Supporting Pacific clinicians' medical education practice change through faculty development: A qualitative case study

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Abstract

Introduction: In the Pacific region, there is a growing need to support medical education and supervision. Following a faculty development initiative, we pondered a question: To what extent and how do Pacific clinicians change their educational practice in a low-resource setting? Current medical education literature advocates exploring educational change in different contexts. Therefore, we aimed to expand current understandings of educational change and provide recommendations for enhancing faculty development in low-resource settings by exploring if and how clinicians in Fiji translated knowledge learnt during faculty development to their educational practice.

Methods: Utilising a qualitative case study approach, we recruited nine clinicians through purposeful sampling. Data collection occurred over 3 months through reflective journals, interviews, lesson plans and videos of teaching. All data were subjected to thematic analysis.

Results: Six themes represented the Pacific clinicians' educational journey: 1) perception of faculty development, 2) reflecting on and evolving educational philosophy, 3) adapting and changing practice, 4) clinicians' perception of student responses to their teaching, 5) inhibitors to change and 6) enablers of change.

Conclusions: We further conceptualised the themes into an educational change model. Our results, together with the international literature, guided key recommendations for medical education faculty development in low-resource settings. The key recommendations included considering cultural organisational influences, clinicians' prior educational experiences and local enablers and barriers to changing educational practice when developing relevant faculty development programs. Furthermore, clinicians in low-resource settings, such as the Pacific, require support through mentorship, flexible

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learning, feedback, developing communities of practice and the promotion of reflective practice to facilitate sustainable educational change.

Keywords: medical education; faculty development; case study; qualitative; Pacific

Introduction

The World Health Organization (WHO) (2013) and experts in medical education (Bligh, 2005; McLean et al., 2008; Steinert, 2020) strongly advocate for medical education faculty development to improve educational practice, student learning and, ultimately, patient outcomes. However, a more global view of medical education faculty development translation is essential to foster clinicians' skills in educating the next generation of health professionals in diverse educational settings (McLean et al., 2008; Ramani & Leinster, 2008; WHO, 2013). The translation of knowledge and skills from faculty development to educational practice is highly contextual and needs to be better understood (Leslie et al., 2013; Steinert, 2020; Steinert et al., 2016). Currently, there is no standardised framework for faculty development, and arguably, a "one-size-fits-all" is inappropriate, as the educational and cultural needs of the faculty and institution need to be considered when designing programs (Justin et al., 2020; McLean et al., 2008; Sorinola et al., 2017). Nevertheless, most medical education courses aim to cover generic topics such as educational theories, feedback and assessment (Swanwick, 2008) but don't always consider the cultural and geographical contexts these occur in (Steinert, 2020), which may affect knowledge translation and practice change. Three international systematic reviews have found that participants appreciate faculty development, with mainly self-reported changes in medical education knowledge, skills and attitudes (Leslie et al., 2013; Steinert et al., 2016; Steinert et al., 2006). These reviews identified a need for more qualitative research into "how" clinicians navigate the translational space of using new knowledge and skills to change educational practice. This recommendation was further advocated by studies conducted in low-resource settings, which also relied on participant satisfaction and self-reported change evaluation (Kim et al., 2015; Mojtahedzadeh & Mohammadi, 2016). After developing a culturally and contextually relevant faculty development initiative for the Pacific (Sweet et al., 2018), with positive evaluation findings on satisfaction and increased confidence (Young et al., 2019), the following questions arose: How do clinicians in low-resource settings experience this translation of knowledge to practice change? What support do they require and how can sustainable change be fostered? There was a clear need to explore clinicians' process of knowledge translation for educational practice change, especially in low-resource settings, to further our understanding and to guide relevant faculty development.

Guided by Kirkpatrick and Kirkpatrick's (2006) evaluation framework, this research aimed to move beyond levels of satisfaction and knowledge acquisition and focus on their third level of practice change. Thus, the main aim of this research was to investigate "if" and "how" faculty development led to knowledge translation and educational

practice change in a low-resource setting. To answer this question, clinicians' post faculty development experiences were investigated to further understand if and how their educational practices changed and, based on this, what factors were important for translating knowledge and skills into practice in this context. The findings from this research are unique to the Pacific setting, however elements that resonate can be used in other low-resource settings to guide faculty development. Furthermore, the research adds to the current international literature to support claims that faculty development is more than just delivering training to promote sustainable educational change.

Methods

Using a qualitative case study approach (Baxter & Jack, 2008; Creswell, 2007; Merriam, 1988), the experiences of clinicians were explored in their natural environment utilising several data sets, including both self-reported and observed data (Merriam, 1988). The case was bound by clinicians who had attended a 5-day faculty development workshop focusing on learners, learning, feedback and assessment and were currently working at the Fiji National University (FNU). Details of the faculty development workshop can be found in a previous publication (Sweet et al., 2018). Nine of the 20 eligible clinicians volunteered after purposeful recruitment 6 months after the faculty development workshop. All clinicians were active educators at FNU, and each chose a pseudonym. Over a 3-month period, from May to July 2018, data were collected through reflective journals, two individual interviews, written lesson plans and observation of teaching sessions, which were videorecorded.

