Clinician to Medical Teacher: Perspectives for the First Year

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**Abstract**

Practicing physicians may follow the desire to enter full-time academic medicine as a clinician-educator. There is a paucity of literature to inform the clinician with a successful framework in transitioning to all the necessary roles encountered as a faculty member in medical education. This article aims to provide clinicians with recommendations for their first year affording a smooth and successful transition. Given the multiple challenges faced in transitioning from clinical practice to medical education, these perspectives, while not typically covered in junior faculty development programs, are proposed for the clinician to consider as they enter into this new sphere of practice.

**Keywords:** medical education; academic medicine; junior faculty; medical teacher; clinician-educator; faculty development

**Introduction**

Practicing physicians choosing to transition into academic medicine face numerous challenges as they incorporate new systems within the medical education community. While the level of involvement in these transitions may differ for each clinician, this article presents perspectives to the practicing physician moving into full-time medical education within a medical school environment.

Faculty development programs are evolving with greater focus on preparing junior faculty to teach, lead, and foster student learning in a complex environment of advancing theory, technology, and curriculum delivery (Baker et al., 2018). Considerable advances in the role of medical educators over the past decade have added professionalism metrics, social diversity, academic inclusion, and cultural competencies propagating more robust responsibilities within the already phrenetic pace of medical education (Bannard-Smith et al., 2012). Furthermore, the adaptation of active learning processes, to include distance-learning, with more refined assessment and evaluation methods guided by detailed entrustable and sustainable activities, obligates the structuring of more in-depth faculty development
programs in an ongoing fashion (Leslie et al., 2013). These changes stem from realizing few clinicians arrive at the nidus of their academic medicine career prepared to adequately implement activities in developing curricular design and instruction, foundational metrics related to learning theory, and processes in assessment and evaluation. Institutions are starting to respond to these issues through more focused faculty development with the goal of achieving some of these metrics before the clinician-educator should start teaching.

It is our perspective that much of the fundamental training in faculty development programs for physicians new to medical education are focused on moving the clinician into their clinician-educator roles as quickly as possible with little time to develop skills and assimilate roles and responsibilities. We suggest a more preferable alternative would be to develop the clinician-educator in an incremental fashion while accepting this may produce some delay integrating into the active faculty environment. If clinicians are not engaged in a structured and validated faculty development program at the onset of their academic career, it is likely to translate into concerns toward negative effects in student learning and performance outcomes. Specifically, it is felt a lack of focused faculty development would incur sub-optimal curriculum delivery, learning, engagement, and performance in student outcomes. For the faculty, it allows for a decline in job satisfaction, an increase in burnout, and loss of cohesiveness in faculty relationships.

It is hoped this article will add insight to the "hidden curriculum" that some may face as they transition into full-time medical education from the clinical practice environment. These steps are felt necessary as medical schools further develop robust processes for faculty onboarding that are practical and deliberate.

**Perspective 1: Learn the Learning Theories to Build the Teaching**

This is perhaps the most important perspective of the process in transitioning from clinical practice to medical education. Much of medical education is built upon learning theory and evidence-based techniques in appropriately delivering curricular content. The new clinician-educator will need to assimilate these aspects quickly as many who transition into medical education do not have substantive knowledge, skills, and attitudes regarding the delivery of medical education. Faculty development programs have looked at educating new faculty accordingly in these precepts, but there seem to be gaps in how that is applied globally. Thus, the educator should seek resources to engage and learn curriculum design, delivery mechanisms, learning technology, processes in active learning, assessment modalities, and evaluation techniques.

Faculty development programs are often viewed in a tiered approach maintaining levels of development for all faculty. New clinician-educators will need more onboarding as evidenced by the steps in this article. Thus, the training of physicians transitioning to medical education seeks a balance in finding appropriate levels of faculty development coupled with the desire to address strained faculty resources by getting the new faculty member engaged in teaching. Therefore, it is incumbent upon the individual to seek resources, contacts, and mechanisms by which they can augment their faculty development through internally motivated experiences. Even at institutions where new faculty are acclimated through a structured process, the individual will need to apply personal effort in transferring this new learning into practice.

The move into academic medicine as a clinician-educator is primarily to teach. Given advances in medical education, the principles and concepts have become multiple and intricate. Most physicians have not been able to afford dedicated time synthesizing the role of teaching, so it becomes imperative that physicians incorporate their learning accordingly.

Teaching modalities are becoming more diverse, particularly during times of social change and current events. The
interests of stakeholders regarding curriculum design and associated student performance and outcomes are more rigorous and focused. The roles of a medical teacher are focused on deriving desired outcomes and then providing focused approaches in a student-centered climate to lead them to those outcomes. There is little left of the "sage on the stage" functionality for medical educators, so one has to adopt a facilitator approach in moving adult learners to an engaged mindset that enhances their present learning and establishes them as life-long learners prior to their matriculation into clinical practice.

**Perspective 2: Process the Process and the Practice**

A common theme with new faculty is exposure to unique processes involved in carrying out roles and responsibilities that differ from those of clinical practice. A new faculty member can find themselves quickly immersed in what seems organized chaos, so the key to success requires identification of these processes in an organized fashion.

