workplace
− assess learning outcomes and awards academic credits.

WIL promotes authentic student learning outcomes. Moreover, it captures the dimension of situated learning, with workplace culture, values and understandings, thus providing the four conditions for effective learning: a knowledge base, a motivational context, learning activity and interaction (Biggs & Tang, 2011).

CONCLUSION

The world of higher education is experiencing change and has been changing significantly for decades. The future seems to promise yet more change to come. This change offers both opportunities and challenges for those who seek to become university teachers of future health professionals. Challenges range from the provision of support to the broader range of students participating in higher education to curriculum reform that endeavours to integrate practice-based education, research, professional values and other demands into a coherent whole. The opportunities for newcomers to university teaching are to become involved in, and to contribute to, all these activities in a manner that not only enriches the education of our students but also enriches their own professional and personal engagement.
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2. HEALTH PROFESSIONALS BECOMING UNIVERSITY TEACHERS

This chapter provides a context for understanding the characteristics and motivations of health professionals who become university teachers and explores the nature of their experiences. Health professionals who become university teachers may do so motivated by varied individual factors. These factors could include an interest in teaching, a positive experience of teaching students in a clinical setting, a strong desire to educate new practitioners in their field, lifestyle choices or an interest in a career direction as an academic. Being a university teacher may involve teaching students on a part-time or casual basis while maintaining some clinical work or a complete change to full-time employment in a university setting. Although health professionals can be involved in teaching in clinical settings or providing occasional specialist lectures, we have limited the scope of the discussion to teaching in university settings.

Being a university teacher in contemporary higher education clearly involves teaching, but teaching is only one element of a full academic appointment. Being an academic comes with expectations of teaching as well as involvement in research and university administration. As we discuss in this chapter the experience of becoming a university teacher is shaped by these broader responsibilities and expectations of academia. Therefore in using the term “university teacher” in this chapter we are including the wider elements associated with becoming an academic in a university context. Health professionals who become university teachers often follow a pathway to academia that has involved a considerable period in clinical practice. Smith and Boyd (2012) observed that the pathway to becoming teachers for health professionals differs to the experience for other academic posts. For example in the sciences the pathway typically involves doctoral study linked to disciplinary research. In contrast health professionals often consider teaching once they are well-established in their profession. Data collected in a survey of nursing, midwifery and allied health academic staff supports the view that becoming a university teacher is frequently regarded as a mid-career decision for health professionals (Smith & Boyd, 2012). For example, this study of academics with between one and five years’ experience in higher education, found that 32% of the respondents to the survey, were aged 30-39 years and 53% were aged 40-49 years.

The experience of becoming a university teacher involves identifying and securing a teaching or academic position, beginning work and then developing skills as a teacher. We will explore each of these phases to pursue an understanding of the particular experiences and challenges for the individuals involved. In the subsequent section we explore proposed strategies to support health professionals in their journey to becoming university teachers.

S. Loftus et al. (Eds.). Educating Health Professionals: Becoming a University Teacher, 15–22. © 2013 Sense Publishers. All rights reserved.
The experience and knowledge of practice that health professionals bring to teaching is highly regarded and valued. However, there are a number of particular challenges for health professionals who apply for positions as university teachers. One of the most significant challenges is that experience as a health professional is often only one of the selection criteria for university positions. Although health professionals may have experience of teaching in clinical settings, they may have limited experience of teaching in contemporary higher education settings. They may have limited experience in the administration involved in university education and may not have attained formal qualifications (such as teaching qualifications or higher degree qualifications) in their field. Health professionals may also have very limited backgrounds in research and established research track records. These factors can make the initial entry into academia difficult, particularly in a competitive employment environment. If this is the case then experienced practitioners may be offered junior academic appointments at reduced salaries compared to their clinical appointments. This is a problem for institutions in attracting skilled practitioners and for the practitioners whose clinical expertise is seemingly valued but not rewarded in academic status and salary. These new university teachers can experience tension between the value placed on their professional expertise and the capacity for gaining acceptable positions and remuneration.

