ARTICLE

Teaching Approaches That Reflect and Promote Professionalism

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ABSTRACT

The teaching and cultivation of professionalism have long been part of medical education and have had recent special emphasis because professionalism has been identified as a core competency by the Accreditation Council for Graduate Medical Education. The author focuses on two complementary teaching initiatives that contribute to the development of professionalism in the academic environment: a resident-as-teacher program and an approach to faculty bedside teaching that mirrors and extends the lessons of the resident-as-teacher effort. These have been implemented and refined over the previous 15 years by the author and his colleagues at Mount Auburn Hospital in Cambridge, Massachusetts. The commitment to the development and refinement of residents' teaching skills serves to promulgate the fundamental elements of professionalism, with emphasis on caring and the educational well-being of the team. The author describes the elements and benefits of these approaches and shows how they can foster the development of professionalism in graduate medical education.

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Professionalism has been characterized by the Accreditation Council for Graduate Medical Education (ACGME)[1] as one of the core competencies that programs for medical school graduates must cultivate and evaluate in their trainees. Under the umbrella of professionalism lies an extended set of responsibilities that include the respectful, sensitive focus on individual patient needs that transcends the physician's self-interest, the understanding and use of the cultural dimension in clinical care, the support of colleagues, and the sustained commitment to the broader, societal goals of medicine as a profession.[2–4] Though many factors in contemporary medicine are impediments to the development of professionalism, the assault on the commitment to education and the weakening of an education community (with its emphasis on the priorities of personal and professional development) may be the most destructive.[5] Other factors include the impact of specialization and the potential for the loss of common clinical values, increasing service demands placed upon housestaff and faculty that affect professional conduct, and an academic reward system that has not historically valued the clinician–teacher and consequently has discounted patient care and teaching as well.[5] Attendant recommendations have focused on reestablishing an education community, developing programs for role modeling and mentoring, establishing a structured curriculum dealing with professionalism, and attention to the evaluation of professional conduct.[2,5]

Of these interventions, educational efforts focused on the training environment are central, as it is here where the template for professional conduct is chiefly learned.[5] When teaching is carried out with practiced commitment by residents and faculty, it is based on precisely the same professional values as those directed at patient care. Teaching valued in this way is done best by skilled residents and faculty, as they effectively model key elements of professionalism in the clinical arena directed at both fellow learners and patients.

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The ACGME states that a broad curricular approach to the development of professionalism in residents must foster:

> Respect, compassion and integrity; responsiveness to the needs of patients and society that supercedes self-interest; accountability to patients, society, and the profession; and commitment to excellence and ongoing professional development
> Commitment to ethical principles in the provision/withholding of clinical care, confidentiality of patient information, informed consent, and business practices
> Sensitivity and responsiveness to each patient's culture, age, gender, and disabilities

In this paper, I focus on two complementary teaching initiatives, situated in the clinical training environment, that incorporate values of professionalism within clinical teaching and in direct patient care: a resident-as-teacher program and a faculty-led bedside teaching model that mirrors and extends the lessons of the resident-as-teacher effort. My colleagues and I at Mt. Auburn Hospital in Cambridge, Massachusetts, have developed and implemented resident-as-teacher programs and bedside teaching initiatives, as described below, since the late 1980s.

Contributions to professional development within these types of teaching efforts arise from a curriculum that seeks to enhance an understanding of the needs of patients and fellow learners, promotes respect for both, and models a commitment to excellence in practice. Teaching at the bedside by both residents and faculty especially provides abundant opportunities to engage, discuss, and demonstrate many of the elements identified as representing professionalism, particularly those listed earlier.[1] The modeling of these professional values and attitudes by residents-as-teachers and faculty is, in my opinion, the most effective teaching strategy to achieve the curricular goal of enhancing professionalism in training and practice. The emphasis in these training and teaching initiatives thus focuses on caring for the fellow learner as well as for the patient, reflecting the core elements of the doctor/teacher role that lie at the center of medicine. These efforts therefore represent an important approach to the development of the ACGME core competency of professionalism within training programs.

RESIDENT-AS-TEACHER TRAINING

The growth in resident-as-teacher programs over the past decade reflects the rising appreciation of the central teaching role of the housestaff and the programmatic need to develop residents' skills commensurate with that responsibility.[6,7] The focus of this program, particularly in the monthly sessions during the second and third years, rests on exploring a central thesis of the program—that teaching and doctoring are fundamentally the same process and that caring for the learner and caring for the patient reflect identically parallel professional skills. Both endeavors require eliciting the learner/patient's needs, stating the teacher/doctor's agenda, use of appropriate diagnostic approaches, ongoing feedback/communication, and evaluation of outcomes. This process helps residents with the transposition of clinical skills into the teaching arena and offers a useable template and an appropriate vocabulary for their teaching role.

