Clinicians or teachers – why not both? Expanding the comfort zone of Swiss clinical teachers in private practice

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Ambulatory medicine is faced with the challenge of continuing to offer high quality and efficient healthcare in the context of a rapidly increasing and aging population that typically suffers from chronic diseases [1, 2]. The vast majority of future generations of doctors will practice in an outpatient setting once they have accomplished their specialty training, and these newly trained primary care doctors will be at the heart of the healthcare system [3].

Several action plans have been developed in Switzerland to promote this discipline academically. In an increasing number of medical schools, undergraduate training has been redesigned to offer students specific primary care training with longitudinal exposure throughout their studies, and with increasing priority given to clinical placements in general practitioners' or paediatricians' offices. Thus, from their second year (four half-days), through their fourth and fifth years (eight half-days) and until their final year (one month), medical students in Geneva Medical School have the opportunity to learn and practice clinical skills in primary care placements.

Pedagogical tools have been well studied in academic settings, such as hospitals or institutionally organised outpatient clinics [4, 5], but what about the private context? What knowledge and pedagogical tools are used by these clinical teachers?

To better understand the challenges faced by clinical teachers in primary care, our unit (Unité des internistes généralistes et pédiatres – UIGP) in Geneva Medical School set up a first study to explore the issues and difficulties encountered by clinical teachers in private practice who supervised students during a pilot 1-month rotation for final-year medical students [6]. The results showed the ways in which clinical teachers struggle to conciliate their two roles as clinician and teacher. As supervisors of
trainees in clinical practice, they had to deal with an additional “adaptive load” (e.g., reorganisation of their consultation plan), a “cognitive load” (e.g., continual efforts to remain explicit and share clinical reasoning), and also an emotional load (e.g., welcoming a student in a personal symbolic territory made up of exclusive caring relationships with patients). The study also showed that the teachers were convinced of the use and relevance of the rotation in their practice since it clearly allowed students to improve their knowledge and gain professional autonomy and maturity when given the opportunity to take on clinical responsibilities.

Then, as part of a Swiss national project to promote medical education in primary care, our research group conducted the MEDTEACH study, which included four national academic primary care institutes in Switzerland (Geneva, Vaud, Bern and Basel) in collaboration with the university of Laval, Canada. This study explored primary care physicians’ teaching methods by identifying the conceptual frameworks they used when supervising students during clinical placements. The results showed that these conceptual frameworks were not used in an explicit way and were not always tailored to the students pedagogical needs; amongst all the conceptual frameworks, clinical teachers favoured communication skills, positive reinforcement to the student and clinical problem resolution. However, they rarely supported the clinical reasoning process of the students.

If clinical teachers further developed their conceptual frameworks, this would allow them to offer more targeted supervision. By doing so, they would feel more at ease with their pedagogical role. Our latest study used the MEDTEACH data to identify the clinical teacher supervision abilities in order to promote students’ learning. For this purpose, we evaluated the quality of the pedagogical content and process of clinical teachers’ supervisions in private practices, using the validated teaching skills assessment tool of Sommer et al. [7]. The results showed that the clinical teachers rarely explored and taught clinical reasoning and that the structure of supervisory processes were not integrated: for example, supervisors failed to formally conclude the supervision and struggled to explain to the student what had been learned and what remained to be learned.

**Which lessons can we infer from these results?**

The clinical teachers who participated in these studies all expressed their enthusiasm for teaching and for sharing their knowledge and clinical experience with their students. We know that clinicians are able to solve complex cases thanks to clinical scripts (networks of relevant knowledge and experiences adapted to goals of clinical tasks) [8] that they developed throughout their training. As clinical teachers, they continually enrich their teaching scripts (networks of knowledge and experience of content,
learners, pedagogy, etc.) as described by Irby, and thereafter solve more easily and efficiently problems encountered with students [9]. We also observed that the clinical teachers in our study did not master teaching tools such as providing effective and targeted feedback during clinical supervision.

Yet a clear parallel can be drawn between a medical consultation, a process totally mastered by clinicians, and that of clinical supervision. Similar steps are necessary for both processes: identifying a clinical/pedagogical problem, exploring it and proposing a clinical/pedagogical action plan. We therefore suggest that pedagogical tools could relatively easily support the clinical teachers' supervising role since their pedagogical role is not very different from the well-mastered role as a clinician.

Expanding their pedagogical skills and consolidating the acquisition and training of those teaching tools certainly represents a way of further developing clinical teachers' pedagogical comfort zone and from there will help them to fully support and assume their dual role.

To achieve these goals in Swiss primary care, academic organisations should focus faculty development programmes on clinical teachers' needs that are specific to private primary care practice. Alongside the pedagogical training delivered within the academic environment, it would be necessary to create a community of clinical teachers rooted in private practice.

Many clinicians already participate in structured discussion groups among peers to share and solve problems they encounter with their patients. A community of practice among clinicians therefore already exists and represents an added value of clinical expertise. This is often well accepted by busy physicians who benefit from peer advice and support to guide their practice in difficult or complex situations [10]. The same sort of structured groups could discuss pedagogical issues and contribute to the creation of a community of clinical teachers.

**Clinicians or teachers: why not both?**

Our research has shown the challenges that face clinical teachers who supervise students in private primary care in Switzerland. There is a decision that has to be made: this dual role of clinician and teacher has to be embraced by the clinicians to create a community of practice around their pedagogical needs. There is an opportunity for them to create their own environment, which is adapted to their reality, to share and to train their teaching experiences and skills to ensure the training of future generations of doctors in ambulatory medicine.

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