

Energizing Rheumatology Training: Put Teaching Back into the Academic Limelight



The effective teaching of clinical medicine is not easy. There are many competing demands for a clinician educator's time that distract from teaching, including the need for clinical and administrative productivity, family expectations, and the required involvement with educational oversight committees. But I believe that the major underrecognized impediments to developing robust rheumatologic teaching programs filled with energetic and effective educators are (1) the relatively few practical and available opportunities for clinical faculty to participate in continued medical education (CME) activities directed toward advancing their teaching abilities, developing innovative educational programs, and enabling realistic self-assessment of their teaching skills; and (2) the lack of rigorously defined and uniformly accepted attributes of the successfully trained clinical rheumatologist¹. As a professional community we need to support our teaching faculty in getting better teaching tools and refine our definition of the final product of professional training: the clinical rheumatologist.

The Accreditation Council for Graduate Medical Education (ACGME) several years ago promulgated the idea (that is, an expectation) that teaching programs should hold annual education program reviews (program self-assessment) and provide formal continuing education for their core teaching faculty on the components of effective teaching (personal self-assessment). On the ACGME Website (www.acgme.org/acWebsite/navPages/commonpr_documents/VC_Evaluation_ProgramEvaluation_Explanation.pdf), this statement can be found: "Faculty participation in faculty development activities should be monitored and recorded... Activities should — over time — include not only CME-type activities directed toward acquisition of clinical knowledge and skills, but also activities directed toward developing teaching abilities..."

Berman, *et al*² are to be congratulated for communicating through the *Journal of Rheumatology* the Hospital for Special Surgery (HSS) rheumatology department's advancement of the concept of providing ongoing education for its

educators (addressing my point 1 above). As Berman, *et al* note, establishing a faculty development program in teaching is not a new idea. This has been embraced in concept and implemented by many postgraduate medical centers around the country, including my own. But the efforts of Berman and his colleagues also represent an excellent example of a successful rheumatology departmental program review, ripe with honest self-appraisal and an action plan. Their plan offers potential for an enduring positive outcome from this educational retreat with resultant program improvement and hopefully an ongoing impetus for continued institution-wide support for faculty development. Time will tell whether this rose will grow in Manhattan.

Why aren't all programs already doing this with vigor? In contradistinction to what we may submit (with the best of intentions) on our formal program information forms to the ACGME, few programs have inculcated faculty development in a serious way into their academic fabric. It is not easy to accomplish.

For most rheumatology sections, a robust faculty development program in teaching is likely best facilitated at the institution or department of medicine level, sharing internal education resources and importing external speakers and facilitators as needed to address topics such as communication, providing useful feedback to fellows, evaluating trainees, identifying and helping the problem learner, etc. Some institutions have used their own faculty and/or imported facilitators trained in nationally recognized programs such as Stanford's Faculty Development Program in Clinical Teaching³. Some institutions have built their own "academies" or certificate programs and expected participation by all program directors and other key educators. Creating comprehensive institution-wide programs can be a challenge, but to individual departments there is the equal or greater challenge of helping their faculty to attend the programs that are offered and then to implement the programmatic changes desired by the newly re-energized

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faculty. The first part of this “resource gap” could easily be supplemented by faculty development programs offered by national or regional societies/organizations at their specialty meetings.

Several years ago, recognizing the need to provide teaching-focused continuing education content to core clinical faculty in rheumatology programs, an identified educator “track” was introduced at the annual American College of Rheumatology (ACR) scientific meeting (initially during the lunch hour so as not to compete with the clinical and research interests of the attendees). Dual goals for this track included providing CME directly to faculty from programs with limited resources to provide this type of material, and facilitating dialogue among attendees, including chairs and program directors of rheumatology teaching programs. As we initially envisioned, I would hope that the ACR through its education- and trainee-focused committees will continue to embrace this track and take complete ownership of it to provide an ongoing curriculum for the benefit of all rheumatology training programs at the annual meeting. Included in this track should be the themes and needs identified by the group at HSS-Cornell² and others who have attempted to create similar programs in faculty development to bolster their teaching efforts. The persuasive rationales for an educator academy expressed in the Berman paper should catalyze the efforts of the ACR to continue this “track” as well as to further energize innovative regional groups such as the Carolinas Fellows Collaborative and international societies to expand their efforts in faculty development.