First, reflective journals allowed the clinicians to record their thoughts about an educational session contemporaneously and without influence from the researcher (Alaszewski, 2006). The journal included guiding questions such as "The good, the bad and the surprising: what went well and what would you like to improve next time, why?" The clinicians were asked to reflect on a teaching session each week for 6 weeks.

Second, two semi-structured interviews, as initially planned, were conducted by the principle researcher (SK). One explored the clinicians' journal entries further, and the second was guided by early data analysis, observed teaching practice and the translation of knowledge into practice literature (Billett, 2013; Eraut, 2004; Fullan, 2015; Onyura et al., 2015). Interview questions included: "Have you changed your teaching practice since the workshop? In what way? What influenced the decision to change?" and "What things helped or hindered making a change?"

Third, clinicians were asked to provide a lesson plan for one lesson. Lessons were observed and videorecorded across a range of educational settings: classroom tutorials (n = 4), clinical skills training (n = 2) and clinical teaching with patients (n = 3). This was important to corroborate teaching intentions and actual educational practice (Fitzgerald et al., 2013). SK was known to the participants as she was involved in conducting the

faculty development and had been a work colleague. At the time of the research, SK was based in Australia and had no authority over the participants or their teaching practice.

Data analysis

The interviews were transcribed verbatim, and each clinician's data were analysed in detail through transcription and rereading the interviews and journals and comparing the lesson plans to the videos of teaching. The videos were analysed using peer observation of teaching forms that encompassed the faculty development learning outcomes. Each clinician's data set was then narrated as a mini-case study with substantiating quotes before looking for shared codes and themes across all data sets (Braun & Clarke, 2006; Creswell, 2007; Merriam, 1988). An excerpt from one clinician's mini-case study is provided in the results selection.

Braun and Clarke's (2006) thematic analysis was used to inductively analyse the data, which included becoming immersed in the data by transcribing and rereading, assigning codes, developing themes and further refining themes to develop a model of educational change. To illustrate each theme, substantiating quotes have been used from the interviews, journals and researcher observation notes. Whilst interpreting the data, biases were bracketed through reflexivity by keeping a journal and discussing findings with GB and IL to improve confirmability. Trustworthiness and credibility were enhanced through data and investigator triangulation, using several data sources. Two independent people (SK and GB) interpreted the initial data, and data were collected over a 3-month period. Member checking, where participants checked their transcripts and endorsed both the narrative and thematic findings, also enhanced the trustworthiness of the findings (Creswell, 2007; Frambach et al., 2013; Pope et al., 2000).

Ethics approval

Ethics approval was granted from both the University of Western Australia and Fiji National University (UWA – RA/4/20/4300; FNU – CHREC 2018.58.C.D) to conduct this research.

Results

The demographics and pseudonyms of the clinicians are provided in Table 1. In addition, their engagement with the research activities is reported. An excerpt from one clinician's (Alice) narrated mini-case study is provided as an example (Figure 1). Including all nine mini-case studies is beyond the scope of this paper, so the remainder of the results reported focus on the shared themes.

Table 1

Demographics of Participants and Research Engagement

Pseudonym	Role	Years of Educational Practice	Gender	No. of Journal Entries	No. of Interviews
Alex	PBL tutor	4	F	4	2
Alice	PBL tutor	2	F	6	2
Arthur	Junior specialist	5	M	6	2
Clive	Senior specialist	30	M	0	2
Jenny	PBL tutor	3	F	1	2
John	Junior specialist	6	M	1	2
Julie	Senior specialist	20	F	1	1
Pretty	PBL tutor	2	F	6	2
Warren	Senior specialist	40	M	1	1

Figure 1

Alice's Story

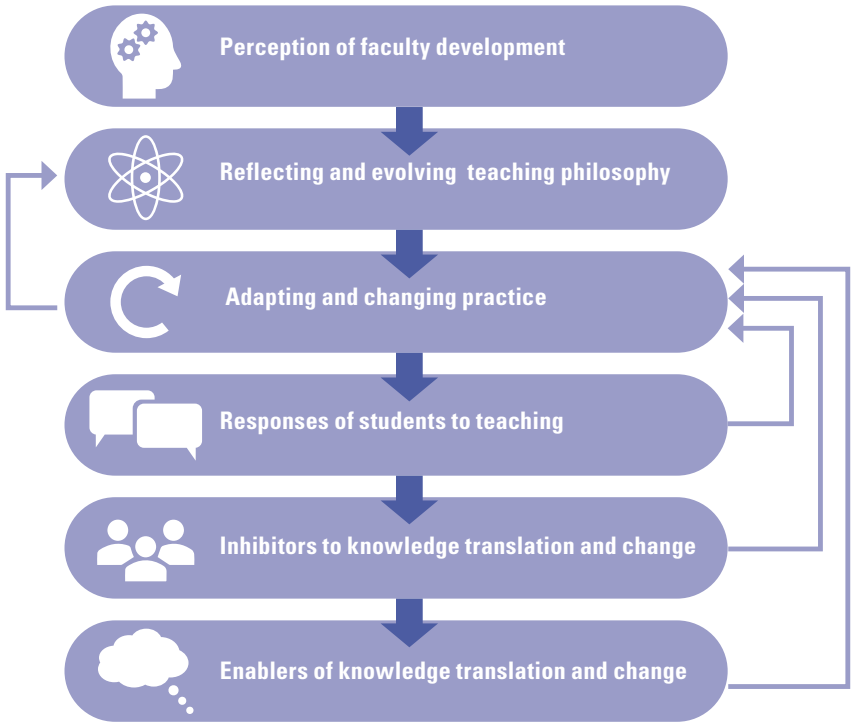
Alice: The struggling new tutor wanting to improve

