Exploring community faculty members' engagement in educational scholarship

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Abstract

Objective To obtain a deeper understanding of community faculty members' perceptions about engagement in educational scholarship.

Design One-on-one semistructured interviews that were audiorecorded, transcribed verbatim, and subsequently analyzed.

Setting Toronto, Ont.

Participants Purposive, theoretical sample of 8 physician faculty members at the University of Toronto.

Methods Interview transcripts were analyzed using a grounded theory approach. Emergent themes were identified by the research team through a process of constant comparative analysis.

Main findings Community faculty members identified themselves professionally as clinicians and teachers, and they did not see themselves as scholars in medical education. While they believed that educational scholarship was important for the field more broadly, they did not see the personal or professional value of being involved. This attitude stemmed from the perception that there was not a direct link between scholarly activity and improvement in teaching or patient care. Instead, participants viewed scholarly activity as a mode of career advancement rather than practice improvement. Furthermore, they equated educational scholarship with clinical research, thereby excluding themselves from participation in scholarly activities.

Conclusion When developing strategies to engage community faculty members in educational scholarship, it is important to consider the implications of members' professional identity, as well as implicit models of scholarship. To expand the concept of educational scholarship beyond research activities, additional scholarly contributions need to be supported, recognized, and valued.

EDITOR'S KEY POINTS

- With new models of health care delivery and changing population needs, community placements have become increasingly important during medical training. Consequently, community clinicians are being recruited to serve as faculty members; however, if community faculty members are not engaged in educational scholarship, there is a missed opportunity to develop excellence in community-based medical education.

- Community faculty members' lack of engagement in educational scholarship is an important issue to be addressed by medical schools. This study found that multiple factors influenced members' engagement in educational scholarship (eg, a dominant identity as a clinician first, low self-efficacy, and lack of role models). To harness educational scholarship as an ongoing part of community-based medical education, universities will need to use a multipronged approach to mitigate these interrelated factors.

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Les médecins qui agissent comme professeurs au sein des communautés demandent-ils des bourses d'étude en enseignement?

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Résumé

Objectif Se faire une meilleure idée de ce que pensent les médecins qui enseignent dans la communauté de la possibilité de devenir boursier en enseignement.

Type d'étude Des entrevues semi-structurées en tête-à-tête ont été enregistrées, transcrites mot à mot, pour ensuite être analysées.

Contexte Toronto, Ont.

Participants Un échantillon théorique raisonné de 8 médecins enseignant à l'Université de Toronto.

Méthodes Les transcrits des entrevues ont été analysés à l'aide d'une méthode basée sur une théorie empirique. Les thèmes repérés ont été identifiés par l'équipe des chercheurs grâce à un processus d'analyse par comparaison continue.

Principales observations Sur le plan professionnel, les médecins qui enseignent dans la communauté se considéraient surtout comme des cliniciens et ne se voyaient pas comme des boursiers en enseignement médical. Même s'ils estimaient qu'il est important d'avoir des bourses en enseignement de façon générale, ils n'y voyaient pas d'intérêt sur le plan personnel ou professionnel. Une telle attitude provenait du fait qu'ils pensaient qu'il n'y a pas de lien direct entre le fait d'être boursier et une amélioration de l'enseignement ou des soins aux patients. Pour eux, ce type d'activité était plutôt une façon de progresser dans leur carrière plutôt que d'améliorer leur pratique. En outre, ils croyaient qu'être boursier en enseignement équivalait à faire de la recherche clinique, s'excluant ainsi d'une participation à une activité de perfectionnement en enseignement.

Conclusion Quand on cherche des stratégies pour inciter les médecins qui enseignent dans la communauté à devenir boursiers en enseignement, il est important de tenir compte du rôle professionnel auquel ces cliniciens s'identifient, mais aussi des modèles implicites qui caractérisent cette activité. Si on veut que le concept de bourse en enseignement ne soit pas restreint à une activité de recherche, ce type d'activité devra être soutenu, reconnu et valorisé.

POINTS DE REPÈRE DU RÉDACTEUR

- Compte tenu des nouveaux modes de dispensation des soins et des besoins changeants de la population, les stages au sein de la communauté sont devenus de plus en plus importants durant les études médicales. C'est pourquoi on recrute des cliniciens de la communauté pour agir comme professeurs; mais quand ces derniers ne font pas de demande de bourses d'étude en enseignement, on se prive d'une occasion de promouvoir l'excellence dans l'enseignement médical en milieu communautaire.