An initial approach would be to analyze the institution's mission statement, vision, values, and programmatic goals. A new faculty member would be remiss in not addressing these aspects in their development since formative standards are essential in understanding the institutional guidelines for medical education in a specific environment.

Understanding an organization includes review of its structure. There are organizational charts in many medical schools useful in noting the hierarchy of reporting and responsibility. It is prudent to realize the organizational matrix in acclimating to overarching processes and practice foundations. Academic institutions, like many other environments, have traditional ways of defining roles, tasks, and inclusion within the culture. Awareness of particular practice styles, leadership approaches, and other faculty perspectives will allow the clinician-educator to integrate with peers in a positive manner.

An example would be planning a topic for delivery where the clinician-educator designs what they feel is the most effective teaching method for a given activity. However, failure to perform due diligence in providing an outline of the practice that informs that delivery method could result in an unsatisfactory delivery outcome. The investigation and planning would be futile if those who are responsible for the logistical and technical aspects of the delivery were not consulted prior to the delivery of this activity. Neglecting to realize the institutional processes and practice environment will cause issues of diminished productivity and time efficiency, both of which are a high commodity in medical education.

As much as being aware of the practice environment is important to integrating positively, so is learning particular characteristics of the institution's culture (Lewis and Steinert, 2020). Is there importance given to rank and promotion? Is there a particular hierarchy that needs to be respected in seeking guidance, offering perspectives, or verbalizing opinions or frustrations? There may be a culture of professionalism that differs from prior experience; therefore, realizing one's level of adaptability will help build a reputation of being an effective team member early in the transition.

Institutional cultures will likely prioritize each faculty member's roles and responsibilities tying them to performance. For instance, there may be categorization of teaching as a percentage of the faculty's time combined with activities focused on research and scholarly activity. Other areas may be required in clinical work and community involvement. Awareness of these parameters is important for a junior faculty as they adapt to the culture and plan implementation of their roles and responsibilities.

Included in the context of cultural adaptation would be a familiarity with the medical school's vernacular in
describing curriculum, process, and practice. The angst produced through dialogue in the midst of uncommon titles, labels, and activities clouds one's ability in effectively comprehending the overall context of the conversation. We have found ourselves asking frequent questions based on institution-specific nomenclature in order to better understand our role in applying conversations.

These tenets bring attention to cultural competency impacting one's associations with not only faculty, but students as well. Medical schools are more inclined to take stricter approaches on creating student-centered learning and the creation of safe, positive learning environments that hold to respectable patterns of diversity and inclusion. Understanding an institution's culture is fundamental for the integration of oneself into any environment. Increasing awareness of cultural processes within the institution will positively impact relationships with both students and faculty while leading to more effective transitions into new roles and responsibilities.

Finally, institutions often have climates that dictate the levels of well-being, satisfaction, and safety. The different climates, for the most part, remain balanced. However, it is imperative that new faculty be able to recognize when the institution's climate is "stormy" or "calm". This demands considerable focus in determining, or predicting, the forecast of different situations within the environment which will allow the new educator to adapt proactively. Actively maintaining this awareness will augment the individual's plan for integrating into the faculty community effectively.

**Perspective 3: Engage the Community**

Integrating into a new community with complex mechanisms and grounded traditions mandates the faculty member seek out mentorship. An important realization is that mentorship is best acquired by seeking a "village" of experts and associates that can guide and influence perceptions, behaviors, knowledge, and skills for medical educators (Fleming et al., 2015). Some institutions may provide a mentor as the clinician-educator matriculates into the medical school, but this may not be an organized onboarding element.

It is important to identify and select a mentor who is felt to have the particular expertise the new clinician-educator seeks. Examples would be connecting with certain individuals willing to discuss item-writing for single-best answer tests. Another would be a simulation-based education expert to explore the process of case construction and evaluation schematics. Distance-learning has become a huge investment for institutions regarding time, finance, and personnel hours; therefore, finding someone who has sound approaches to planning, organizing, and implementing learning experiences in a remote environment are essential.

Communication in academic medicine obligates new clinician-educators to develop strong interpersonal skill by addressing areas of emotional intelligence that the clinical arena may not deem as important. New faculty will need to develop personal and professional approaches which align with the institution's culture adding to the effectiveness and productivity as the faculty member takes on more responsibilities in the first year. Communicating in a direct fashion with tactfulness, clarity, and integrity will serve to distinguish the new faculty member positively while serving to develop trusting relationships with faculty, peers, and students alike.

In as much as professionalism, communication, and mentorship afford impetus in developing oneself in this new role, networking is an added benefit in understanding the processes, practices, and patterns of medical education within any environment. This allows the retrieval of learning resources, professional organizations, and access to scholarly activities serving to define a clinician-educator's development as a quality team member.
Perspective 4: Live Your Goals

Faculty performance is specifically assessed by an appraisal process using defined metrics. These metrics are intended to gauge an individual faculty member’s proficiency and effectiveness in their specific roles and responsibilities. Much of the appraisal process will be goal-directed, therefore the educator will need to be acclimated in formulating their outcomes with specific performance goals. Academics has started utilizing teaching portfolios with integration into complex rank and promotion standards. Therefore, it will be necessary to learn how to prove one’s impact for the institution through thorough and detailed documentation. The concept of performance hinges on outcomes. Specific performance goals should be uniquely focused such that daily activities are able to define performance in all categories of one’s roles and responsibilities in an ongoing fashion. Being able to articulate professional desires, interests, and meaningful contributions through the completion of performance goals will solidify advancement within any organization.

