Faculty development: Why it fails to impress us

TEJINDER SINGH

INTRODUCTION

Ever since we embarked on medical education in India, we do not seem to have been comfortable with the way we have gone about it. To an extent, this discomfort with the status quo has been responsible for the changes that have taken place in the past several years. While the Medical Council of India (MCI) regulations of 1997 emphasized internal assessment (IA), integrated learning and newer assessment tools, such as the objective-structured clinical examination (OSCE), the changes proposed recently seek to revamp the system completely. They include a reduction in the duration of the course, early clinical exposure, horizontal and vertical integration, and exit examinations. Unfortunately, the (in)famous line, ‘Indians are good at planning but poor at execution’, has been applicable to the area of changes in medical education.

From an educationist’s point of view, the 1997 regulations had lots of ‘educational’ inputs. They were the first to attempt to bring out the importance of IA, especially its distinctive character and its focus on abilities that cannot be assessed by conventional examinations. IA was made a prerequisite for appearing in university examinations and this focus on using assessment as a tool for learning stood out as a useful educational strategy. The notion of IA as an ‘examination without external examiners’ or ‘as a preparatory examination before finals’ was also demystified, with the regulations focusing on the need to give the process of learning as much importance as the product thereof. A number of non-cognitive attributes were included in the assessment process, in line with the objective of promoting the overall development of medical students. The emphasis on IA made educational sense because, as mentioned earlier, IA has the potential to assess skills and competencies which do not lend themselves to assessment by traditional summative examinations. Further, it was in synchrony with contemporary thinking, which places greater reliance on the longitudinal assessment of performance in contrast to snapshot observations.

Unfortunately, we failed to make much use of IA because teachers, who were the major stakeholders of this process, never seemed to have been convinced of the importance of the process. Most of them continued to see it as a preparatory examination which was necessary only for the sake of meeting university requirements. To make matters worse, since IA marks were added to the final marks, it was abused to inflate the total marks obtained by students (or sometimes to penalize students who were not in the good books of examiners). A number of dishonest practices were reported both in the scientific as well as lay literature. The net result was that IA was branded ‘unreliable’, subjective and prone to abuse.

The current medical education scenario in India is about to witness rapid changes and planners have rightly realized the importance of training to ensure that the changes percolate down to the level where they have to be actually implemented. This is crucial because the proposed changes are going to be a culture shock for many medical teachers. A number of training programmes will probably be organized. However, going by our past experience, most of this training is unlikely to make any impact on the medical education scenario, at least in its present form. Is training the only input we require for successful change? We have been training medical teachers in educational methods for over three decades now. Though there are no data to this effect, there has hardly been any change (with a few exceptions) in medical education as a result of such training. In the majority of instances, the change seems limited to the reactions of the participants (who praise the training programme) and short-term gains in knowledge (measured by multiple-choice/short-answer questions of doubtful value). Everyone seems happy with the bar diagrams of pre- and post-test scores.

UTILITY OF TRAINING

There is no doubt that medical colleges need to view training as an investment to improve productivity and ensure quality. Why is it that medical colleges do not hesitate to nominate faculty for an expensive training course in neuroimaging but are reluctant to send teachers for low-cost training, such as in teaching methodology? The reasons are not difficult to guess—any manager would like to see training and development programmes produce tangible and measurable benefits. In contrast to clinical training, it is generally difficult to show tangible gains from teacher training, especially in a short period of time. While rightly pointing out that it is difficult to prove the outcomes of faculty development (FD) programmes, Guskey suggests that we can surely collect evidence to show that these programmes produce certain outcomes. Given the complicated nature of change, the impact of FD programmes is difficult to capture in the commonly used narrowly defined quantitative studies. However, a large amount of qualitative data is beginning to appear and supports the premise that FD makes an impact.7

There is a common belief that faculty training should immediately result in an improvement in the students’ grades. Some Deans tend to gauge the effectiveness of faculty training by the number of distinctions in a class, while others consider parameters such as whether the participants are nominated for best teacher awards. In this context, it may be noted that no training is required to give undeserved distinction to half the class. Also, as teachers become more aware of the intricacies of assessment in terms of its validity and blue-printing, there may be an initial decline in the marks awarded to students. Later, as expectations become clearer on both sides, the performance of students improves. It is worth remembering that given the present scenario with respect to assessment, it is unwise to think that
marks represent the true ability of a student. Also, the aim of teacher training is not to develop ‘popular’ teachers, but to produce better teachers.