Through my involvement with the oversight of residency and fellowship programs, I have come to feel strongly that we must particularly continue to push for our clinical teachers (and trainees) to recognize that the formative evaluation and feedback process is *not* equivalent to examination and grading. The goal of formative feedback during training must be to help direct (coax, entice) our trainees toward achieving the desired level of competence to fulfill their anticipated role as clinical rheumatologists and consultants (which means we *must* as a subspecialty coherently define these roles). Creative and focused evaluation methods need to be developed. Evaluation “scores” should be eschewed as the primary form of feedback. Giving constructive corrective feedback, with or without a lower-ranked evaluation score, must not be viewed as potentially hampering that fellow’s career path or as a reason for that fellow to reciprocally be more critical of that faculty when completing the faculty’s teaching evaluation. For many programs this will reflect a paradigm shift. It will take effort and creativity by program and national rheumatology education leaders, as well as time and commitment from “in the trenches” faculty, with ongoing reinforcement to succeed. Ongoing faculty development will pay off.

But formative feedback to trainees can only be successful

if the image of our successful graduated rheumatology trainee can be explicitly defined. It is difficult, if not impossible, to design effective training programs without this definition. Yet as an academic rheumatology community, we quite clearly are not yet of one mind when we speak of our graduating rheumatology fellows. We must insist on providing rigorous high-volume clinical training to all of our fellows who intend to sit for the clinical rheumatology certifying examination, including those few genuinely aiming for research-based academic careers. We must not confuse book knowledge, scholarly prowess, and test-taking skills with clinical skills. We must work hard at defining expected clinical expertise in our graduates, and we must honestly, seriously, and objectively assess the clinical skills and experience of those for whom we provide the honor and opportunity to teach our trainees¹. I do not believe that we can assume that providing our fellows with a few half-day “continuity” clinics per week for the second year of a 2-year fellowship provides sufficient clinical exposure to guarantee that all of our graduates can function as trusted independent clinical consultants. We need to find a way to strike an appropriate balance between providing clinical and scholarly (research) experience to our trainees based on their likely future endeavors — and statistically, the over-whelming majority will be pursuing primarily clinical careers (not forgetting that our young research faculty are likely to supervise some of the fellows’ clinics, to bolster their own clinical work relative value units while limiting the work associated with primary patient care responsibilities). Hopefully the American Board of Internal Medicine and ACGME milestone projects will provide a forceful nudge to programs in this direction; we will all soon be challenged to behaviorally define and document the acquisition of the core competencies that are expected of each of our graduating fellows. The fundamentals of a competency-based curriculum have been proposed by a regional consortium of program directors⁴, but a true national standard of competency has yet to be embraced.

As for academic recognition and promotion in traditionally structured academic medical centers, it is time for the teaching facet of the academic unicorn, the triple-threat academician, to achieve equality in rigorous expectations and institutional support alongside research and clinical care. Educating future specialists is not free, yet we will all benefit when it is done well. At present, our teaching medical centers in the United States receive extra funds to compensate for the inefficiencies intrinsic to the training of our future physicians at these sites. We should insist, if necessary, that some of those funds be applied to support the time and professional development needs of our teaching faculty. If nothing else, the external enforcement of limited trainee work hours has taught us that replacing trainees in the hospital is a difficult and very expensive proposition when compared to adequately supporting quality training

programs. Thus, for most medical centers the elimination of training positions (a logical outcome if we cannot develop and support faculty) is not an ideal option. We need now more than ever to invest in our clinician educators. As academic centers strive to provide high-quality clinical care in a cost-effective and compassionate manner, our clinical educators must be viewed as necessary and relevant role models. With the creation of appropriately structured educational “academies” and defined teaching expectations (more than just time spent teaching), we can demonstrate that clinical educators really are *not* second-class academic citizens.

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