Since the beginning of the resident-as-teacher programs a variety of different time slots and formats have been tried. I now find it more successful to lead sessions for second- and third-year residents during one regularly scheduled morning report session per month over the course of the year. The monthly use of the morning report slot is a statement of programmatic value for clinical teaching. The program introduces clinical teaching skill sessions, including help with oral presentations, instruction in effective audiovisual aid use, and direct observation of the residents as teachers in a variety of venues as residents advance into the second year.

In the monthly resident-as-teacher program, sessions typically begin with a request for the discussion of educational (or team management) issues or problems that the residents may be experiencing. Taking advantage of a teaching moment, the ensuing discussion frequently supplants the intended topic for the day. At the beginning of the academic year the residents receive an overview of the basic template for teaching, which consists of the principles described in the following paragraphs. These principles build upon one another; the more fundamental ones are presented first. In the practice sessions the residents explore these principles in depth and review relevant literature.

> *Know the learner.* As is true clinically, the teaching role is rooted in the need to know the learner. Obvious perhaps, but a few minutes spent gathering details about team members sets a tone of caring. Being *known* is as validating for the student as it is for the patient. It is a central contextual point, as powerful as finding out the nature of a patient's work. I still vividly recall the enormous personal impact I felt when, as a first-year medical student on the eve of a block just beginning, I met the course chair, previously unknown to me, who knew my name—a not-so-small statement of value from a gifted teacher, remembered decades later with respect.

> *Use an educational contract.*[8] This is a negotiated exchange of educational intent; it is mutually defined and refined, and extends the understanding of the learner by explicitly asking about his or her educational needs. With stated expectations by the resident to follow, it is

emphasized that the educational contract can be quickly incorporated into the initial discussion with the team. Who of us, as either student or house officer, hasn't experienced the just-show-up-and-go approach to a clinical rotation, with attendant ambiguity about goals and roles? Moreover, if feedback is to work, it must begin with clear expectations, and the commitment to meet individually at the middle and the end of the rotation.

Use Neher's microskills of teaching.[9] These skills, described in the list below, are powerful as "educational probes" designed to characterize the learner's understanding of issues. Adding this template for regular use by residents has been shown to yield improvements in their teaching skills.[10] Clearly, the twin basic inquiries "What do you think?" and "Why do you think this?" are fundamentally respectful of the learner, a key element in professional behavior for others, both colleagues and patients. These microskills are:

Get a commitment: "What do you think?"
Probe for supporting evidence: "Why do you think this?"
Teach in general rules.
Reinforce what was right. Tell them what they did right and the effect that it had.
Correct mistakes. Tell them what they did not do right. Tell them how to improve for the next time.

Create a safe learning environment. A safe learning environment, established by attention to the three principles of the template for teaching discussed above, encourages educational growth. Knowing the learners, understanding their needs, and eliciting their clinical thinking are the essential substrates of a committed, caring approach to the individual and the team. Safety permits the less experienced to take educational risks. "I don't know" becomes an acceptable phrase for all and a sign of growth and not necessarily one of educational weakness. (It is worthwhile—and humbling—for all teachers to periodically undertake a totally new course of study or skill development. One quickly is reminded about the essential issue of safety in education.) Safety permits curiosity to flourish, and curiosity is the wellspring of inquiry.[11]

Develop a learning community. The successful creation of such a community is the summative result of the other four teaching template processes. The sense of team, vital to the work of patient care, flows fundamentally from the understanding that learning in the clinical environment is a collective responsibility, for which the resident plays a central leadership role.

Reflecting on this basic template fuels the discussion for the first half of the year. As the year progresses and experience grows, other topics emerge, such as skills in lecturing or leading group discussion. Reflection on the use of failure proves as valuable as reflection on success in improving teaching.[12,13] This is a vital element in the resident's growth as teacher, as central as it is in the clinical realm, and represents the beginning of a reflective educational practice. Linked to these curricular issues is observing residents as teachers during ward rounds, conducting small-group sessions, or giving scholarly presentations at grand rounds.

The resident-as-teacher program is intended not so much as an exercise in technique but to foster and develop respect for the fellow learner and the team. Knowing the learner establishes personal knowledge and context. Explicit educational contracting reduces ambiguity and demonstrates respect for the learner's agenda. The microskills of teaching are useful as educational "probes" as well as a statement of respect for the fellow adult learner. Attention to these perspectives contributes significantly to the establishment of safety, and by extension, inquiry and growth. Finally, this mindset is central to the creation of a learning community, where curiosity and contribution are fostered, sought, and acknowledged. The resident-as-teacher program is a realistic way to contribute significantly to professional development of the housestaff.