Increasingly those seeking to enter academia from the health professions are recognising the value of pursuing postgraduate research studies prior to entering university employment or during their early academic years. Both pathways into academia (experienced clinicians and practitioners who engage in postgraduate studies earlier in their careers) reflect the link between levels of academic appointments and varied practice, teaching and research capabilities and achievements. Mid to higher level academic appointments typically require the appointee to hold a doctoral qualification. In some circumstances there is a significant financial disincentive for health professionals to become university teachers. The implication of these challenges point to the need for new university teachers to consider carefully their move into academia and their motivations. Becoming a university teacher may be best regarded as a career change or “new profession” and therefore may require further training and entrance at a lower level rather than a career progression from expert status as a health professional. However, it is also important for universities to recognise that professional knowledge is not only acquired from research but also from practice and that the expertise of academics needs to cover both spheres for the advancement of the knowledge base of the profession and for the education of new graduates.

Beginning Work as a University Teacher

Once a teaching position has been secured, either on a permanent basis or a casual basis, the literature has identified a number of common experiences shared by new teachers. These are reflected in health professional academics and compare with the experiences of other professionals such as school teachers. Smith and Boyd (2012)
summarised these challenges as relating to the practice of being a teacher and the development of an identity as a teacher in a new professional role. New university teachers become very quickly immersed into the responsibility for teaching and supporting students requiring a rapid adaptation to their new role (Boyd, 2010). Health professionals who become university teachers bring high levels of content knowledge related to their professional practice field to their new jobs. In contrast they may have limited knowledge of teaching beyond clinical education.

Teaching in a university context requires knowledge of how to promote learning and skills in teaching. Some of the differences between clinical education practice and teaching practices experienced by new university teachers are teaching larger numbers of students, different assessment and marking strategies, using new teaching technologies, involvement in curriculum design, and interpreting and applying university regulation and policy and supporting students (see McArthur-Rouse, 2008; Smith & Boyd, 2012).

In addition to developing core skills in teaching, new university teachers need to develop what Shulman (1987) referred to as pedagogical content knowledge. This is the knowledge of how university teachers use their content knowledge from practice and transform it for students; to be able to present and explain concepts in multiple ways and to be able to diagnose and resolve student errors in understanding. These skills differ from those used in clinical teaching which often involves smaller groups of students in practice contexts. New teachers entering academia from professional practice may experience challenges in transferring knowledge of teaching learnt in the practice context to their new role (Trowler & Knight, 2000). However, they have the advantage of a deeper knowledge and experience of practice (in comparison to academics in physiology and sociology) that serves them very well in relation to their capacity to be practice role models for their students and sharing with students real life experiences of professional practice and the practice world.

In university settings new academic staff describe an expectation of independence and autonomy in the conduct of their work that they may not have experienced in a practice context (Trowler & Knight, 2000). Trowler and Knight have represented university settings as having local cultures, practices, languages and ways of working that new teachers need to come to understand.

Traditionally university academics have experienced autonomy and independence. In professional practice the concept of professional autonomy exists but the reality of health professional settings typically involves large numbers of people working in close relationships and through teamwork with a higher degree of job clarity, line management, supervision and scrutiny of work. Thus universities have often been experienced as less structured than healthcare settings in terms of tasks and routines.

For new university teachers their roles can be associated with a lack of clarity, broad job descriptions and lack of task specificity in traditional academic settings which allow new academics to “find their own feet”. McArthur-Rouse (2008), for instance, found that new nursing academics felt a lack of clarity in their role and had difficulty judging their effectiveness in their new role, particularly when they came into environments where established staff were already functioning and the skills required were taken for granted. For example timetables are flexible, teachers are given relative freedom to plan
their work days and teaching activities and there are long periods of the year when students are off-campus. The cycles of workload in universities can vary from periods of high teaching and assessment load to other periods when there is time for planning, curriculum development and research. The new teacher may be inexperienced in how to manage the new workload to meet new targets and deadlines or to fill unstructured time. Universities are also characterised by distributed leadership where there are much flatter organisational structures and there is less direct supervision of work. Some health professionals may be unfamiliar with this and find themselves feeling alienated and lacking support and guidance and being unaware of where to find information and appropriate communication channels in the organisation (McArthur-Rouse, 2008; Trowler & Knight, 2000). McArthur-Rouse (2008) identified that although health professionals joining academia may have skills in management and organisational knowledge these were not readily transferable to working in an academic context.