- Les médecins qui enseignent dans la communauté sont peu intéressés à se perfectionner en enseignement, ce qui constitue un important problème auquel doivent s'attaquer les facultés de médecine. Cette étude a observé que plusieurs facteurs jouent dans la décision des professeurs cliniciens communautaires de ne pas recourir aux bourses d'étude en enseignement (p. ex. le fait de s'identifier d'abord comme cliniciens, de se penser peu efficaces et de ne pas avoir de modèle de rôle). Si on veut que les bourses d'étude en enseignement deviennent partie intégrante de l'enseignement médical en milieu communautaire, les universités devront s'attacher à diminuer l'importance de ces facteurs.

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One of the pressing challenges faced by medical schools is enhancing the development of social responsibility and accountability in future physicians, thus enabling them to better respond to the diverse needs of communities and individuals.[1-3] In response, Canadian medical schools have been actively developing models of community-based medical education (CBME) that extend the teaching and supervision of learners from traditional academic hospital teaching centres to community settings.[4] This investment in CBME is based on the premise that community experiences provide students with a greater understanding of complex issues such as "professionalism, social determinants of health, cultural competence, and systems-based practice," thereby more effectively fostering social responsibility and accountability.[5]

Establishing effective CBME involves actively recruiting physicians from the community to serve as faculty members.[6] With their deep connections to communities and wealth of experiential knowledge, community faculty members are well positioned to educate future physicians in ways that go beyond direct supervision of learners in clinical settings to include a comprehensive range of education practices, such as delivering lectures and seminars, mentoring learners and junior faculty members, and conducting educational research. Thus, the ongoing development of the educational practices of community faculty members is critical to sustaining the delivery of high-quality CBME.[4]

Engagement in educational scholarship has been cited as key to maintaining high levels of achievement in medical education practice.[7] Educational scholarship is built upon the sharing of education practices for the purpose of collaborative improvement and offers a potential mechanism to foster sustainable education practices among community faculty members. Building on Boyer's seminal definition of *scholarship,*[8] Shulman and Hutchings cite 3 criteria for educational scholarship: "being public ..., open to critique and evaluation, and in a form others can build on."[9] However, there are challenges to engaging community faculty members in educational scholarship. While models of expertise suggest the day-to-day problem solving inherent to the practice of CBME produces creativity and innovation worthy of educational scholarship, community faculty members might perceive a disconnect between this daily work and scholarship.[10] If community faculty members are not engaged in educational scholarship, there is a missed opportunity to develop excellence in CBME. Accordingly, the aim of this qualitative study was to obtain a deeper understanding of community faculty members' perceptions about engagement in educational scholarship.

METHODS

During a 6-month period in 2011, we conducted a constructivist grounded theory study with the goal of contributing to the development of a substantive theory of the engagement of community faculty members in educational scholarship. Constructivist grounded theory is rooted in pragmatism and relativist epistemology. It assumes an interactive process in which data and theories are not discovered but are constructed as a result of the researcher's interactions with the field and its participants.[11] Given that we wanted to generate theory, this method was appropriate. We obtained ethical approval from the University of Toronto Research Ethics Board.

Setting

As is typical in grounded theory research, our study was not intended to predict or to generalize, but rather to generate an explanation and deep understanding of the phenomenon of interest.[11] To achieve this goal, we purposefully chose a powerful setting to better understand community faculty members' perceptions about engagement in educational scholarship. The Department of Family and Community Medicine (DFCM) is one of North America's largest departments of family medicine with a distinguished history of contributions to scholarly work in the discipline of family medicine in urban, suburban, and rural communities of Ontario.[12] Within the DFCM, medical learners are dispersed among 18 teaching sites in the greater Toronto area, including academic teaching hospitals and urban and suburban community settings. Additionally, as a community faculty member of the DFCM, the principal investigator (M.L.) has considerable institutional knowledge of the clinical and academic demands on fellow faculty members, the departmental culture, and the departmental supports available to faculty members who pursue educational scholarship, which was helpful at all stages of the study.

