THE PHYSICIAN AS TEACHER

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It is curious that so many of our most important responsibilities are undertaken without significant preparation. Marriage and parenthood are probably the most ubiquitous illustrations, and there is little reason to expect that these states will ever evolve rationally. The task of medical teaching, on the other hand, is accepted deliberately and dispassionately, yet the preparation for that influential role is equally frail (Miller 1980).

Many efforts by physicians to pursue some type of instruction on teaching, such as reading a book on teaching skills or attending a workshop on faculty development, meet with less than astounding success. (After all, if the reader were already a master teacher, why would he* be reading this book?) Why are so many well-intentioned efforts at developing the teaching skills of physicians so modestly successful? One major reason is that medical teaching has been taught in the same manner as other disciplines in medicine: students are taught an isolated field of study with specialized concepts and skills.

* It should be noted at this point that our readers are both male and female, of course, but our text consistently uses the pronoun he (or his). Although the he/she construction may reduce gender bias, we feel that it makes awkward reading. Our intention is not to promote sex stereotyping, but simply to provide concise writing.
Physicians as Communicators

Physicians as Teachers

The Physician as Teacher

jargon. Similarly, physicians wishing to improve their teaching skills are confronted with a profusion of rules and paradigms that bear little relationship to their past experiences. These ideas are usually presented in a language that is as foreign as Latin to most physicians. Physician teachers are asked to adopt skills that do not apply to their immediate needs and to accept principles that are too theoretical for the realities of a physician's usually hectic life. In summary, physician teachers who have either excellent or dismal teaching skills acquired these skills intuitively regardless of any formal teacher training they may have received.

So how might this apparent gap between the training and performance of physician teachers be bridged? One way, which is also the basic premise of this book, is to approach learning as a basic human experience, and teaching as a basic interpersonal communication skill that is intuitive to physicians. Physicians possess powerful communication abilities that are derived from providing patient care. Given a chance, physicians have the natural ability to become excellent teachers. Thus instead of forcing more theoretical principles into the reader's already brimming store of medical and scientific facts, this book seeks to build upon the strong sense of communication that is inherent in the physician's interpersonal repertoire. Darley and Turner wrote in 1950 that "it is logical . . . that medical faculties are distrustful of principles that have been arrived at by teaching young children or by studying rats and other laboratory animals." Since this skepticism is still well placed in 1986, this book will not risk creating further skepticism by presenting impractical theories.

We believe that teaching is an interpersonal communicative event that occurs because of the physician's concern and desire to help. The same concern that a physician teacher has for his patient is revealed in his concern for his student as an individual. Similarly, the physician teacher's desire to help his patient translates into helping his student gain new knowledge, attitudes, and skills that will help the learner become a competent physician and future colleague. Holcomb and Garner (1973, p. vii) have noted, when describing excellent medi-
5. Increased understanding and retention—the techniques by which a teacher enhances the learners' understanding and retention of the discussion by stating the basis for the teacher's ideas and opinions, permitting questions to check understanding, emphasizing the relevance of the information to the learner (and ultimately a patient), and repeating and summarizing in relevant terms.

6. Stimulation of continued self-learning—the processes by which a teacher encourages learners to voluntarily continue learning beyond the goals or time set for a particular course.

The Employer-Employee Relationship

Of the considerable literature on constructive characteristics of employer-employee communication, Blanchard and Johnson's (1982) The One-Minute Manager is particularly adaptable to teaching. Interestingly, the second author of this book is a physician trained at the Harvard Medical School and the Mayo Clinic and Foundation. This small but invaluable book begins with a description of effective managers as those who "manage themselves and the people they work with so that both the organization and the people profit from their presence." Similarly, effective teachers are those whose method of teaching benefits the teacher, the learner, the teaching setting (e.g., hospital ward or medical office), and the learner's future patients. The One-Minute Manager offers three "secrets" of effective management that are equally applicable to effective teaching. These are presented next.

Clarifying the Learning Objectives

The first secret proposes that employers should help employees understand exactly what their responsibilities are and exactly what performance standards are necessary to meet those responsibilities.