It is interesting to note that in recent decades the shift of universities to be education providers within a higher education market has emphasised the commodification of higher education and external accountability. In this context the level of academic autonomy has diminished with a greater degree of role specificity and performance targets - another adaptation context for new and experienced academics alike.

The process of becoming a university teacher is most frequently represented in the literature as a transition (Hurst, 2010) and there is a tendency to explore the transition in terms of stages. Although a staged view of transition can be critiqued on the basis that using stages simplifies a complex individual process of adaptation to new roles, individual choices and pathways plus an ongoing connection to previous roles and identities, the concept of using stages to understand becoming a teacher as requiring a process and period of change is useful. Health professionals joining academia have been reported as experiencing feelings of anxiety, uncertainty, lack of confidence but also more positive feelings of excitement, stimulation and exhilaration that aligned to expectations in their new role (Hurst, 2010; Smith & Boyd, 2012). In the initial period of becoming a teacher the health professional typically retains strong feelings of identity as a health professional in a new context, such that academics describe themselves in terms of their health profession, for example as a nurse or physiotherapist (Boyd, 2010). New teachers draw on their feelings of expertise in their profession to validate and add credibility to their role as a teacher (Hurst, 2010).

A second phase in the transition to becoming a university teacher is a period when health professionals experience feelings of being novices in their new profession. New academic staff may experience a perceived loss of status when they join a university when they are no longer regarded as an expert among other experts (Boyd, 2010). The notion of identity has been frequently applied to make sense of the experience of new academics (Clegg, 2008; Trowler & Knight, 2000).

The experiences of health professionals as they become university teachers involves a process of socialisation that provides changes and challenges to re-shape individuals’ sense of their identity as they become involved in the work and social practices in their university department (Trowler & Knight, 2000). The socialisation process involves the development of an identity where health professionals see themselves as teachers, not as clinicians who are teaching their craft, but as teachers embracing the profession of
teaching and the skills and expectations of this role (Boyd, 2010). There exists a complex, dynamic set of demands upon the new academic related to identity formation which emerges from tensions and their resolution (Smith and Boyd). Trowler and Knight (2000, p. 34) proposed that new university teachers need to do identity “work” as they establish themselves in their new environment and cultures and need to “make and re-make their identities”.

A further phase of development can be experienced when individuals redefine their identity as, for example a “nurse lecturer”, in which they integrate their identity as a professional but also their new career identity as an academic. New academics who are unable to redefine themselves as having a new identity may experience discomfort in their new role and may choose not to continue in academia and return to clinical practice (McArthur-Rouse, 2008).

Health professionals who become new university teachers often experience considerable pressure, as well as a desire, to maintain currency or identity within their profession. Clegg (2008) proposed that for academics there are porous boundaries between the university and the professional practice world. New university teachers may feel pressure as they face expectations to learn new knowledge for teaching while maintaining existing knowledge to sustain their identity as a credible practitioner (Smith & Boyd, 2012). For example, Hurst identified that physiotherapists felt the need to retain competency and remain professionally up-to-date, and their established identities as clinical experts. It has been our experience that a number of health professionals often transition into academia and university teaching in a staged way where they prefer to commence with part-time positions, retaining some clinical work or seeking opportunities either in or outside of their academic roles to continue clinical work. This may be related to factors such as their desire to maintain currency and credibility but also to experience comfort in a familiar environment where their identity is well-established and they reaffirm their (professional) self-worth.

As we noted above, the new university teacher may be drawn to an academic role by their motivation to teach resulting in the primacy of teaching in their perception of their role (Smith & Boyd, 2012). Smith and Boyd identified in their 2008 survey of health professionals becoming university teachers that few health professionals entered academia with doctoral qualifications (4%). Most new academics in the study reported the considerable stress they experienced as they faced expectations that they would conduct research and publish.

