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# Residents' perceptions of the ideal clinical teacher—A qualitative study

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**Abstract**

*Objective:* The object of this study was to establish what residents in 1994 and 2003 characterised as an ideal clinical teacher and whether differences existed between residents' views in 1994 and 2003.
*Study design:* Setting: postgraduate medical education in the Netherlands. Subjects: 207 obstetric-gynaecologic residents. Intervention: open-ended questionnaire. Analysis: qualitative data analysis with two coding dictionaries based on current literature. Differences between 1994 and 2003 were estimated using the Chi-square test.
*Results:* Residents preferred the 'person' role both in 1994 (42%) and in 2003 (48%). The 'physician' role was significantly more important in 1994 than in 2003; the 'supervisor' role was significantly more important in 2003 than in 1994 ($p < 0.05$). Seventy percent of the comments related to 'direct interaction' (i.e., between residents and clinical teachers), 30% to 'indirect interaction' (i.e., clinical teachers' behaviour affecting residents indirectly).
*Conclusion:* The data showed that almost half of residents' comments described 'person' role characteristics. There was a significant shift in the role ranked second, from the physician role in 1994 to the supervisor role in 2003. The findings highlighted that teachers, in order to be perceived as ideal, should adapt their behaviour to residents' learning needs.


*Keywords:* Medical education; Graduate medical education; Teaching and learning; Qualitative research

## 1. Introduction

Residency typically involves apprenticeships in university and non-university based hospitals where a resident delivers patient care under progressively diminishing supervision of a clinical teacher [1]. The relationship between residents and faculty members is of great importance for the clinical learning environment. According to Paice ''...the quality of that relationship can make the difference between a post that is rewarding and one that is demoralising'' [2].

Most research on the concept of the ideal clinical teacher relates to personal traits he or she should have [3–11]. In these studies students, residents, and sometimes clinical teachers themselves filled out questionnaires or took part in interviews to define the ideal clinical teacher. Some studies were concerned with general practitioners, anaesthetists, or surgeons, and one older study described characteristics of gynaecologists, rated by medical students [3–7,10]. A compelling paper was written by Ullian et al. [9]. They describe four roles based on the literature and on research of residents' perceptions of their clinical teachers. These roles are: '''*physician*' (models knowledge and skills in performing

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medical duties), '*supervisor*' (provides opportunities for performance, observes, gives feedback), '*teacher*' (selects, organises and delivers information), and '*person*' (exhibits certain interpersonal and intrapersonal characteristics)" [9]. A study among medical students on their opinion of clinical teacher characteristics confirms this pattern of roles [8].

In our view, the aforementioned literature on teachers is predominantly written from a cognitivistic perspective [12]. Cognitivism focuses on individuals and their mental activities. Knowledge can be seen as consisting of schemata or symbolic mental constructions [13]. Teachers play a central role by, for instance, organising knowledge. In recent years, however, there has been growing interest in social cultural theories of learning [12,14–16]. Social cultural frameworks emphasize the importance of the social context and relations in which learning takes place [17–19]. Swanwick states "...it takes two to tango", stressing the importance of reciprocal interaction between learner (i.e., resident) and workplace environment (i.e., residency) [12]. Similarly, people and personalities are constructed in relation to others; as Burr states "...one way of looking at this is to think of personality (...) as existing not within people but between them. Take some of the personality-type words we use to describe people: for example, friendly, caring, shy, self-conscious, charming, bad-tempered, thoughtless (...) words which would completely lose their meaning if the person described lived on a deserted island. The point is we use these words as if they refer to entities within the person they describe but once the person is removed from their relationship with others the words become meaningless" [20]. We hypothesised that whether or not a clinical teacher is perceived as ideal depends on the interaction of a resident with his/her teacher in a certain context.

The clinical learning environment, i.e., the context, has changed over the past 15 years. Shifts in the organisation and delivery of health care make residency an ever-changing endeavour, apart from the challenges posed by evolution of medicine itself. A significant change, for example, is limits on the number of hours residents are allowed to work [21,22]. This leads to additional pressure on quality of patient care and creates fewer possibilities for training [1,12]. Moreover, residents spent fewer hours with clinical teachers. This may have led to changes in residents' requirements of an ideal clinical teacher.

In this study we asked obstetric-gynaecologic residents in 1994 and 2003 which characteristics they value most in clinical teachers. The first objective of this study is to take the current literature as a point of departure and describe characteristics of clinical teachers favoured by residents. The second objective is to complement this point of view using a socio-cultural approach as described above. Our third objective is to establish whether there are differences in residents' perceptions of ideal clinical teachers between 1994 and 2003.

## 2. Material and methods

Multiple quantitative questionnaires measuring clinical teachers' effectiveness or quality exist. However, to answer our research questions a qualitative research method is most appropriate. This kind of research enables participants to express their personal views without forcing them to choose predefined answers. In 1994 and 2003 we asked all obstetric-gynaecologic residents in the Netherlands to fill out a questionnaire containing three open-ended questions. In this study we report the responses to the first question on the questionnaire: "Which three characteristics should an ideal clinical teacher have?" The other two questions were: "What do you miss in your clinical teachers?" and "What suggestions do you have for improving residency-training?" The second and the third question were aimed at local quality improvement and they did not add to the current research question. Therefore, we did not include the answers to the last two questions in our analysis. The form did not include a section on resident's year of training or sex.

### 2.1. Participants

In 1994, 74 obstetric-gynaecologic residents (62% of a total of 120 obstetric-gynaecologic residents in the Netherlands at the time) filled out the questionnaire. In 2003, 133 residents (55% of a total of 240 obstetric-gynaecologic residents) filled it out. In both cases, we sent a questionnaire to the home address of every resident and we requested them to return the filled out form. Since we included every obstetric-gynaecologic resident in the Netherlands, residents with varying experience levels received the questionnaire. All completed forms in 1994 were readable; they contained 248 'units of analysis'. A unit of analysis is every word, line or phrase that expresses a single characteristic of a clinical teacher. Out of 133 questionnaires in 2003, 13 were not readable due to photocopying problems, and therefore, excluded from analysis, making a total of 120 questionnaires. These questionnaires contained 316 units of analysis.

### 2.2. Analysis of qualitative data

According to Miles and Huberman the analysis of qualitative data roughly consists of three concurrent 'flows of activity': *data reduction* (i.e., classifying unstructured data into coding categories for retrieval and organising purposes), *data display* (i.e., using matrices, charts, etc., both for data reduction as for explaining and seeing 'the bigger picture'), and *conclusion drawing and verification* (for instance making conceptual coherence and checking for researcher effect) [23].

As a means of *data reduction* we constructed two coding dictionaries. The first author (KB) created the first coding dictionary using the four roles described in Ullian's study ('physician', 'supervisor', 'teacher', and 'person') [9]. She coded the 564 units of analysis into 64 codes that were each