"The difficulty I have is giving effective feedback, because of the time, so much to do. So in the future I would want to see myself as an effective tutor."

Alice said she initially struggled because there was little support or preparation for her new role. She described her tutorial as "office meetings" with everyone seated quietly with pens poised. Alice stated that through the medical education faculty development and reflective journal use, she identified strategies to improve the tutorial process, assisting students to become engaged as active learners. Alice also identified difficulties she faced, including a paucity of appropriate teaching spaces and a lack of time for faculty development.

Figure 2

Themes Identified



Themes identified

After comparing and contrasting each clinician's narrated mini-case study, six representative themes were identified (Figure 2). The first theme embodies the clinicians' perception of faculty development and how useful they find it. This led to the second theme of faculty development enabling reflection on their educational philosophy, which resulted in the third theme of adapting and changing educational practice. The fourth theme addresses clinicians' perceptions of student responses to their teaching. The fifth and sixth themes were factors "inhibiting" and "enabling" knowledge translation and practice change, respectively. Inhibitors were represented by four subthemes: time, increasing student needs, clinicians resisting change and university infrastructure and processes. The two enabling subthemes were current university assistance and the clinicians' recommendations for the future.

Theme 1: Perception of faculty development

Clinicians' perceptions of the medical education faculty development appeared to be influenced by their educational experience. Two of the three senior specialists did not find the faculty development very helpful. Conversely, all clinicians with less than 6 years of teaching experience embraced the educational concepts presented in the faculty development:

> *It really just reinforces what we have already been doing.* (Julie, senior specialist, Interview 1)

> *I think that's a good way of giving feedback to students and the micro-skills because it's evidence-based. … So now I teach them that way.* (Jenny, PBL tutor, Interview 1)

In addition, those clinicians who did not perceive the faculty development as useful did not provide a reflective journal entry or provided one that was mainly descriptive, which made it difficult to find evidence of reflection and practice change. The first step identified for changing practice was personally valuing the educational principles presented during faculty development. Once valued, clinicians began reflecting on their educational philosophy.

Theme 2: Reflecting and evolving educational philosophy

Clinicians' educational philosophies were stimulated through engagement in the workshop, with many experiencing insights and reflecting on their medical educator role to facilitate learning:

> *After undergoing this medical education workshop, it has really changed parts of my teaching and looking at it from the students' point of view.* (Warren, senior specialist, Interview 1)

> *After the workshop, I have been more conscious about my responses and my way of interacting with students so that they might benefit from that interaction.* (Arthur, junior specialist, reflective journal entry 1)

The clinicians' evolving educational philosophy was demonstrated through the reflective journals and interviews, which provided space for clinicians to reflect and led to many becoming more student-centred in their educational philosophies.

Theme 3: Adapting and changing practice

Self-reported changes to teaching practice were corroborated with lesson plans and observed teaching practice. Six clinicians demonstrated evolving educational techniques:

> *Giving them feedback … one thing I have learnt and I have stuck with is giving the positives first to the students. I wouldn't say bad or negative feedbacks; I would say "gaps" identified with the students and where I think they can improve.* (Jenny, PBL tutor, Interview 2)

> *The teacher provided specific feedback at the end of each case, focusing on one positive element and one area for improvement. She also gave feedback at the end on general things done well and the gaps that need addressing.* (Researcher (SK) observation of teaching)

> *I remembered the four parts of skill teaching but ended up modifying it to my teaching style. I thought it was still well received.* (Arthur, junior specialist, reflective journal entry 2)

> *Arthur used Peyton's four-step approach in a modified way. [He] changed order and omitted one student step.* (Researcher (SK) observation of teaching)

Three clinicians who reported changing educational practice did not obviously demonstrate this during the observed lesson:

> *I thought about the arrangement. … I usually do not. … I just come in and sit down, … but now I feel I should be included in the group discussion, with [the students] in the arrangement.* (Alice, PBL tutor, Interview 2)

> *The room was cluttered. The "horseshoe" arrangement did not quite work because of the extra chairs.* (Researcher (SK) observation in videoed lesson)

Importantly, each clinician's learning journey was unique, and they used different concepts from the workshop to inform their evolving educational practice.