SUPPORTING HEALTH PROFESSIONALS TO BECOME UNIVERSITY TEACHERS

The nature of the challenges that new academics face are significant and understanding these challenges is important for new university teachers and their employers. McArthur-Rouse (2008) identified that it is an important issue for universities to effectively recruit but also retain health professionals in the academic workforce to ensure the quality of teaching. From the work described above this implies ensuring that health professionals who become university teachers are supported to develop strong academic identities and to develop the skills required for university teaching.
There have been a number of factors identified and proposed in the literature which contribute to health professionals being supported in the transition to becoming university teachers. Health professionals considering becoming university teachers conceptualise the process as a career change, requiring support through the transition process and realistic expectations of the transferability of their existing skills to the university context. It would appear to be perilous for individuals to hold to a view that expertise as a clinician will transfer directly to recognition, status and expertise as a university teacher. There needs to be expectations that taking on this role will require learning new abilities and knowledge, participation in training and learning how to cope with changing identity and roles. This means that good information about the role and expectations of academics needs to be part of recruitment and induction and that ongoing support is required. Such support could take the form of decreased workload in the first year of employment, having an assigned mentor, clear specification of and performance targets, online staff development modules, workshops and drawing early career academics into new tasks like designing curricula, publishing and grant writing.

Smith and Boyd (2012) identified from their participants’ feedback that there was value in ensuring new university teachers had access to others at the same peer level. Trowler and Knight (2000) argue, in a theorisation of universities as activity systems and communities of practice, that understanding how new staff become socialised and have access to learning the systems are important to their successful induction. The authors proposed that induction activities are needed for the support of new university teachers, such as providing them with access to discussions with existing staff about their daily activities and experiences of working in their department, giving them opportunities to shadow and work collaboratively with other staff and providing leadership which supports socialisation and positive cultures. Trowler and Knight draw on the recognised value of local informal cultures to promote learning and development of university teachers, to propose that “the most important way to improve induction of new university teachers is to concentrate on the normal quality of communication and relations in teams and departments” (p. 33). Smith and Boyd (2012) suggested new university teachers learnt more from less experienced peers; they found more experienced teachers less accessible and less helpful.

The discussion above also indicates the importance for induction into university teaching for health professionals to pay attention to the unique experiences of health professionals, with their later entry into academia and the support required for identity formation. Such processes could include discussions about expectations and role clarity, awareness of what new staff are likely to experience, familiarity with the culture and acknowledgement of the changes in structure to established routines. Supervision may also need to be structured to provide feedback on effectiveness of performance initially until individuals are able to draw on intrinsic feedback within their role. There is also a need to explore the tensions around maintaining currency of practice with expectations from the university and also the individuals desires to maintain their credibility. Further, specific attention is needed to support new academics to develop an identity as a researcher, particularly if they bring to the role only expectations about teaching with limited ideas about how they will engage in research.
Becoming a university teacher is a personal journey of career change. In this chapter we have described the motivations and challenges that are experienced by those undertaking this journey. To conclude we offer a reprise as our reflection of the unexpected, testing and rewarding journey to a career in academia.

REPRISE

In my profession I was a senior clinician.
For fifteen years - I had built my expertise expanded my practice knowledge
my patients told me I was good,
so did my students I enjoyed being a practitioner –
I was part of a community and a workplace
I had a good sense of who I was what my role was
and where my career was going
I was a senior staff member
I had status
I had earned respect

I enjoyed clinical teaching which led me to consider becoming a university teacher.

So I applied for a job at university
But a university job is so much more than teaching

First – my pay went backwards – significantly
Next – I became a junior all over again
Then – I lost my sense of professional self
Who was I?
Did my practice expertise matter any more?
My head was in a spin
Every day I went to work
it was to an unknown world
to some new unexpected challenge
to something else
I was not prepared for
A really big deal
was “the wall”
RESEARCH

“you have to do research”
“you have to do a PhD”
I don’t know how this will look for me
I started out at this part-time
I kept my feet grounded in my practice world
Sometime in the next two years
I’ll find out if this is really the place for me.

For now I love teaching
And there is such satisfaction in seeing students learn and share my passion for my
practice world.

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3. BEING A UNIVERSITY TEACHER

Teaching in Professions

There is a common view that becoming and being a university teacher is a relatively straightforward process, and there are popular websites that provide what appear to be simple steps to achieve this (e.g., http://www.wikihow.com/Become-a-College-Professor). We argue, however, that becoming a university teacher is a complex process and not to be taken lightly.

