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**Title: Educational expectations of professionals who teach in Primary Health Care**

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## **Abstract**

With more emphasis on primary health care (PHC) both in the undergraduate and postgraduate curriculum, there is an increasing demand for high quality teaching in primary care centres. However, professionals in low and middle income countries often have little training in teaching. Britain could have an important role in supporting training the trainers in other countries. However the needs of these PHC teachers may differ from those teaching in British PHC. We explore the needs of professionals who teach in PHC in Chile through an online survey and focus groups.

All the domains of competence of a clinical educator were considered to be important for training by 83% or more of the questionnaire respondents. 90% of the respondents agreed that PHC professionals should be given permission to attend courses about teaching and preferred B-learning methods. Three dimensions emerged in the focus groups. 1) The specific role of the teacher in PHC. 2) The challenges faced by teachers in PHC. 3) Intuitive teaching. An unexpected theme that emerged was the desire of the teachers to analyse and reflect on their teaching. There are enthusiastic and dedicated professionals in PHC in Chile with a strong felt-need for training in teaching skills.

**Key words: Needs Assessment; Continuing Education; Primary Care; Teaching; Family Practice/\*education**

## **INTRODUCTION**

It is important for any health system to have well trained health teams in Primary Health Care (PHC). The WHO is advocating for a renewed investment in PHC and recognizes the need for a strong cadre of physicians and other professionals who are able to deal in a timely way with the challenges of communities whose basic health needs are impacted by the growing burden of non-communicable diseases.(1) Most countries now have formal training in Family Medicine (FM), a large part of which takes place in the PHC setting.(2) Increasingly, universities are including activities in PHC throughout their undergraduate curricula. The more students are exposed to PHC during their training, the more likely they are to take an interest in a career in PHC.(3) However, these changes have put extra pressure on the professionals working in PHC to provide teaching to the students and residents who rotate through their centres.(4)

In many countries the quality of teaching in PHC is variable and inconsistent and there is a lack of teachers in PHC.(5–8) PHC teachers are expected to be proficient at adult education, and, particularly in countries where PHC and FM are emerging, to be able to help students learn in a new and changing health care system. They should be able to teach clinical and communication skills and include the advances in evidence-based medicine (EBM). Often PHC professionals have little experience in teaching and those who do, may need to adapt to manage larger number of students in small-group teaching and vertical integration.(9,10)

There is no doubt that a clinician who supervises residents' or students' practice should be a competent physician, but it should not be assumed that competent physicians are

always competent teachers.(11) There is growing evidence that educators in primary care would benefit from systematic training in teaching skills, knowledge and theory.(12,13) When physicians working in PHC receive training in teaching skills, they not only improve their teaching skills(14) but also have more job satisfaction and improve their clinical practice. (15) CME for professionals working in PHC presents specific challenges that differ from those of faculty development in the university setting.(5,16)

Britain is in a unique position to be able to support other countries in training the trainers: it has a vast experience of running successful training the trainer courses in general practice and has a clear strategy for assessing the quality of trainers in PHC. (17) Theory suggests that it is important to take into account the learners' needs when designing adult education.(18) Expert opinion has attempted to define the competencies of PHC teachers,(19–22) but this may not reflect the views of the teachers themselves.(23) particularly in low- and middle-income countries.(6)

As in the UK, countries in Latin America have difficulties in training and retaining excellent health professionals in the primary care sector. Chile, which has a strong PHC system, started to train doctors in FM in 1990 and training for other PHC professionals followed later. FM in Chile is now a recognized speciality with clear definitions of its own set of skills, curriculum and forms of assessment. Recent curricular changes in many Chilean universities have increased the PHC training for undergraduates. There is a challenge to provide high quality teachers for this new teaching and demand for teachers far exceeds the supply of available expertise. Academics are not always available in the PHC centres and there is a need to improve the teaching skills of the non-academic professionals working in the PHC centres in all regions of Chile.

In 2015 we developed a collaborative partnership between Scotland and Chile to design a training course to provide quality training for PHC professionals throughout Chile. In this study, we set out to define the educational needs of PHC professionals who teach in PHC in Chile.

## **METHODS**

The mixed-method study using two approaches to collect the data has the approval of the research ethics board of the Faculty of Medicine, P. Universidad Católica de Chile.

### **1: Needs assessment Survey**

An on-line questionnaire based on 10 competency domains defined as important for clinical educators(24) was developed by the research team and pilot-tested on an expert panel of primary care professionals.

Invitations were sent by email between July 2016 and Jan 2017 to a convenience sample of 199 professionals who work and teach in PHC in 16 different centres of PHC from 3 different regions of Chile inviting them to participate in a web-based survey. Follow-up e-mailed reminders were sent at 1, 2, and 4 weeks after the initial invitation. The survey responses were analysed using descriptive statistics.

### **2: Focus groups**

All the participants of a pilot course on teaching skills were invited via email to participate in focus groups held in August 2016. Three focus groups were run in parallel, each group guided by a sociologist with experience in running focus groups. Each focus group of 8-9 PHC professionals lasted about 2 hours and was audiotaped.