Theme 4: Clinicians' perception of student responses to their teaching

Most clinicians perceived that their students were benefitting from their changing educational practice, reporting that student attendance and assessment marks had improved. Additionally, students were requesting the new educational techniques, such as Peyton's four-step approach for teaching a clinical skill, for other classes. However, attributing all the improvements to changes in educational practice from one workshop is difficult, as Arthur noted:

> *Some groups I had last year were very demotivated, but this year they are very motivated. So, it's difficult to say it is because of different teaching styles, but I think whatever group it was, this is a better way of teaching them.* (Arthur, junior specialist, Interview 2)

Some senior clinicians were also reluctant to seek student feedback, recognising the existence of a hierarchical and patriarchal cultural context:

> *Like old time teaching, we are the boss; the students are the students. I am trying to change, but if I ask, and the students bluntly say, "You are wrong here", then I might feel it. That's the only reason I am holding back, but I will do it.* (Warren, senior specialist, Interview 2)

In addition, cultural hierarchical influences may have hindered students' willingness to give feedback:

> *I have never had anyone say anything different. I don't know what they are thinking. … I haven't had any feedback yet.* (Arthur, junior specialist, Interview 2)

> *I just ask generally during my sessions, and they say they are OK with both.* (Pretty, PBL tutor, Interview 2)

Interestingly, reluctance to receive feedback was not specifically perceived as an inhibitor to change by the clinicians.

Theme 5: Factors inhibiting knowledge translation and change

Four subthemes of inhibiting knowledge translation and change to educational practice were identified, including lack of time, increasing student needs, senior clinicians resisting change and university infrastructure and processes. First, a lack of time for faculty development is experienced by clinicians in remote low-resource settings due to multiple clinical, administrative and educational roles:

> *I haven't had time to really read much medical education stuff.* (Alex, PBL tutor, Interview 2)

> *In resourced countries, it's OK, they have a team of 10, but here, you are everything. It comes at the cost of teaching and patient care.* (Clive, senior specialist, Interview 2)

Second, with increasing student numbers and the growing needs of Pacific regional students, clinicians in Fiji felt that education and supervision were being compromised:

> *Our student numbers are more; time is less. So it is just testing us.* (John, junior specialist, Interview 1)

Third, there is a perception that changes to promote educational best practice are not always supported by senior clinicians who have not attended faculty development:

> *Some are senior to me and are difficult to approach. … I find it hard to say I want this standard method.* (Pretty, PBL tutor, Interview 2)

Lastly, university infrastructure was identified as inhibiting change, including a lack of teaching spaces, staff shortages and laborious university administrative processes:

> *Hindrances would be space. The clinical skills lab is relatively spacious, but it can still feel crowded.* (Alex, PBL tutor, Interview 2)

> *I wish the university would let us do our teaching the way we think it should be done. This points system is driving me crazy.* (Julie, senior specialist, Interview 1)

These challenging conditions in this low-resource setting make it difficult for some clinicians to find time to reflect and change their educational practice.

Theme 6: Factors enabling knowledge translation and change

The clinicians also identified enablers for knowledge translation and changing educational practice and provided some key recommendations for this low-resource

setting. Current enablers included a supportive head of school and dean, collaboration with Australasian universities and emerging communities of practice:

> *It helps that everyone has attended the workshop. We all have a bit of background, so we sometimes discuss. I was discussing Pendleton's and SET GO [feedback models] with Susan.* (Alex, PBL tutor, Interview 2)

Future recommendations included improving university infrastructure and more responsive medical education faculty development through mentorship and flexible learning:

> *Maybe as a CME [continuing medical education] on a Friday, "How medical education is changing". Also, I would like to enrol in some course that is flexible.* (Arthur, junior specialist, Interview 2)

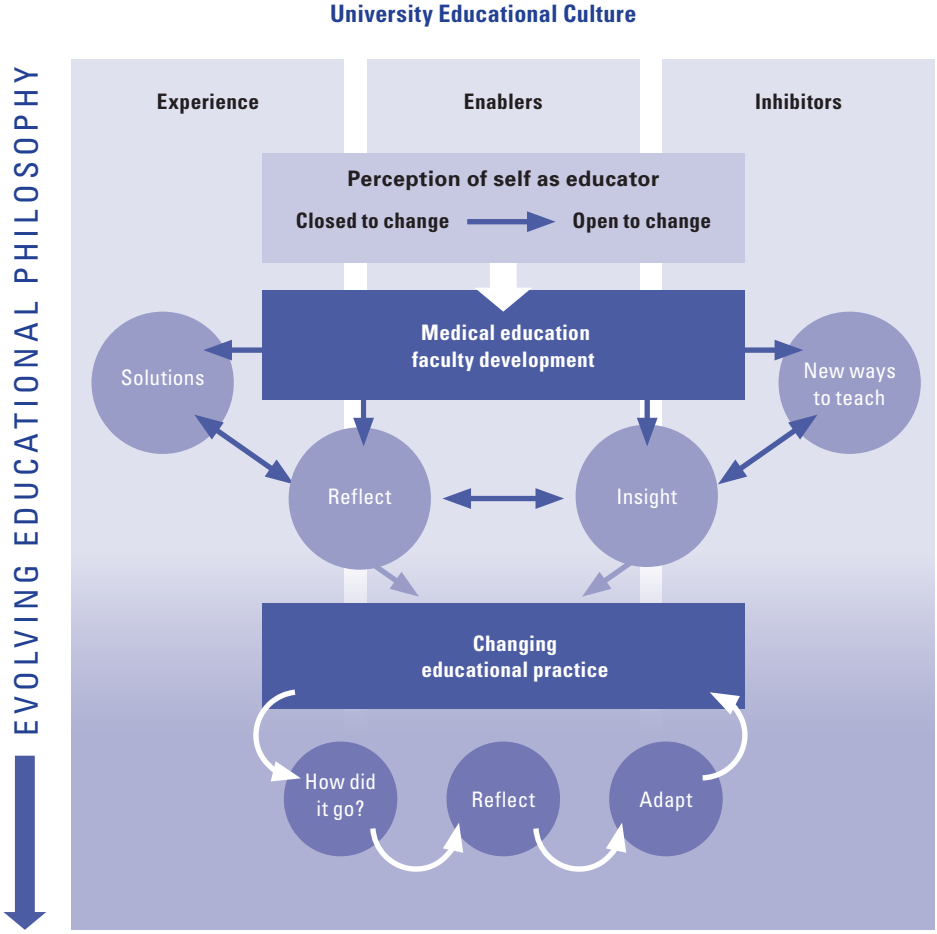
> *I would definitely welcome some peer learning and guidance please.* (Jenny, PBL tutor, Interview 1)