Identity and Recognition

University teachers are a heterogeneous group, reflective of the society from which they are drawn, but can be considered in three loose groupings. One group is made up of people who are primarily educators and who hold educational qualifications in support of their academic roles. Another group hold qualifications in a health profession such as nursing and forego their professional practice in order to become full-time university teachers. Many such teachers have no formal education credentials and find themselves in a teaching role simply because of expertise in their professional field. A third group are those who decide to contribute to their professional community in a teaching role while continuing regular professional work. Universities often employ the latter teachers on a casual, infrequent basis despite the valuable contribution they can make to teaching. Indeed, the existence of all three groups of teachers provides rich variety in university teaching as a discipline. In particular, the knowledge and practical experience they bring from the “real” world of work is crucial within a learning institution where the focus is on the need for graduates who are able to perform in the workplace. One further note of interest is that, although a teaching qualification is optional, research training is essential to progress in an academic career. This clear inequity is reflected in the perceived value of research over teaching which still exists in the tertiary sector, despite the growing realisation that education is just as important as research. On closer inspection, therefore, the process of developing an identity as a university teacher is rather more complex than it seems at first.

Moving from a workplace environment where one was a health professional into the academic space of a university requires a shift in professional identity. Coming as they do from many different backgrounds, it is not surprising that university teachers forge their new identities in diverse ways. Skelton (2012) differentiated three types of teachers: those who are “specialists in teaching” and spend much time in face-to-face teaching activity; “blended” professionals who regard both teaching and research as
contributing to learning; and “researchers who teach”. Teaching specialists see their educational role as encompassing a broader professional responsibility than simply lecturing or taking tutorials. They tend to take a holistic view of teaching and are aware of the need to spend time supporting students in their learning beyond the mere transmission of information characteristic of recognised teaching activities such as lecturing. In contrast, for those who consider themselves researchers who teach, teaching is often an activity secondary to research. This impoverished view of teaching seems to be still widely held in many academic institutions and needs to change if high-quality teaching and learning within universities is to flourish. Those who Skelton dubbed “blended professionals” approach the issue from a different perspective. For them, learning is the primary activity of a university, and they consider that everyone, be they staff member or student, is a learner. Blended learners tend to regard both teaching and research as learning activities and therefore can more comfortably combine the two aspects of their work.

Not everyone can successfully blend teaching and research identities. Skelton (2012) captured the tension that can arise for individuals as they seek to establish a new identity as a university teacher. He referred to the “identity struggles” that occur when people try to integrate a teacher identity alongside a researcher identity. This is because it is hard to meet teaching responsibilities as well as attend to the research activities expected of academics in tertiary institutions. New academics can feel overwhelmed by these demands. These professionals can find themselves working with two quite separate groups of people, a research community and a teaching community, but feel they are not being embraced by either. A further challenge for academics who identify themselves as teachers is the strong sense of duty they feel towards their students (Calvert, Lewis, & Spindler, 2011). Tension also exists for teachers in the dynamic environment of universities where the breadth of scholarly activity extends to high calibre and well-qualified professional staff who work alongside academics and where traditional academic boundaries in work allocation are blurred (Whitchurch, 2012). This blurring has resulted in expanding the range and heterogeneity of academic identities. In addition to all this, university teachers are under extra pressure as financial constraints on higher education and higher student numbers have an impact on what they are expected to do. As the tertiary education sector adopts more business-oriented processes in response to this pressure, academics must take on new roles and identities that are becoming increasingly fragmented (Clegg, 2008; Gale, 2011). An idea that allows us to conceptualise teaching identities in more depth is the community of practice (Wenger, 1998).

The Teaching Community of Practice

The website How to Become a College Professor suggests that one of the steps you can take to become a university teacher is:

when searching for a full-fledged professor position, apply everywhere. Start by looking at universities that are looking to expand the department you are interested in becoming a part of.
The advice is clearly to look broadly for a community of practice in which you would fit. The higher education literature focuses not only on teacher approaches and tips for teaching but also on conceptions of learning and how to engage students and teachers in a learning community. This can be seen as an attempt by university teachers to form an open and collegial community of practice (Lave & Wenger, 1991) dedicated to improving their contribution to the university. This is much more than just a community of interest where participation is reduced to little more than a passing interest in a topic. A community of practice is distinguished by structural characteristics that Wenger, McDermott, and Snyder (2002) described as a “domain of knowledge; … a community of people; … and … shared practice” (p. 27). The emphasis is particularly on the shared practice of the community. The community grows and develops a shared understanding of the value of the knowledge and practice of its members by exchanging information, expressing opinion, and providing support. The underlying motivation is that members of a community of practice need to share knowledge to constantly improve their practice both as individuals and as a community.