Participants

The principal investigator interviewed a purposive sample of University of Toronto faculty physicians appointed to the DFCM. Snowball sampling was used to recruit participants via e-mail. Maximum variation sampling was subsequently used to enrich the data by selecting a range of dimensions of interest to identify "important common patterns that cut across variations."[13] Male and female participants were recruited from a variety of community settings, representing a diversity of appointment ranks (from lecturer to associate professor) and years in practice (11 to 31 years). The sampling strategy evolved into theoretical sampling as new participants were selected to challenge and evolve emerging themes, including interviews with 2 non–community-based

academic faculty physicians for possible contrasting experiences. As the principal investigator was a member of the DFCM, he drew on his knowledge and took advantage of his familiarity with the faculty to recruit participants with diverse experiences in their academic and teaching roles.

In qualitative research, increasing the sample size does not always yield an increase in the information gathered.[14] The concept of *theoretical saturation,* or the point at which no new information emerges that would be useful to understanding the phenomenon under study, was used to determine the sample size. We achieved theoretical saturation after interviewing 6 community-based and 2 non–community-based participants.[15,16] Five to 8 "sampling units" (ie, 5 to 8 participants) are usually sufficient to achieve theoretical saturation within relatively homogeneous samples.[17]

Data collection

Participants provided signed consent to participate in a 45- to 60-minute semistructured interview. Interviews were audiorecorded and transcribed verbatim, removing identifiable information for anonymity. The initial interview guide, based on relevant literature, was modified as themes emerged following concurrent analysis of interview transcripts. An iterative approach to interviewing is a key element of constructivist grounded theory. The questions were modified from the original interview guide after a few interviews—when themes began to surface from the concurrent data analysis—in order for the interviewer to contextualize, challenge, and refine the information gathered to date. During the course of interviews, the questions also changed based on the interviewer's familiarity with the topic. In line with constructivist grounded theory, sampling continued until saturation of the information was achieved. Transcripts were entered into NVivo qualitative data analysis software for data organization.

Data analysis

A constructivist grounded theory analysis of the interview transcripts was undertaken.[11] In grounded theory, emergent themes are not only used to explore an issue, but also to construct a cohesive explanation about an investigated phenomenon. To pursue emergent themes, we conducted data analysis in tandem with data collection, using the constant comparative method.[18] We investigated existing and emergent themes throughout the data collection process and continuously reworked the initial coding structure to ensure the representativeness of the resulting categories. We carried out data analysis using the following steps: coding, memoing, and theory generation. Open and axial coding were performed independently by 2 authors (M.L., M.M.) to identify features of the data pertinent to the research questions and to organize data into more concise ideas that were subsequently grouped into themes.[19] Over time, a coding framework was agreed upon and applied to the data set. We used NVivo software to facilitate further exploration of the prevalence of each theme. Through discussion, the research team summarized the relationships between the themes and formulated a general theory.

FINDINGS

Data analysis provided a rich understanding of community faculty members' perceptions about engagement in educational scholarship. Community faculty members articulated having a powerful identity as clinicians who put patients first. They expressed that educational scholarship was a low professional priority and a lack of confidence in their ability to produce research, which they equated with educational scholarship.

Community faculty members have a powerful identity as clinicians who put patients first. Participants highly valued their relationships with their patients and believed that their role as clinicians outweighed other professional roles. The patient-physician relationship was consistently mentioned as being central to the role of the family physician.

> I feel that I still make a difference with my patients, and I know that the difference is really because of the relationship that I've had with them ... I could really make a huge difference with many of them, and I feel that was my first calling, and the learners my second one. (F6)

Interestingly, participants did not see themselves as scholars, one of the intrinsic core competencies endorsed by dominant frameworks of medical education.[20,21] They did not view themselves as educational scholarship *creators*, but rather as educational scholarship *users:* "Well, I like to be on the receiving end of those kinds of things." (F4)

They also considered their own professional development in the area of educational scholarship a "luxury," separate from their job description. Scholarly undertakings were thought to be isolated activities, not a means to improve teaching, learner knowledge, and, ultimately, patient care.

> Interviewee: When I give a talk or something, I write down that I gave the talk; there is [an] evaluation form and everything, but it sort of disappears into the air. So it's different, when someone writes an article or stuff like that; it's there for everybody to see. (F2)
> Interviewer: So it's not as valued as something that can be published?
> Interviewee: Right. (F2)

Participants described career advancement as an academic game requiring rule following and publications to demonstrate an effect in the academic world. They acknowledged differences in their community responsibilities compared with their perceptions about the responsibilities of academic faculty members.