Discussion

To answer the question "If and how do clinicians in low-resource settings utilise faculty development initiatives to change their real-world educational practice?", six themes were identified that represented their educational journey. This led to the development of a model for educational change to help explain the interrelated themes of how clinicians in Fiji are translating knowledge and changing their educational practice (Figure 3). This model highlights how Fijian clinicians' perspectives of themselves as educators impact their perceptions about faculty development and their openness to evolve and change their educational practice. This is influenced by three main factors: clinicians' personal educational experiences and the enablers and inhibitors of change. These three main factors are further shaped by the university educational culture. Clinicians who perceive faculty development as useful begin reflecting upon and evolving their educational philosophy and practice in several key ways. First, faculty development provides solutions to existing educational problems. Second and third, it affords clinicians time to reflect and gain valuable insights for improving their educational practice. Fourth, faculty development provides new techniques applicable to their current educational practice. The university culture, clinicians' educational experience and inhibitors and enablers of change influence the intention to change and whether it becomes a reality. This is also dependent on clinicians' individual capacity to evaluate the impact of, reflect upon and adapt to the changed educational approach. The model is underpinned by the clinicians' changing educational philosophy, which evolves during their entire journey. It is acknowledged that this is a dynamic and iterative process rather than a linear development, with the background influences significantly impacting the process of change. The model can act as a guide to the complexity of factors that influence knowledge translation and practice change following faculty development.

Figure 3

Model of Educational Change



These findings are corroborated, in the main, by research conducted in Western settings but highlight and provide evidence for the support required in low-resource settings for medical education faculty development. The following discussion provides empirical support for the themes identified and a series of recommendations for how faculty development can be supported in low-resource settings similar to Fiji and the wider Pacific context.

The initial theme identified that clinicians' perceptions of the usefulness of the faculty development were influenced by past educational experiences that have shaped their existing educational beliefs. Previous qualitative research supports this finding, advocating that clinicians need to understand themselves as educators prior to making

change (Ash, 2009; Pololi & Frankel, 2005). It is also widely acknowledged that individuals' experiences impact on their ability to reflect and change (Billett, 2013; Steinert, 2017), which is why Morris and Swanwick (2018) suggest that it is essential to consider clinicians' worldviews when designing faculty development initiatives.

Reflective practice influenced the second and third themes—evolving educational philosophy and adapting and changing practice—and is consistently argued as key to transforming practices (Higgs & Mcallister, 2007; Schön, 1991; Sorinola et al., 2017). Reflective practice was not witnessed in all clinicians during this study, however it is purported that reflective practice can be learnt and improved through practice and mentorship and, therefore, should be a key component in faculty development programs (Mann et al., 2007; Sandars, 2009).

The fourth theme highlighted the need to establish and formalise culturally situated student feedback to assist clinicians to improve their ongoing educational practice. Student feedback is common practice in the Western world (Moore & Kuol, 2005), and although it is advocated to improve educational outcomes (Goldie, 2006; Ramani & Leinster, 2008), there can be resistance to giving feedback if perceived as a tick-box activity (Moore & Kuol, 2005). In the Pacific cultural context, where respect for elders is central, obtaining honest and constructive student feedback can be challenging.

The fifth and sixth themes are inhibitors and enablers. Inhibitors included increasing demands from clinical work, research and teaching (Ramani & Leinster, 2008; Steinert, 2012), resulting in a lack of time, and are often cited as barriers to faculty development (De Golia et al., 2018; Higgs & Mcallister, 2007). This is particularly true in low-resource settings, where poor university infrastructure and processes compound the above issues (McKimm et al., 2018). Senior colleagues' resistance to change was not addressed specifically by the literature, however motivation to change is identified (Sorinola et al., 2017), and those with substantial educational experience who are nearing retirement may lack this motivation to change. Identified enablers were often solutions to inhibitors and included the need for advocated university support (McLean et al., 2008; Searle et al., 2011; Sorinola et al., 2017) and facilitating communities of practice through peer support (Cruess et al., 2018) and reflective practice (Schön, 1991) to promote educational change.