There is strong motivation to join a community of practice when knowledge is valued in this way. The strength of the motivation can overcome potential barriers to forming a community such as time poverty or geographic separation (Ardichvili, Page, & Wentling, 2003). The engagement of teachers within a community of practice can encourage the exchange of practice stories, for example, that will enhance their ability to do their job as teachers. A good community of practice, therefore, deliberately sets out to foster strong social engagement and collaboration where participants can continue to negotiate the meaning of their knowledge and their practice and develop a sense of identity. In this way participants can develop a sense of the professionalism needed in being a university teacher. This raises the issue of what teachers need to know in order to teach.

Imparting Discipline-specific Knowledge Versus Deep or Lifelong Agentic Learning

We might ask, what do university teachers need to know in order to teach? Several authors have addressed this question in the context of higher education. A common conclusion is that teachers need to possess a range of skills, attitudes, knowledge and values in both discipline-specific and pedagogical areas. Discipline-specific knowledge is essential knowledge, described by Ramsden (1999, p. 25) as involving

an understanding of the main issues in a subject, an appreciation of the nature of appropriate arguments in it, an awareness of what counts as relevant evidence, and the wisdom to think critically and admit one’s deficiencies in knowledge.

There is clearly much more involved than simply imparting textbook information. For example, in the health professions, teachers who are also practitioners provide a unique dimension with their experiential understanding of professional practice. The value to students is that their teacher’s experiential understanding is important in supporting students to develop their own notions of the realities of professional
practice from an “insider” perspective. In other words, teachers can convey the realities of the profession to students and the meaning of professionalism. This is why teaching in the clinical environment presents a challenging and complex task, a task many clinicians often assume without adequate preparation or orientation. Harden and Crosby (2000), in the medical profession, described six major roles that the clinical teacher takes on: information provider, role model, facilitator, assessor, curriculum and course planner, and resource material creator. All these roles must be co-ordinated and used to help students become members of the community of practice that is their profession.

Billett (2009) calls university-based discipline knowledge “canonical”, adding that these concepts need to be augmented by learning experiences of authentic professional practice where that knowledge can be applied in ways that can allow students to develop a deeper understanding of what professional practice entails. Discipline-specific knowledge is also constrained by complex institutional requirements and the demands of accreditation bodies that validate and certify courses. This means that professional practitioners who are also teachers must carefully integrate their experiential practice knowledge and skills with the knowledge and competencies that are formally stated within the curriculum. It is now clear that discipline-specific experiential knowledge is essential but not sufficient to become an effective teacher. An important implication of this is that a great deal of interpretation is needed when deciding what to teach and how to teach it (i.e. pedagogy).

Pedagogical knowledge, or ways of knowing, is knowledge of instructional strategies, curriculum resources and tools that are effective in supporting students’ learning. We now realise that successful pedagogy requires engagement with the prior conceptions and experiences that students bring to their learning. Therefore, professional development of teachers in pedagogical knowledge is increasingly focused on helping teachers to understand and engage with student thinking. But just as discipline-based experiential knowledge is essential but not sufficient for effective teaching, understanding of student thinking addresses only part of the challenge. The challenge of effective teaching is to combine these different aspects of education. We must make the complex knowledge, from both the curriculum and our own practice knowledge, accessible to students in a manner that relates to their abilities to understand. This means that teachers need to able to use a range of instructional strategies and techniques and know when and how to use them. All this activity must be constructively aligned with the aims of the course and with the way learning is assessed. Moreover, we should be encouraging students to become autonomous learners who have the intrinsic motivation to manage their own learning (i.e. self-directed learning). Students need to be agentic.

Billett (2009) described agentic learners as those who are “pro-active and engaged in making meaning and developing capacities in ways that are intentional, effortful and actively critical in constructing their knowledge” (p. 5). It is remarkable, though not unexpected, how closely this definition matches that provided by patients when asked what expectations they have of the health professional who provides their care (Gerzina, unpublished). It is not surprising that there is alignment between the
qualities patients expect to see in their healthcare providers and the objectives of health professional education in universities. However, university teachers should also think of themselves as agentic and active learners.