> So, whereas in downtown there is a culture of clinical [work] and teaching are, like, even; in a community setting sometimes, even though you are faculty, you will prioritize your clinical. Patients come first and then the teaching comes second, and under that umbrella of teaching, maybe scholarly work. (F4)

Without the implicit model of linking scholarship to better patient care, faculty members separated their roles as strong clinicians from their roles as scholars, and as a result believed that they had little to contribute to educational scholarship. Instead, educational scholarship was considered a mode of career advancement rather than practice improvement.

For community faculty members, educational scholarship is a low professional priority. Perhaps not surprisingly, given their strong sense of identity as clinicians, community faculty participants consistently described conflict between clinical work and scholarship. They described the difficulty of fulfilling all professional roles (ie, clinical, teaching, scholarly) without sacrificing professional time, income, or personal life. These opportunity costs, in turn, represented deterrents to community faculty members pursuing scholarly work.

> If you tell me, here, you're paid [and] you don't have to worry about patient care, that we've got someone who is going to look after your patients, take that half day, go around, educate people about your program, I wouldn't even mind going and presenting the actual modules, or working with the residents presenting the modules at different [residency] programs. (F3)

The sacrifice of clinical income also influenced the way faculty members set priorities: "A big elephant, I think, too, is money because certainly at my stage of career, people equate practically any activity with money, and research is not as remunerative." (F1)

Participants implied that the only way to participate in educational scholarship was to sacrifice personal time:

> The frustration comes predominantly from finding the time among everything else and the fact that you often spend your evenings or your holidays working on [scholarly work]. Not everything needs to be remunerated, that's not the purpose of what we're doing, but it becomes frustrating when you don't have a down time or you've got a deadline coming up. (F3)

Community faculty members do not feel confident in their ability to produce "research," which is what they understand educational scholarship to be. Participants were proud of the innovative teaching methods and programs (eg, mentoring program, creative teaching activities, curriculum development, new assessment program) they had developed in the community. However, there was a general sense that they were not familiar with or interested in producing educational scholarship. Critically, community faculty members equated educational scholarship with doing research rather than being a pervasive part of their daily work.

> Well, publishing research, I am just not interested in research and writing. I always feel guilty about that. I feel like I should be doing more of that, but my interest in academics has never been in the research realm; it's always been about the practical teaching component. (F4)

Participants commented that while research resources were provided to medical students and residents, they were less available to faculty members, and they did not believe they belonged to a community of practice that valued and supported educational scholarship. This might have contributed to low self-efficacy and difficulty initiating educational scholarly activity: "It's a very foreign territory for you so you don't know whether it is easy or difficult. You just know that it is foreign to you. To get through to learn how it actually can be done, it would be a deterrent already." (F5)

Participants perceived a paucity of role models and mentors who were experts in educational scholarship in the community setting, which represented a barrier for community faculty members to access the tools and skills they believed were necessary for participating in scholarship.

> I think the leaders are downtown, and they know how to write grants to get research funding; they know how to submit an article; they know a whole pile of just technical skills about things. Most family physicians wandering around would have no clue how to write an article. (F2)

DISCUSSION

Our results provide a theory of community faculty members' engagement in educational scholarship. Community faculty members consistently expressed

having a strong identity as clinicians, seeing themselves secondarily as teachers and not so much as scholars. The factors that drew them away from identifying as scholars (eg, seeing themselves as scholarly work recipients but not as creators, and as outsiders of the academic community) reinforced their identity as clinicians foremost and de-emphasized their professional identity as scholars. This contributed to the lesser professional priority these community faculty members placed on educational scholarship. Participants' belief that educational scholarship was mainly equated with research, and their associated lack of confidence to engage in such activity, further exacerbated the diminished role and value placed on educational scholarship.

In light of new models of health care delivery and changing population needs, community placements have become increasingly important during medical training.[4] Consequently, community clinicians are being recruited to serve as faculty members. While there are benefits to educating learners in the community setting, our research suggests that community faculty members are less prepared to engage in educational scholarship than academic faculty members are. This lack of engagement is problematic for 2 main reasons. First, the professional identity being reproduced by community faculty members in their trainees represents an ongoing barrier to community educational scholarship. Second, there are missed opportunities for valuable scholarship in the community setting and a resulting absence of community perspectives shaping the medical education landscape.