Communicating Positive Feedback

The second secret advises employers to make sure, "in no uncertain terms," that the employee understands when he or she is doing something well. As Blanchard and Johnson (1982) put it, "Catch them doing something right." Most physicians are fairly good at giving positive feedback to learners at later times, however, the correct time to give it is immediately after a learner has performed well. Positive feedback is relatively easy to give in the presence of the patient, other health care personnel, or students. Waiting until some more formal time for delivering positive feedback (such as the end of the day, the end of the rotation, or the regularly scheduled advisor meeting 2 months hence) unfortunately delays the "good news" and dilutes their impact.

Communicating Negative Feedback

The third secret tells employers to ensure that the employee understands when he or she is doing something wrong. Not only do physician teachers infrequently criticize learners but they rarely do it at the time the learner performs poorly. Physicians generally do not want to be "bad guys (or gals)" and are usually uncomfortable giving nega-
tive feedback. Unsurprisingly, 4 to 8 weeks after the unmentioned error has occurred the student or resident is shocked at receiving a bad evaluation, and rightly so. Physician teachers must remember that medical teaching is a huge responsibility and that well-placed (i.e., shortly after the incorrect behavior) negative feedback is a critical part of that responsibility. Blanchard and Johnson (1982) also note that the “one-minute reprimand” should be followed by a reaffirmation of the employee’s (i.e., student’s) personal worth and general value to the organization. (This concept is discussed in greater detail in chapter 4.)

The second and third “secrets” of good employee management are directly applicable to Skeff’s (1984) objective of giving students and residents information about their current clinical or academic performance so that they can either improve poor performance or continue to perform well.

The Parent-Child Relationship

From the wealth of excellent research on the communication characteristics of the parent-child relationship, some of the most useful work is found in Parent Effectiveness Training (PET) Gordon 1970). Interestingly, these principles also have been applied to teaching at the secondary school level in Teacher Effectiveness Training (Gordon 1975), and certain aspects apply equally well to medical teaching. PET describes an approach for parents working with children (theirs and others) based on intense active listening, so as to understand at both a factual and emotional level what children are saying. This is, of course, quite similar to active listening taught in basic patient interviewing courses. PET describes a method, with which to constructively address children during a confrontation and to negotiate a “win-win” solution satisfactory for both parent and child. As part of this style of communication, 12 types of parental communications are described in the book, along with their potential for positive and negative effects on children. These 12 styles have directly analogous behaviors in teachers, and the effects on medical students and residents are also quite similar. This direct applicability does not imply that medical education is like secondary school teaching but rather that PET takes a particularly adult approach to teaching students of all ages.

Styles of Parental Communication

These 12 behaviors or styles (Gordon 1970) are directly useful in accomplishing Skeff’s (1984) objectives of setting a helpful learning climate and controlling the tone and pace of the teaching-learning relationship:

Ordering, directing, commanding. While sometimes necessary, these behaviors often result in humiliated and/or rebellious students. Publicly yelling at a medical student is demeaning and almost never justified, except perhaps in medical crises.

Warning, admonishing, threatening. Although the demonstration of power here is more subtle than in the first style above, the adverse effect on learners is the same.

Moralizing, preaching, obliging. Using moral, ethical or professional failure to stimulate guilt has the effect of developing covert or passive resistance in the learner. Teachers may sometimes try to persuade students in favor of a certain test or treatment approach that is based more on personal bias than on scientific evidence. This type of influence will be short-term at best, and the teacher’s credibility and opportunity to exert a long-term influence on students will dwindle.

Advising, giving suggestions or solutions. This style approach is the collegial relationship that is most effective in medical teaching. However, frequent advice giving may imply that the learner is inferior to the teacher, and the teacher may end up caring more about
particularly important with senior residents who (presumably) are at a level of experience where more support and confirmation of medical skills is needed rather than advice on how to “do it best.” A more supportive approach by the teacher encourages the senior resident to ask for help from the teacher and to view the instructor as a mentor rather than as a busybody.