Teacher Approaches to Teaching

McLaughlin and Zarrow (2001) claimed that teachers should consider themselves active learners in both the evolution of their understanding of discipline knowledge and their abilities as teachers. There is a need to be engaged in ongoing development of teaching, assessment, observation and reflection. Ongoing development as a teacher should be seen as a professional commitment, part of the professionalism of being a teacher. Both successes and failures may occur, reflected in teaching evaluations by students, peers, supervisors and institutions, but ongoing development as a teacher can be sustained by the accumulated wisdom of experience over time (Dadds, 2001). It must be remembered, however, that individual development as a teacher takes place in a social context that is always changing. Higher education in the Western world has been characterised by constant and regular change in response to pressures from a wide range of organisations and governments. The demands and expectations of institutions seem always to be undergoing reform and renewal. University teachers are expected to keep abreast of such change and adapt to it. For example, it is now accepted that student ratings of teacher effectiveness are a normal part of being a university teacher because these evaluations are seen as valid metrics of teacher effectiveness (Cohen, 1981). Such evaluations are now a reality that many university teachers must come to terms with, no matter what reservations they may privately hold about the claims to accurately measure effectiveness. One reservation is that these measures take no account of a teacher’s approaches to teaching and learning. For example, what attitude do teachers have towards issues such as student-centred learning?

Student-Centred Learning

Åkerlind (2003), reviewing studies that examined university teachers’ conceptions of and approaches to teaching, considered two issues. The first is a perception of teaching as a transmission of information to students vs. the development of conceptual understanding in students; the second is teachers and their teaching strategies vs. students and their learning and development. The first issue emphasises the importance of encouraging students to undertake higher order thinking about what they learn by providing structured learning activities that require substantial engagement in decision-making and critical thinking. The second issue concerns the teacher-student axis and the need to find a fine balance between what the teacher does and what the student does in order to achieve the learning goals. Ramsden (1999) adds that students should undergo a gradual change in their perceptions of a subject, from a simplistic view of knowledge and learning towards a more relational view where they become aware of the sophisticated relations and connections between different bodies of knowledge. This means that the balance between
academic teaching and student learning is dynamic and changing. These concerns have led to a growing interest in student-centred learning.

For many years, a growing number of scholars have argued for a form of education that puts students rather than teachers at the centre of educational activity (e.g. Vygotsky, 1978). Student-centred learning contrasts with teacher-centred learning in the balance of power, the function of content, the role of the teacher, the responsibility for learning, and the purpose and processes of evaluation (Weimer, 2002). The term student-centred learning was articulated by the psychologist Carl Rogers (1951), and it is often considered to be synonymous with other terms like active learning and participatory learning. Rogers asked:

If the creation of an atmosphere of acceptance, understanding, and respect is the most effective basis for facilitating the learning which is called therapy, then might it not be the basis for the learning which is called education? (p. 384)

There is a clear link between student-centred learning and adult education. Knowles (1970) argued that adult learners consider themselves to be independent, bringing experience to their learning and having a problem-centred or problem-solving approach. The problem-solving approach also links with patient-centred teaching, with the complex relationship between teacher, student and patient playing an important role in the education of health professionals. The aim of patient-centred teaching and learning is to provide authentic education. Further complexity is added by the involvement of other stakeholders, adding further tensions to teaching.

Tensions in the Teaching Environment

Many tensions exist in the teaching environment of the university. Sources of tension include heavy workload expectations vs. the quality of life balance for teachers, the tension between teaching and research, the requirement to constantly master the pedagogical implications of new technologies and media, and the shifting view of tenure with a growing trend towards casualisation and short-term contracts. It is important for new academics to be aware of all these tensions so that they can engage with these issues, which are likely to be with us for many years to come. One particular tension at the present time is the issue of workload.

Teaching workload typically includes all time spent on instructional and scholarly activities face-to-face with students, and the preparation of those activities. This is an issue because there is a widespread sense that workload demands are steadily increasing with rising student numbers but often without a concomitant rise in staff and resources. Many academics feel that they are being asked to do more with less. This is complicated by the casualisation of many teaching roles and the uncertainty this can bring.