Overall, this research found that educational practice change was unique to the individual and substantially influenced by participants' prior knowledge, beliefs and values. However, the degree of educational change varied, with enablers being university and peer support and inhibitors including a lack of resources and time. These findings are supported by seminal educationalists Fullan (2015), Eraut (2004) and Billett (2013), who respectively posit that change occurs within a social context—peers support each other to reflect and change, while a lack of resources and time are inhibitors to changing behaviours. Additionally, this research highlighted the importance of cultural and institutional contexts, which are essential to consider in developing medical education

faculty development initiatives as advocated elsewhere (Justin et al., 2020; Morris & Swanwick, 2018; Sorinola et al., 2017; Steinert, 2017).

In Fiji's low-resource setting, there is a paucity of formal courses, feedback, time for reflection, mentorship and communities of practice for educators. These activities have been included in a framework for faculty development by Steinert (2010) and are considered important to enhance educational change. The framework encompasses learning through formal, informal, individual and group learning, with mentorship at the centre. Low-resource settings may find this difficult to achieve. So, how can medical educators in low-resourced settings be supported in their educational journey?

Implications for faculty development and further research in low-resource settings

Drawing on the results from this research and the international literature, the implications for faculty development in low-resource settings led to a series of recommendations. First, as engagement with the faculty development was inconsistent, we postulate that it may be advantageous to involve clinicians and faculty in designing medical education programs that are culturally and situationally relevant. This could increase engagement with faculty development initiatives and meet the educational needs of both the individual and the institution (Justin et al., 2020; Steinert, 2017). Second, reflection was not always evident but is considered central to practice change, therefore reflective practice needs to be taught and promoted to provide clinicians with opportunities to develop skills to reflect and evolve their educational practice (Mann et al., 2007). Third, clinicians expressed a need for more university support in addition to faculty development. In low-resource settings, clinicians require support for educational practice change through mentorship, flexible learning, communities of practice and regular feedback (Cruess et al., 2018). This can be achieved by the university valuing educational practice and prioritising educational development by providing space and time for faculty development (McLean et al., 2008; Sorinola et al., 2017) and enlisting sustained support from established medical education institutions (Hill et al., 2021; Justin et al., 2020; McLean et al., 2017).

Further research is required to investigate which of the factors identified in this study are most important in influencing clinicians' sustained change in educational practice and how to engage more experienced clinicians in faculty development as well as to investigate the impact on student learning. In addition, although the model of educational change developed in this research is supported by mainstream faculty development literature, confirmation of its applicability to other low-resource settings is needed.

Strengths and limitations

The strengths of this study include: collecting multiple sources of data to provide a rich description of the themes identified; specifically documenting educational practice change through observation, as previous studies have mainly relied on self-reported data (Steinert et al., 2016); and going beyond the themes to conceptualise a model for educational

practice change (Merriam, 1988). Thus, with its focus on a low-resource setting, this research provides a unique perspective on how educational knowledge translation and practice change occurs and what type of formal, informal and mentorship structures are required for sustained educational practice change.

While this study affirms the need to grow faculty development in low-resource settings, it must be acknowledged that it is only a small snapshot of clinicians in Fiji who attended one medical education faculty development initiative, and further research is required to substantiate the results. Furthermore, evidence of practice change would have been strengthened through observation prior to the faculty development program and multiple observations over time, and there is the possibility that more subtle practice change was not perceived by the researcher. As the researcher who helped conduct the faculty development initiative was known to the participants and considered an "insider", there is the potential for bias. This was minimised by using reflexivity, independent coders and member checking at each analysis stage. Strengths of having an "insider researcher" were that trust had been built with the participants, and they were willing to share their honest perspectives, and the researcher had an understanding of the cultural context.

Conclusion

This case study supports existing literature on the contextual nature of educational change and gives insight into the individual and contextual factors that, in this case, influenced health educators' translation of new knowledge and skills into changing their own educational practice. At a time when formal faculty development is growing in the Pacific, this research adds to a growing understanding of the enablers and barriers clinicians face in low-resource settings and their need for support from established institutions through mentoring, low-cost flexible learning, communities of practice, feedback and collaboration to facilitate sustainable educational change.

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Conflicts of interest and funding

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References

Alaszewski, A. (2006). *Using diaries for social research*. SAGE. https://doi.org/10.4135/9780857020215

Ash, J. (2009). Understanding clinical teaching in times of change. *The Clinical Teacher*, *6*(3), 177–180. https://doi.org/10.1111/j.1743-498X.2009.00294.x

Baxter, P., & Jack, S. (2008). Qualitative case study methodology: Study design and implementation for novice researchers. *The Qualitative Report*, *13*(4), 544–559. https://doi.org/10.46743/2160-3715/2008.1573

Billett, S. (2013). Recasting transfer as a socio-personal process of adaptable learning. *Educational Research Review*, *8*(9), 5–13. https://doi.org/10.1016/j.edurev.2012.05.004

Bligh, J. (2005). Faculty development. *Medical Education*, *39*(2), 120–121. https://doi.org/10.1111/j.1365-2929.2004.02098.x

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Creswell, J. W. (2007). *Qualitative inquiry and research design: Choosing among five approaches* (2nd ed.). Sage.