Our results found that participants did not identify with the role of scholar. Conflicts of multiple professional roles have been documented elsewhere[22-24] and can have powerful implications for professional identity development in the next generation of learners.[25] Professional identification is a process of self-categorizing[26] and is part of how individuals define themselves.[27] The values held by role models and peers are likely to shape the professional identities of medical trainees. Our results suggest that the strong identity held by community faculty members as clinicians first is likely to be reproduced in the identity formation of residents. Interestingly, community faculty members did not link educational scholarship to better education, better learning, and ultimately better patient care. To address the perceived disconnect between the identities of clinician and scholar, universities might want to leverage community faculty members' uniformly strong identity as clinicians by explicitly linking scholarly work in medical education with better outcomes for learners and ultimately better health care.

Community faculty members represent a growing population of physicians teaching future doctors and serving a large proportion of patients. Our participants' perception of educational scholarship as research, rather than part of their existing education practice, has been noted in other contexts.[10] Community faculty members perceived themselves to be recipients rather than creators of knowledge, thereby positioning themselves as outsiders to the academic community. However, community faculty members are delivering high-quality educational programs, discovering new pedagogic methods, and solving challenges in their unique educational settings. Without the desire, confidence, skills, resources, and support to disseminate this knowledge, these contributions to the field of CBME will remain unknown. When educational scholarship from the community context is "out of sight," it might become "out of mind" too—community faculty members do not think about how their work can be scholarly, further disengaging them from these activities.

Limitations

A limitation of our study is that it was conducted at a single, urban university. While this limits generalizability of the data, our goal, as is typical in grounded theory research, was not to generalize, but rather to generate a deep understanding of the phenomenon of interest. The DFCM was purposefully selected as a powerful setting to explore community faculty members' perceptions about engagement in educational scholarship given its size (it is one of North America's largest departments of family medicine), its distribution, its history of contributions to scholarly work in the discipline of family medicine, and its involvement in multiple recent changes in primary care education and care delivery models.[12] Further research at other universities seeking to engage their community faculty members in educational scholarship would add valuable additional insight to our work. Another limitation is the age of the data, as this study was conducted in 2011. However, given that university expectations around scholarship remain, it is likely that the issues raised by participants in 2011 remain relevant in 2016.

Conclusion

Given the growth of the community faculty population, lack of engagement in educational scholarship is an important issue to be addressed by medical schools. Our study shows that there are multiple factors influencing the current engagement of community faculty members in educational scholarship. These factors (ie, a dominant identity as a clinician first, a dissociation from the scholar role, barriers to scholarship such as time, opportunity cost, skills, low self-efficacy, and lack of community mentors and role models) do not act in silos. To harness educational scholarship as a pervasive part of CBME, universities will need to use a multipronged approach to mitigate these interrelated factors. As this study was conducted in 2011, it would be worthy conducting further research to verify these findings in an expanded university population.

A critical review of how educational scholarship is currently defined, valued, and rewarded in the field of medical education could help shape the identity of this faculty group. For example, publications are perhaps viewed as more prestigious and are considerably easier to quantify than teaching and educational effects are. Whether all faculty members should be required to engage in educational scholarship defined in this manner and whether increased scholarly activities will actually help students learn are questions worthy of debate. This study revealed the ways in which community faculty members feel ill-equipped and unsupported to engage in scholarship, particularly research, contributing to feelings of exclusion from current conceptions of the scholar role. We argue that a reframing of the term *scholarship* by medical schools could promote and recognize the important contributions being made by community faculty that expand beyond research activities. Perhaps such recognition to also include teaching activities would help shift community faculty members' identities from clinicians first and teachers second, to one in which their current activities are formally recognized as scholarship, which would directly benefit students. This might also work to reduce the perceived barriers to engaging in scholarship and identify the ways in which the expanding community faculty can be supported. Further engagement in scholarly research activities might then serve to model the role of scholar to medical trainees. This would indeed be a cultural shift that would need to be reflected in formal measurements of excellence.

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Contributors

Dr Law led the study and was responsible for and was substantially involved in all phases of the work. **Dr Mylopoulos** provided input on study concept, study design, and data collection. All authors contributed to data analysis, as well as writing of the manuscript and preparing for its submission.

Competing interests

None declared

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