The uncertainty brought about by casualisation and short-term contracts means that it can be difficult for an academic department to establish continuity in research, scholarship and teaching. Percy and Beaumont (2008) argued that there are significant risks to teaching if casualisation merely reduces the costs of providing
education. This situation is not helped by the growing number of staff who are required to generate grant funding to help pay their own salary, although this relates more to those with a research commitment. On top of all this is the demand for all academics to generate more publications in order to be seen to be productive.

The teaching environment for practitioner teachers is further complicated by additional elements at play, each with distinct challenges. The teaching environment may consist of inpatient, hospital outpatient and community settings, all with different practice cultures and ways of doing things. All these settings need to be understood by the teacher so that students can be successfully introduced to them. What students learn in practice settings takes on particular relevance for them, as they can see that it relates directly to what they will do as autonomous practitioners (Spencer, 2003). In these settings a university teacher also needs to balance patient care with the requirement to teach and supervise students as they practise their emerging skills, apply their knowledge, communicate with patients and do so in a professional manner. It is one of the duties of a practitioner teacher in these settings to provide a role model, embodying and demonstrating the values and attitudes of the profession. Yet until recent years very little preparation has been provided for prospective university teachers to take on these roles.

For many practitioner teachers the only preparation for teaching is their own experience of learning or being taught. This is problematic for a number of reasons. The tendency is to emulate one’s teachers, regardless of whether the experience was good or bad. In some of the health professions, particularly medicine, there has often been a tradition of intimidation and humiliation in clinical teaching (Knight & Bligh, 2006), which is now recognised as counterproductive for students and can have detrimental consequences for the teaching practice of new medical teachers if it is allowed to continue. One response to this situation is to provide formal preparation in higher education for new university teachers.

Preparation for Teaching at Tertiary Level

Formal courses to orient newcomers to the teaching environment of the university and to impart knowledge about theories of education and methods of instruction have been shown to improve understanding and skills of teaching (Foster & Laurent, 2013; Gibbs & Coffey, 2004). This alone is not sufficient. Research shows that interaction with and support from colleagues within the community are essential experiences in the process of identity development as a university teacher (Trowler & Knight, 2000). New university teachers most value work-related discussion with more experienced colleagues, but in general find that opportunities for talking about teaching are rare (Remmick, Karm, Haamer, & Lepp, 2011). This experience can be isolating, and such loneliness saps the self-confidence essential to be an effective teacher. It is increasingly recognised that successful professional socialisation and preparation for teaching require collegial support for novice teachers as they become familiar with the culture and practice of their new environment (Boyd & Harris, 2010; Remmick et al., 2011) and gain confidence in teaching. In other words, besides
formal preparation to teach it is important to be a member of a community of practice of teachers who can provide regular support for each other.

Remmick et al. (2011) showed that when new teachers have the opportunity to observe teaching colleagues at work they tend to adopt the norms and values of the particular department or institution. Support and guidance from more experienced teachers is as important for novice teachers as instruction in teaching methods. The warmth of interpersonal relationships within a community of practice can be the foundation to successful integration into the university teaching community. New university teachers need to adopt a critical and questioning attitude to existing educational practices and values that they encounter. This is another reason for new teachers to take advantage of any formal preparation offered to become an educator. A well-designed course will encourage teachers to be critical and questioning of educational and professional practice and to encourage this in their students. No community of practice is perfect; new members of the community of university teachers need to accept responsibility for reforming and gradually improving the practice of educating health professionals.

Conclusion

We have attempted here to describe the stresses, large and small, that confront those who choose the vocation of university teacher. The community of practice of health professional educators is complex, though reflective of society at large with all its expectations and tensions. Such teachers are required to bring a deep understanding of a profession to their teaching while bringing a degree of professionalism to the teaching as they fathom their emerging identity as a teacher. Having deep and thorough discipline-specific knowledge on its own does not equip someone to be a university teacher. Teachers are responsible for student engagement with this knowledge and are obliged to support the construction of a professional reality for their students, who are, after all, junior colleagues of the teacher. Teaching approaches should place the student in the centre of the endeavour, and encourage student-centred learning. There is a great range of issues to consider when setting out to become a university teacher. A final tip comes from our opening website, How to Become a College Professor:

Remain humble. Don’t succumb to “professor’s disease”. Just because you spend your days in front of students who, by definition, have a lot to learn, doesn’t mean you are omniscient or have an exalted place in the universe.

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