The first year of being a medical educator will place demands on time and energy much differently than clinical practice. The timelines, deadlines, and opportunities will be endless and the tendency to add on tasks will be a critical factor in a new faculty member’s initiation. It is important to communicate with directors and chairs in developing a sense of how many activities one should commit to versus how much one can defer in order to keep a reasonable momentum.

From a productivity standpoint, one should become proficient with time management in their roles and responsibilities. Persistence in analyzing additional workload demands will require intentional communication with other faculty, directors, and chairs to maintain balance in one’s roles and responsibilities. This healthy balance is critical to ensure an equitable and sustainable commitment to the institution, the students, and most importantly, one’s self.

In seeking balance, it is imperative to pay attention to wellness, self-care, and mindfulness of how much is being added, or taken away, from your basic life needs. Determining this health balance is often difficult in highly demanding professions such as being a full-time clinician-educator. The importance of a healthy diet, regular exercise, and protected personal and family time will be even more important as one moves into being an educator.

Realizing activities that are sustainable, or non-sustainable, will take consistent reflection as to not only “what” you are doing but “how” you are doing it. Strategically planning productivity and setting boundaries on when you engage work and life tasks are important to long-term survival in any profession. As experienced clinicians, our tendency is to extend ourselves for the purpose of the mission and those we serve. Acknowledging this as a non-sustainable process will create more meaningful outcomes for yourself, your medical school, and particularly, the students.

Our collective experiences in the first year as clinician-educators have been associated with multiple conversations surrounding frustrations, barriers, and whether the whole process is sustainable. Many of us have moved into medical education with a long list of trade-offs. Some of the factors realized in transitioning to medical education, for most of us, involve decreased financial compensation, lack of control in practice, and loss of time flexibility.

Many of us have several years of clinical practice experience whereby we were used to functioning as the resource person for staff in either the hospital or the clinic environments. We were used to being available for questions such as "Doctor, how do you want us to address this?" in addition to questions such as "Doctor, we need to fix this problem, what are your thoughts?". Moving into medical education finds one in the position of very few being interested in your thoughts as to solutions, innovations, and change in the first year.
It is important for the clinician-educator to realize what prompted a change to medical education in the first place. Our experience causes us to consider one of passion based on teaching and learning within an environment that builds future physicians. That passion is processed based on foundational internal motivations of a desire to be a part of something to which one feels called. It is felt to be a driving force that allows us to accept the trade-offs as we are devoted to the greater good to which our passions and desires guide us.

The last aspect of our "why" is based on the consideration of context regarding our "why". In clinical practice, much of our energy was devoted to our patients. This is highly relational, personal, and emotional with some clinicians; thus, giving up patient interaction takes away an important part of our vitality. Clarifying how our relational, personal, and emotional tendencies translate to student interaction is quite a different discovery. While we desire to have meaningful relationships with students, the parameters and boundaries present in medical schools are guarded by more stringent cultural frameworks through various regulatory functions such as Title IX and the Family Educational Rights and Privacy Act (FERPA). We consider student relationships highly effective and rewarding; therefore, we work to function as teachers, preceptors, and mentors to our students in every way possible while maintaining the institution’s operational integrity.

The ability to define what drives our daily energy in being a clinician-educator requires us to readily access our "why" for being in medical education through mindfulness, awareness, and reflection. We have found the above steps paramount in modeling constructive behavior that keeps us positively motivated and actively engaged in our roles and responsibilities. The structure of our fundamental desires and motivations has to take precedence over the smaller "incidentally" that, when considered in the overall scheme of things, do not really matter. Our longevity in this endeavor requires dedication to finding our strengths, needs, and desires in developing sustainable approaches to our longevity in medical education.

### Conclusions

These perspectives are based on the experiences and circumstances of our own faculty development and the realization that many aspects in being a productive and effective faculty member are not necessarily communicated but gained through trial and error in the acquisition of new roles. The steps are not typical recommendations for new medical educators in a structured faculty development environment, but we feel they represent cogent aspects relevant to a new clinician-educator. Our hope is that we have provided the clinician moving to full-time medical education sound recommendations that can be considered in navigating their first year safely, effectively, and healthily.

### Take Home Messages

- Learn the learning theories to build the teaching
- Process the process and the practice
- Engage the Community
- Live your goals

### Notes On Contributors

Robert Tyler, DO, MScMEL, FACP; Dr. Tyler specializes in the practice of General Internal Medicine and is an Assistant Professor of Medicine at Kansas City University College of Osteopathic Medicine in Joplin, Missouri. He
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Bibliography/References


Appendices

None.

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Ethics Statement

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