Teachers who have received training in instructional methodology do not teach differently. To clarify this, one can cite a parallel situation—that of the treatment of a patient of enteric fever by a quack and by a qualified doctor. The overt actions taken by the two are not different. Both will order blood tests and prescribe the same antibiotics. While the quack will do it as a matter of routine, the qualified doctor will do it after giving it careful thought. The latter is also likely to pay attention to matters such as protecting the patient’s family members and to suggest steps to prevent the disease from spreading. In addition, she/he will keep in mind the sensitivity pattern of the antibiotics before selecting one. This analogy applies to untrained and trained teachers as well.

Teacher training has failed to get its due as the outcomes are not immediate, and worse, they are not defined and measured. According to Clarke and Hollingsworth, the development of teachers following FD is non-linear and greatly influenced by school support. No doubt teacher training initiates a change, but that change occurs in the way a teacher views, conceptualizes and promotes learning. Swan and Swain have reported that training has a profound effect on the behaviour and practices of teachers. Teaching practices become less transmission-oriented, and there is a shift to discovery and connectionist approaches. The teachers begin to create more collaborative learning environments, challenging the students to confront difficulties. The effects of FD go well beyond simple changes in teaching. Research has suggested that teacher training leads not only to development as a teacher (teaching ability), but also intrapersonal development (changes in the self and approaches to self-management), interpersonal development (interaction with others) and career development (professional growth and career opportunities). Since such research has hardly been thought of in Indian medical education, we hesitate to accept the utility of teacher training.

TRAINING AND ITS APPLICATION

Training is a costly affair. The direct costs (travel, stay, course fee, etc.) are very high, as are the opportunity costs (lost work, spending on replacements, etc.). These costs are justified only if the trainees go on to apply their new knowledge and skills in their institutions. This process, known as transfer of training, is vital to the success of any training intervention. Transfer of training has proved to be a challenge worldwide and only less than 10% of what is learnt during any training is applied on the job.10,11

There have been valid concerns about the lack of transfer of training and experts generally agree that it does not reflect on the quality of the trainers or the training. The fact is that learning is an ongoing process rather than a product or an event. When we utilize a training mindset, we tend to classify people as untrained or trained and training is seen as an input to change the status of a person from untrained to trained. However, repetition of new knowledge and skills are applied in the work environment, at all stages of the process—before, during and after the training, requires an effort. Much of this effort may need to be directed outside the training room because that is where transfer actually takes place. The strategy stresses that training or trainers alone cannot attain the desired goals. Together they can achieve certain objectives, but the outcomes of training additionally depend on a number of organizational factors.

For a training design to be transfer-oriented, it must consider the characteristics of individual trainees. These include their levels of skills and motivation, ability to learn and apply knowledge, learning style, personality factors (attitudes and values), level of education, age, life experiences, degree of burn-out and expectations from training. An equally important factor to be taken into consideration is the trainees’ environment. This includes the degree of support or interference the supervisor shows with respect to learning, technology, the training, the personnel and the administrators. In many research situations, peer support has emerged as the most important factor favouring the transfer of training.12 Similarly, the value that an organization attaches to training makes a difference to the extent of the use of the skills acquired during training. Training receives a low priority in many medical colleges where there is tension between the role of the teacher as an innovator, administrator and service provider.

BARRIERS TO TRANSFER OF TRAINING

Seniors often exhibit a number of negative behaviours with respect to training, especially when the venue of training is within
the organization. These include reluctance to release teachers for training; calling them away from training; expecting them to ‘get back to work since they are back from a holiday’; asking them to carry on teaching as usual and not allowing them to apply new skills; and ignoring their own role in promoting transfer. Seemingly innocuous remarks by supervisors have the potential to block the transfer of training. Some examples are: (i) ‘It is good to go for such training, but I know that this will not work in our college,’ (ii) ‘It is a good method, but it is not realistic in our setting,’ and (iii) ‘This training will be useful only if you can ensure a good result.’ Many of the common barriers to participation also become barriers to the transfer of training.

Although training is not like an immunization shot, there are some similarities between the two. As in the case of immunization, it takes time to develop antibodies (read: desired behaviours). Adjuncts (read: organizational support) can improve the efficacy of the intervention. The absence of interfering factors (read: negative atmosphere) helps with the development of immunity. Levels tend to dip over a period of time and boosters are required (read: periodic training).

THE WAY OUT
The existence of a problem with the transfer of training implies that individuals who have been trained are not improving their behaviour or performance on the job, and such training is unlikely to affect the organization’s performance. Saks and Belcourt have reviewed the literature and suggested some activities which will aid in the transfer of training (Table I). Broadly, these can be divided into activities that may be undertaken before, during and after training.