Cruess, R. L., Cruess, S. R., & Steinert, Y. (2018). Medicine as a community of practice: Implications for medical education. *Academic Medicine*, *93*(2), 185–191. https://doi.org/10.1097/ACM.0000000000001826

De Golia, S. G., Cagande, C. C., Ahn, M. S., Cullins, L. M., Walaszek, A., & Cowley, D. S. (2018). Faculty development for teaching faculty in psychiatry: Where we are and what we need. *Academic Psychiatry*, *43*(2), 184–190. https://doi.org/10.1007/s40596-018-0916-4

Eraut, M. (2004). Transfer of knowledge between education and workplace settings. In A. Fuller, A. Munro, & H. Rainbird (Eds.), *Workplace learning in context* (pp. 201–221). Routledge. https://doi.org/10.4324/9780203571644

Fitzgerald, A., Hackling, M., & Dawson, V. (2013). Through the viewfinder: Reflecting on the collection and analysis of classroom video data. *International Journal of Qualitative Methods*, *12*(1), 52–64. https://doi.org/10.1177/160940691301200127

Frambach, J. M., van der Vleuten, C. P. M., & Durning, S. J. (2013). AM last page: Quality criteria in qualitative and quantitative research. *Academic Medicine*, *88*(4), 552.

Fullan, M. (2015). *The new meaning of educational change* (5th ed.). Teachers College Press. http://mehrmohammadi.ir/wp-content/uploads/2019/07/The-New-Meaning-of-Educational-Change.pdf

Goldie, J. (2006). AMEE education guide no. 29: Evaluating educational programmes. *Medical Teacher*, *28*(3), 210–224. https://doi.org/10.1080/01421590500271282

Higgs, J., & Mcallister, L. (2007). Being a clinical educator. *Advances in Health Sciences Education*, *12*(2), 187–200. https://doi.org/10.1007/s10459-005-5491-2

Hill, E., Gurbutt, D., Makuloluwa, T., Gordon, M., Georgiou, R., Roddam, H., Seneviratne, S., Byrom, A., Pollard, K., Abhayasinghe, K., & Chance-Larsen, K. (2021). Collaborative healthcare education programmes for continuing professional education in low and middle-income countries: A Best Evidence Medical Education (BEME) systematic review. BEME Guide No. 65. *Medical Teacher*, *43*(11), 1228–1241. https://doi.org/10.1080/0142159x.2021.1962832

Justin, B., Jayne, L., Ardi, F., & Diantha, S. (2020). Establishing and sustaining a transnational clinical teacher faculty development initiative. *Asia Pacific Scholar*, *5*(1), 8–15. https://doi.org/10.29060/taps.2020-5-1/ra2087

Kim, D.-H., Yoon, H. B., Sung, M., Yoo, D.-M., Hwang, J., Kim, E. J., Lee, S., & Shin, J.-S. (2015). Evaluation of an international faculty development program for developing countries in Asia: The Seoul intensive course for medical educators. *BMC Medical Education*, *15*(1), 224–236. https://doi.org/10.1186/s12909-015-0518-8

Kirkpatrick, D. L., & Kirkpatrick, J. D. (2006). *Evaluating training programs: The four levels*. Berrett-Koehler.

Leslie, K., Baker, L., Egan-Lee, E., Esdaile, M., & Reeves, S. (2013). Advancing faculty development in medical education: A systematic review. *Academic Medicine*, *88*(7), 1038–1045. https://doi.org/10.1097/ACM.0b013e318294fd29

Mann, K., Gordon, J., & MacLeod, A. (2007). Reflection and reflective practice in health professions education: A systematic review. *Advances in Health Sciences Education*, *14*(4), 595–621. https://doi.org/10.1007/s10459-007-9090-2

McKimm, J., McLean, M., Gibbs, T., & Pawlowicz, E. (2018). Sharing stories about medical education in difficult circumstances: Conceptualizing issues, strategies, and solutions. *Medical Teacher*, *41*(1), 83–90. https://doi.org/10.1080/0142159X.2018.1442566

McLean, M., Cilliers, F., & Van Wyk, J. M. (2008). Faculty development: Yesterday, today and tomorrow. *Medical Teacher*, *30*(6), 555–584. https://doi.org/10.1080/01421590802109834

McLean, M., McKimm, J., & Gibbs, T. (2017). Medical education in difficult circumstances: A global responsibility to contribute. *Medical Teacher*, *39*(1), 4–6. https://doi.org/10.1080/0142159X.2017.1254758

Merriam, S. B. (1988). *Case study research in education: A qualitative approach* (1st ed.). Jossey-Bass.