**Persuading logically, arguing, instructing, lecturing.** This is the usual medical teaching style of the “teacher as expert,” but good teaching requires more than just dispensing scientifically based facts. A teacher who bases most of his interactions with students on intellectual weight denies the interpersonal nature of the teacher-learner relationship that requires the teacher to understand the student as a person with needs that are not always rational.

**Judging, criticizing, disagreeing, blaming.** Feedback and evaluation are essential, but attacks on self-esteem and self-worth are not. Comments such as the one about the surgical resident “not being fit to be a butcher” are not only demeaning, they are unhelpful criticisms because they do not offer the learner any insight as to his specific professional deficiency. In addition, the surgical resident has a hard time accepting later feedback from this surgeon-teacher.

**Praising, agreeing, evaluating positively, approving.** Accurate and well-timed approval is helpful, but excessive or gratuitous approval can be condescending and insulting. The attending who tells all students their workups are excellent and show “evidence of great promise and hard work” will ultimately lack credibility as much as the charlatan or the abusive teacher.

**Name-calling, ridiculing, shaming.** These devastating attacks on a learner’s self-esteem have absolutely no place in teaching (or in any other interpersonal relationship, for that matter).

**Interpreting, analyzing, diagnosing.** A rigorous and thorough analysis in which the learner participates actively is a powerful teaching tool. The chief resident who masterfully interprets a set of blood gases from a complex pulmonary patient without fully involving the third-year clerks has advanced his own learning, not theirs.

**Physicians as Communicators**

Reassuring, sympathizing, consoling, supporting. When genuine behavior is critical; unfortunately it is rarely expressed. Reassurance and support are almost impossible to overdo, but most medical teachers seem to subscribe to the theory that “If I could make it through this horrible, stressful process, so can they!”

**Questioning, questioning, interrogating.** Questioning is the core of medical teaching, but manipulation and the resulting resentment is a risk. Many teachers seem not to advance beyond the guess-what-I’m-thinking style of questioning: “I think the only one reasonable cause of this patient’s abdominal pain is...” This type of teacher is usually remembered more for his attention to detail than for his contributions as a medical educator.

**Drawing, distracting, humoring, diverting.** These can be adjuncts to teaching, but, when used inappropriately or excessively, can trivialize the “teachable moment.”

None of these behaviors is always “good” or always “bad” for the learner relationship (except for name-calling or ridiculing, which is always bad), but using several of these behaviors discreetly enhances the physician’s teaching style. One’s basic style of personal communication is not limited to just a few behaviors; should one’s teaching style be so limited?

**Physician-Patient Relationship**

The third relationship, with which the physician is probably most familiar and, presumably, most experienced, is the physician-patient relationship. Many disciplines including psychiatry, psychology, ethics, and communications have written about the physician-patient relationship. Chapter 3 describes specific communications with patients that have direct counterparts with learners. It examines the relationship itself to discover characteristics...
Physicians already appreciate the tremendous power of the physician-patient relationship. An outstanding review by Dodge (1983) describes the influence of this relationship on patient satisfaction, knowledge, compliance, and outcomes. Patients feel that the most important characteristics of a physician that lead to high patient satisfaction are "knowledge, understanding, interest, sympathy, and encouragement" (Reader et al. 1957). These equally worthy qualities of an excellent teacher lead to high learner satisfaction. Patient compliance is markedly improved when the physician demonstrates a warm, sensitive, and compassionate manner that stimulates patient confidence. The same is true for the teacher's demeanor and the learner's willingness to work. Finally, patient outcomes are directly influenced by the physician's communication style. For example, the length of the postoperative hospital stay and amount of analgesics prescribed is strongly affected by the anesthesiologist's interpersonal behaviors (Egbert et al. 1964). Similarly, learning outcomes, such as learner behavior change or information retention, are strongly and positively influenced by the teacher who is knowledgeable, concerned, open, and enthusiastic. As already stated, being a knowledgeable expert is not enough in either the physician or teacher roles.