Before training
The most important factor during this phase is support from the supervisor, i.e. the dean or departmental head in our context. It has been suggested that the supervisor should meet the faculty to discuss what the training is about and to set training goals, provide them protected time to prepare for training, and plan a post-training assessment. Pre-training preparation helps to enhance the potential trainees’ belief in their self-efficacy. Involving trainees in the process of the assessment of needs and offering them a choice of training programmes is also useful. It is interesting to note that nomination or grant of leave for training alone is not considered to constitute supervisor support.

During training
Training designs which follow adult learning principles are more likely to result in the transfer of training than other designs. In such training programmes, trainees are involved in the discussion process, given and encouraged to do problem-solving exercises, and allowed to reflect on what they have experienced and to provide feedback. This helps them to construct rather than passively acquire knowledge. Using multiple training methods and teaching the general principles that underlie the application of particular skills are also likely to promote the transfer of training.

Keeping the training environment as close as possible to the work environment helps the trainees transfer learning to work. As an example, microteaching sessions using video recordings may make training interesting, but may not aid in the transfer of training as the trainees are unlikely to have access to such facilities at their workplace.

Teachers have to be provided enough opportunities to apply their new skills. For example, training in OSCE will turn out to be futile if the teachers have no opportunity to use it during assessments. Over a period of time, the knowledge and skills acquired through such training are likely to be lost. Conversely, ongoing changes can provide a good opportunity to apply skills. Acceptability and use of methods such as integrated teaching are likely to be more in the present scenario.

After training
Constraints and obstacles in the post-training environment can interfere with the transfer of training. For example, if projectors are not available, training in the use of PowerPoint will be rendered useless. Rigid university regulations will interfere with innovations in assessment. Social support from peers, supervisors and students plays a major role in the transfer of training. Formal and informal rules can help to clarify responsibility for such transfer. For example, when trainees are required to report back what they learnt during training and how they plan to use this knowledge during the course of their work, transfer of training is promoted. On the other hand, transfer is hindered when the college management tells the trainees to get back to work ‘as they have had enough of a holiday’. Booster training and relapse prevention training are also good examples of post-training interventions.

Research has shown that pre-training and post-training activities have a greater influence on the transfer of training than activities undertaken during training.

CHANGING THE EVALUATION PARADIGM
There is a need to change the way we look at the evaluation of training. At present, evaluation of teacher training focuses on reactions (i.e. whether the teachers liked it) and short-term gains in knowledge (often tested by short-answer or multiple-choice questions). Such evaluations go against the very concept of what is being taught. For example, most training in assessment stresses the need for testing in context and using tools to test the application of knowledge, but most often, non-contextual, recall type of questions are used to evaluate such training. This must be making the participants wonder about the discrepancy between what the trainers are preaching and what they are doing.

It has been shown that there is no relation between the transfer of training and positive reactions to a training programme or short-term learning. A meta-analysis by Alliger showed only a very weak correlation between reactions of any type and learning, making the authors conclude that reactions cannot be used as a surrogate for other measures of the effectiveness of training. Utility reactions (i.e. use of the training as perceived by the trainee) seem to be more useful in predicting the utility of training than affective reactions. In fact, we have discarded the use of affective reactions, as well as of pre/post tests, in our training programmes and are using only utility reactions. To get back to the Kirkpatrick model, there is no linear relationship between levels 1–2 and 3–4. The evaluation of training needs to move beyond levels 1 and 2 so that it can provide some hard data on the behavioural and organizational change brought about by the training.

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**Table I. Salient interventions to promote transfer**

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<tr>
<th>Category</th>
<th>Interventions</th>
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<tbody>
<tr>
<td><strong>Before training</strong></td>
<td>Supervisor support, trainee input and involvement, pre-training preparations</td>
</tr>
<tr>
<td><strong>During training</strong></td>
<td>Training design using principles of learning, knowledge of results and feedback</td>
</tr>
<tr>
<td><strong>After training</strong></td>
<td>Transfer climate of the institution, organizational support, post-training follow-up programmes</td>
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CONCLUSION
Transfer of training means a change in work behaviour following training. Transfer is the key concept underlying any training because the goals of training are not achieved unless the knowledge and skills taught are transferred. Strategies need to be devised to not only encourage factors which promote transfer, but also minimize factors which inhibit transfer. Training serves no purpose if the knowledge is not put to productive use and the trainee simply hoards facts. Let us view FD as an activity aimed at improving teaching and assessment rather than merely increasing the number of those trained.

REFERENCES