Mojtahedzadeh, R., & Mohammadi, A. (2016). Concise, intensive or longitudinal medical education courses, which is more effective in perceived self-efficacy and development of faculty members? *Medical Journal of the Islamic Republic of Iran*, *30*, 402–411.

Moore, S., & Kuol, N. (2005). Students evaluating teachers: Exploring the importance of faculty reaction to feedback on teaching. *Teaching in Higher Education*, *10*(1), 57–73. https://doi.org/10.1080/1356251052000305534

Morris, C., & Swanwick, T. (2018). From the workshop to the workplace: Relocating faculty development in postgraduate medical education. *Medical Teacher*, *40*(6), 622–626. https://doi.org/10.1080/0142159X.2018.1444269

Onyura, B., Légaré, F., Baker, L., Reeves, S., Rosenfield, J., Kitto, S., Hodges, B., Silver, I., Curran, V., Armson, H., & Leslie, K. (2015). Affordances of knowledge translation in medical education: A qualitative exploration of empirical knowledge use among medical educators. *Academic Medicine*, *90*(4), 518–524. https://doi.org/10.1097/ACM.0000000000000590

Pololi, L. H., & Frankel, R. M. (2005). Humanising medical education through faculty development: Linking self-awareness and teaching skills. *Medical Education*, *39*(2), 154–162. https://doi.org/doi:10.1111/j.1365-2929.2004.02065.x

Pope, C., Ziebland, S., & Mays, N. (2000). Analysing qualitative data. *British Medical Journal*, *320*, 114–116. https://doi.org/10.1136/bmj.320.7227.114

Ramani, S., & Leinster, S. (2008). AMEE guide no. 34: Teaching in the clinical environment. *Medical Teacher*, *30*(4), 347–364. https://doi.org/10.1080/01421590802061613

Sandars, J. (2009). The use of reflection in medical education: AMEE guide no. 44. *Medical Teacher*, *31*(8), 685–695. https://doi.org/10.1080/01421590903050374

Schön, D. A. (1991). *The reflective practitioner: How professionals think in action*. Avebury Ashgate. https://doi.org/10.4324/9781315237473

Searle, N. S., Thibault, G. E., & Greenberg, S. B. (2011). Faculty development for medical educators: Current barriers and future directions. *Academic Medicine*, *86*(4), 405–406. https://doi.org/10.1097/ACM.0b013e31820dc1b3

Sorinola, O. O., Thistlethwaite, J., Davies, D., & Peile, E. (2017). Realist evaluation of faculty development for medical educators: What works for whom and why in the long-term. *Medical Teacher*, *39*(4), 422–429. https://doi.org/10.1080/0142159X.2017.1293238

Steinert, Y. (2010). Faculty development: From workshops to communities of practice. *Medical Teacher*, *32*(5), 425–428. https://doi.org/10.3109/01421591003677897

Steinert, Y. (2012). Perspectives on faculty development: Aiming for 6/6 by 2020. *Perspectives on Medical Education*, *1*(1), 31–42. https://doi.org/10.1007/s40037-012-0006-3

Steinert, Y. (2017). Staff development. In J. Dent, R. Harden, & D. Hunt (Eds.), *A practical guide for medical teachers* (5th ed., pp. 306–314). Elsevier.

Steinert, Y. (2020). Faculty development: From rubies to oak. *Medical Teacher*, *42*(4), 429–435. https://doi.org/10.1080/0142159X.2019.1688769

Steinert, Y., Mann, K., Anderson, B., Barnett, B. M., Centeno, A., Naismith, L., Prideaux, D., Spencer, J., Tullo, E., Viggiano, T., Ward, H., & Dolmans, D. (2016). A systematic review of faculty development initiatives designed to enhance teaching effectiveness: A 10-year update: BEME guide no. 40. *Medical Teacher*, *38*(8), 769–786. https://doi.org/10.1080/0142159X.2016.1181851

Steinert, Y., Mann, K., Centeno, A., Dolmans, D., Spencer, J., Gelula, M., & Prideaux, D. (2006). A systematic review of faculty development initiatives designed to improve teaching effectiveness in medical education: BEME guide no. 8. *Medical Teacher*, *28*(6), 497–526. https://doi.org/10.1080/01421590600902976

Swanwick, T. (2008). See one, do one, then what? Faculty development in postgraduate medical education. *Postgraduate Medical Journal*, *84*(993), 339–343. https://doi.org/10.1136/pgmj.2008.068288

Sweet, L., Young, L., & Kado, S. (2018). Enhancing health professional education capacity in the Western Pacific region. *Rural and Remote Health*, *18*(3), 4306–4311. https://doi.org/10.22605/RRH4306

World Health Organisation (WHO). (2013). *Transforming and scaling up health professional education and training*. https://apps.who.int/iris/bitstream/handle/10665/93635/9789241506502_eng.pdf;jsessionid=BE064740D7733C0E96BE0214920E36F1?sequence=1

Young, L., Kado, S., & Sweet, L. (2019, September 23–25). *Faculty development in the Pacific* [Paper presentation]. 5th International Conference on Faculty Development in the Health Professions, Ottawa, Canada.