Dodge (1983) characterizes the physician-patient relationship as three important exchanges between two individuals:

1. An exchange of information, in which the patient provides subjective and objective information on illness and the physician gives a diagnosis and treatment;
2. An exchange of emotion, in which the patient and physician exchange feelings about themselves, and the illness;
3. An exchange of meaning, in which the patient communicates to the physician the patient's previous attempts to understand the illness and the physician offers a revised interpretation that the patient can accept.

These three exchanges have direct applications to the teacher-learner relationship, including Skeff's (1984) stress on the importance of providing feedback and evaluation, the use of techniques to increase understanding and retention of factual material, and the stimulation of further self-directed learning.

**Exchange of Information**

An effective exchange of information requires powerful listening, observational, and responding skills. Listening skills include demonstrating respect and concern for the student or resident by questioning, focusing, facilitating, paraphrasing, and being silent. All these behaviors serve to elicit accurate and important information from the learner; a lot of instruction will be worthless or redundant if the teacher does not assess what the student already knows.

Observational skills include looking for both verbal and nonverbal cues, such as patterns of speech and word choice, as well as skin color, facial expressions, gestures, and body posture. Any teacher who has confronted an auditorium full of medical students, half of whom are asleep and the rest slouched in their seats, will attest to the value of observing carefully for learner cues and adjusting the teaching accordingly.

Responding skills include verbal behaviors (Ley et al. 1976) such as giving important information first, avoiding jargon, using clear organization and specific instructions, and giving the student some choices in the courses of action that might be taken next. During a discussion on teaching rounds about a patient with chest pain, the teacher might give specific instructions about the need for cardiac isoenzyme testing, but might also give the resident a choice on using oral or transdermal nitrate therapy. The resident is then much more involved in the direct care of the patient and more focused on the potential learning.
Exchange of Emotion

In the exchange of emotion, the physician must demonstrate certain qualities in order for the physician-patient relationship to move from the initial stage of no commitment to a stage of confidence, and hopefully on to a stage of total commitment in which the relationship is stable. The teacher-learner relationship, while perhaps not as intense as the physician-patient relationship, progresses similarly. The teacher qualities that encourage this progression are the same:

1. Empathy—understanding the learner's emotional state;
2. Respect—accepting both the positive and negative qualities of the learner (“unconditional positive regard” (Rogers, 1951));
3. Warmth—expressing care, concern, and compassion for the learner's stresses and the difficult nature of medical education;
4. Concreteness—clarity and brevity in the formulation and understanding of the learner's needs and problems and the teacher's recommendations;
5. Genuineness—congruence between what the teacher says and how it is said (the teacher who expresses interest in the student's presentation while dictating a letter and answering a telephone call does not fool the student);
6. Self-disclosure—the willingness of the teacher to share personal feelings and experiences (perhaps the most powerful role-modeling behavior a teacher can have);
7. Commitment—the willingness by the teacher to deal with unpleasant matters or to confront the learner about inadequacies or problem behaviors.

Exchange of Meaning

In the exchange of meaning, teachers and learners approach their relationships with often markedly divergent past experiences and current expectations, which can result in conflict. This conflict must be resolved before any good can come from the interaction. This resolution requires skills in negotiation, which are described in chapter 4.

Summary

Certain characteristics of the employer-employee, parent-child, and physician-patient relationships have considerable applicability to the teacher-learner relationship. Of these three relationships, some physicians may not have experienced the first two, but certainly all physicians have experienced the third. Physician skills in communicating with patients have considerable utility in teaching. The next chapter will examine the characteristics of the teacher-learner relationship, in preparation for directly comparing skills as a physician communicator with those needed to be an effective teacher communicator.

The first chapter made two basic points. First, teaching is best studied as a type of normal interpersonal communication between two people, a teacher and a learner. Second, the considerable experience that physicians have with certain other interpersonal relationships has applicability to the physician's role as a teacher. This chapter examines more closely the roles of the teacher and learner and the conditions that facilitate communication between the two. As a traditional problem,” successful teaching and learning requires that the teacher understand and make constructive use of four factors.

1. The role of the teacher and the teacher's attitude and what that the teacher brings to the relationship.
2. The role of the learner and the experience and knowledge that the learner brings to the relationship.