The questions used in each group to guide the discussion were drawn from a review of the literature and results of the survey.

1. *Please describe what you do when you receive your students, and how you face the challenge of teaching your profession in PHC*
2. *What are the principal problems that you face in your teacher-student relationship?*
3. *What do you feel that you need to learn about (in terms of knowledge, generic skills or technical skills) in relation to your role as a tutor/teacher?*

The audiotapes were transcribed to maintain the anonymity of the participants. The research team analysed the transcripts using content analysis to understand the phenomena by identifying themes(25,26)

## RESULTS

### **Needs assessment survey**

101 non-academic PHC professionals who work and teach in PHC responded to the online survey (50% response rate): 49 doctors, 14 nurses, 8 midwives, 7 social workers; most were between 25-35 years old, only 17% had had any training in teaching skills. 99% considered that PHC needs professionals who have had training in how to teach.

All the domains of competence were considered to be important for training by 83% or more of the respondents, particularly leadership, curriculum and feedback. There was slightly less interest in technical skills teaching, preparing educational material, communication, evaluation and clinical observation (Table 1). 90% of the respondents agreed or strongly agreed that PHC professionals would be given permission to attend courses about teaching. B-learning was the preferred type of course (79%).

### **The Focus groups:**

24 professionals from 9 different primary care health centres (33% doctors, 21% midwives, 16% nurses) participated in 3 focus groups (Figure 1). They had taught for an average of 4.5 years (0.5 to 27 years) to different groups of students (Figure 2). The focus group participants consistently identified the following three dimensions of teaching in PHC. All citations can be found in Table 2.

### **1. The role of the teacher in PHC**

This dimension describes how the professionals in PHC carry out their teaching: the practicalities of their teaching. It includes how the professionals handle teaching their students whilst also caring for their patients, all in limited time (*Person 5 Group 1*). The participants describe the specific characteristics of primary care and how these affect the way they teach: teaching teamwork, interpersonal skills to promote empathy with their patients and how to care for patients within a finite time (*Person 6, Group 1*). Primary care is a new environment for their students whose training is primarily in hospital, and the participants recognise that their role-modelling is important in this scenario (*Person 4, Group 1*)

### **2. The challenges faced by teachers in PHC**

This dimension has three different areas. Firstly the professionals describe how the student's motivation affects the teachers' motivation and the difficulties faced by the teachers when students have no motivation for learning in primary care. Motivation is a complex phenomenon. There is the question of how to motivate students in general, how to catch their attention and help them see PHC as an opportunity to develop professionally, whether or not the student likes or dislikes PHC. There are many students that arrive in PHC unenthusiastic and with certain prejudices against about learning in PHC: teachers need to develop practical motivational activities for these students(*Person 5 group 2*).

Secondly the professionals describe how little experience they have in feedback and evaluation. They recognise their lack of communication skills to give constructive feedback and they discuss the problems of objectivity in evaluation and feel that they lack knowledge and practical skills in these areas (*Person 7, Group 2*).

Thirdly an unexpected theme arose in which some participants expressed their frustration and anger at what they see as a lack of understanding of how PHC works by the university teachers who run the courses (*Person 8, Group 1*).

### **3. Intuitive teaching or how do the teachers manage?**

This dimension describes how the health professionals manage to teach despite having no formal training in teaching. The professionals showed their ability to analyse and reflect on how they get by in their teaching (*Person 1, Group 1; Person 8, Group 1*). They teach with a common-sense pragmatic approach, using intuition and by being flexible in the way they teach (*Person 2, Group 2*). They try different ways to motivate the students and to create a good teaching atmosphere (*Person 7, Group 2*).

## **Discussion**

To our knowledge, this is the largest study in Latin America of the educational needs of professionals who teach in Primary Care. The only other Latin American study describes the educational needs of 28 family doctors working in PHC in Cuba; many of the subjects were still in training themselves, with little teaching experience.(27) Our questionnaire includes responses from over 100 different professionals from the PHC team and our focus group included 24 professionals with varying teaching experience.

The professionals in our study rated all the categories of a clinical educator highly, suggesting that there is a strong felt need for training in this area. Our findings largely agree with other needs assessment studies for teachers of PHC: the emphasis on feedback and evaluation, leadership and curriculum appear in all the studies.

It is particularly interesting that communication skills are considered as important in Latin America where communication skills training is relatively new (Moore et al. 2010) Perhaps this fact supports the finding that the supervision relationship is probably the single most important factor for the effectiveness of supervision, more important than the supervisory methods used.(28) It has been proposed that there may be differing needs according to the years of experience of the professional, but our study supports the European needs study which showed that there were many themes in common between novice teachers and those with experience.(12)

Some challenges for teaching in PHC are common to all the studies. Providing quality teaching while running a busy clinic is not easy in any country. The huge pressure in Latin America to provide care to large populations with low resources makes this particularly challenging. Guldal suggests protecting time for teaching so that it is not just an “add-on”. (12) However this requires action, not just at a micro-level but also at a macro-level. There have been calls for a united effort between institutions, accrediting bodies and national organizations(22) Organizations such as World Organization of Family doctors (WONCA) and its branch Confederacion Iberoamericano de Medicina Familiar (CIMF) can have an important role in Latin America to assure that political and institutional decisions support training and resources so that quality teaching is provided in PHC.