BEDSIDE TEACHING

Bedside teaching similarly is an extraordinary opportunity to deal with the issues of professionalism. The challenges and rewards of bedside teaching have been clearly described,[14] along with effective approaches for doing it well.[15] Engel's emphasis that clinical effectiveness is connected to the ability to extract and interpret historical and observational data places the pedagogic action at the bedside.[16] Much of the bedside teaching has been co-taught with colleagues from the Department of Medicine and the Department of Psychiatry at Mt. Auburn Hospital. I have used a variation of Engel's model[16] for weekly bedside teaching that reinforces the resident-as-teacher perspective and contributes to greater understanding of patient needs as well as to professional development. These weekly bedside rounds, designed for the second- and third-year residents, occur in addition to the assigned attending rounds of the service.

The current format of these sessions follows this model:

- A patient is identified for rounds, and permission is sought by his or her resident of record.
- A resident not familiar with the patient is assigned to conduct a ten-minute interview, followed by additional questions from the team at the bedside.

- Given the historical details obtained, I do a focused physical exam, and/or a resident may be asked to demonstrate a particular aspect of the physical examination.
- The group leaves the bedside, and in a conference room setting, observations are elicited as to what was seen. Initial hypotheses are generated.
- Input is elicited from the resident of record concerning other relevant items in the history, and pertinent laboratory information. Primary data (X-rays, blood smears, and the like) are then examined by the group.
- Hypotheses are re-thought and tentative conclusions reached.
- Issues of the case are summarized, and unanswered issues are identified. Residents volunteer for (or are assigned) topics to be researched.
- At the beginning of the subsequent session, a follow-up of the prior week's case is given and assigned reports on previously undefined questions are briefly presented. Based on the previous case a connected teaching point is made (described below) and the cycle is repeated.

This approach to bedside rounds models the teaching template taught to the residents that was described earlier. The teachers know the residents' interests and expertise and incorporate these regularly into the discussions. An educational contract is set with a new group of residents at the beginning of the academic year and reaffirmed at the beginning of each new rotation. The microskills of teaching inform the discussion, and there is a sense of safety in the group as well as a commitment to mutual efforts in the learning arena. Moreover, this approach to bedside teaching permits the regular modeling of inquiry that often is truncated or abandoned under the admitting pressures characteristic of our current system. The dialogue at the bedside regularly elicits disease/illness distinctions.[17] "How can we best understand what it is like to have your problem?" or "What is it that you want most from the doctor(s) caring for you?" are the types of questions regularly heard, initially from the faculty, but then incorporated as the year progresses into the language of the interviewing resident. Sessions end by asking the patient, "What questions do you have for us?"

Second, this approach at the bedside offers a direct and regular opportunity to observe and demonstrate interviewing skills, as well as to observe and demonstrate physical examination skills. Feedback is given to the resident after the session, and a note sent to the program director for inclusion in the resident's record about the observed skills. Each session is an interactive, problem-solving exercise based on primary data, summarization techniques, and the identification of unanswered questions. It is a comfortable zone for both the faculty and residents to offer "I don't know" without penalty. It is a learning community that is safe and stimulating.

Finally, by beginning the following session with reports from the residents about previously unanswered questions, this model crystallizes the mutual responsibility for learning. I then present a clinical vignette or primary data that links new material with the case of the prior week. For example, following a recent discussion of an elderly woman with pericarditis, the next session began with four electrocardiograms demonstrating different etiologies of ST-segment elevation that encouraged the extension of the experience from the prior case and allowed an expansion of material learned.

Bedside rounds, as described, actively incorporate recognized principles of learning that link expertise with case experience and show that active involvement enhances learning, and that learning has personal and social dimensions.[15] Both the resident-as-teacher sessions and the bedside rounds are well received and valued for the emphasis they provide in areas that are relatively unattended within our teaching systems.

FINAL THOUGHTS

We can best convey the values of professionalism by teaching about teaching, and caring for and learning from patients at the bedside. Palmer's insight about the core ingredient of effective teaching rings true: "good teaching cannot be reduced to technique; good teaching comes from the identity and integrity of the teacher."[18] The valuing of good teaching and its derivative impact on patient care as well as its qualitative enhancement of the training experience are core messages of these programs. As noted, professionalism within the language of the ACMGE clearly includes the elements of respect for patient and colleagues, responsivity to their needs, commitment to excellence, and ongoing professional development. These approaches to teaching, therefore, have the potential for contributing significantly—but by no means exclusively—to fostering and implementing the values espoused by our profession.

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