Motivating students was seen as an important challenge in our study. In many parts of Latin America, PHC has a stigma of providing poor quality health care for the poor. Hospital doctors can still be heard discouraging students from careers in PHC or stating that “real” medicine is only in hospitals. The pride and dedication of the health professionals who attended the focus groups highlight how important these professionals will be in encouraging more students to consider a career in PHC.

We detected two unexpected emerging themes that are worth consideration. The first that arose from the focus groups is the ability of the PHC professionals to reflect on and critically analyse their teaching. If a focus group can create a space for reflexion, perhaps a similar “space” could be created within the health centres - a “learning community” where PHC professionals could learn from each other and create local solutions. Boedenmaker describes five personality traits that form part of the core characteristics of a teacher in PHC: our professionals expressed all five during the focus group: integrity, flexibility, insight, ability to self-criticise and enjoyment of their role in PHC(20) He also identifies what he describes as “an important new characteristic” for PHC teachers: the

ability to inspire reflection in the trainee. Reflective practice and mindfulness have been extensively promoted within family medicine training in the northern hemisphere but are new terminologies for Latin America. It will be interesting to see if this becomes a new need in the future in Latin America.

The second unexpected emerging theme is the PHC teachers' perception that the universities do not understand how and what students can learn in PHC. The dangers of universities as "Ivory towers" has been discussed in the literature(29) and the problems of evaluation across clinical centres(30) it is clearly a challenge to take into account when including teaching in primary care and community centres. Several initiatives have been proposed to bridge the gap between academic centres and communities.(31,32) In contrast to other studies, none of the respondents to our questionnaire and few of the participants of the focus groups had received formal training in teaching skills. This is in contrast to another Latin America study in which 27/29 of the participants had been to a workshop to prepare to teach(33) There are several ways to learn teaching skills in Chile: workshops offered by specialty society courses, faculty development activities, formalized diploma programmes certified by universities and formal postgraduate education programs (e.g., master's, doctoral). However, faculty development activities are rarely available for PHC professionals, who do not have a university contract. Formal university training requires candidates to invest a protracted period of time and often involves theoretical content that may have limited practical application and the emphasis is in the hospital setting. It is interesting that our PHC professionals believe that training in teaching is important and that they believe their employers would be willing to give them time to learn teaching skills. They recognize that they teach intuitively, often as they were taught, and this makes them insecure and yearn for more help. There appears a felt need for B-learning courses directed specifically for PHC professionals.

### **Limitations**

Although we had a good response rate for our online questionnaire and received 100 completed questionnaires from professionals of 16 primary care centres in three different regions, it would be interesting to repeat the study to include professionals from other parts of Chile or Latin America.

The professionals in our focus group had chosen to participate in a pilot taster course on teaching. They may not represent the point of view of all professionals that teach in PHC and may be more enthusiastic about their teaching role than other professionals.

Our questionnaire asked the professionals to rate importance on a range of themes related to teaching. A theme that is rated as extremely important yet currently performed well is defined as much a need as an extremely important theme that is not performed well.(34) An alternative method of needs assessment could be to ask the professionals what they would most value learning : in this case the participant is expected to take into account the two complex features of need (importance and current performance) and to summarize them in a single measure. We cannot be sure if respondents are addressing both or one aspect of need. In our study by enriching the information from the questionnaire with that collected during the focus group, we believe that we have a clearer picture of the professionals' perception of both the



importance and the current performance of their teaching needs

## Conclusion

Our needs assessment study confirmed that all of the core competencies for a teacher in PHC are considered important in Chile. We also found that there are enthusiastic and dedicated professionals in PHC who would like to be trained in teaching skills. In Latin America we need to learn from initiatives in the northern hemisphere, such as the Scottish National training schemes(17) and Leonardo da Vinci Project(12) so that we can provide cost-effective quality training in teaching skills for the professionals in our PHC.

## Practice Points

- Primary care health (PHC) professionals who teach in PHC in Chile have a strong felt need for training in teaching skills
- All 10 domains of competence of a clinical educators were considered important by the PHC professionals, particularly leadership, curriculum and feedback
- How to teach communication skills was one of the competencies deemed as important for PHC professionals, despite the fact that communication skills teaching is relatively new in Latin America.
- A challenge in primary care health, is providing quality care to the patients and quality teaching to students while running a busy clinic
- Academic departments of Primary care must ensure they are not “ivory towers”

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## Declaration of Interest

The authors report no declarations of interest.

**Geolocation: Chile, Latin America; and Edinburgh, Scotland**

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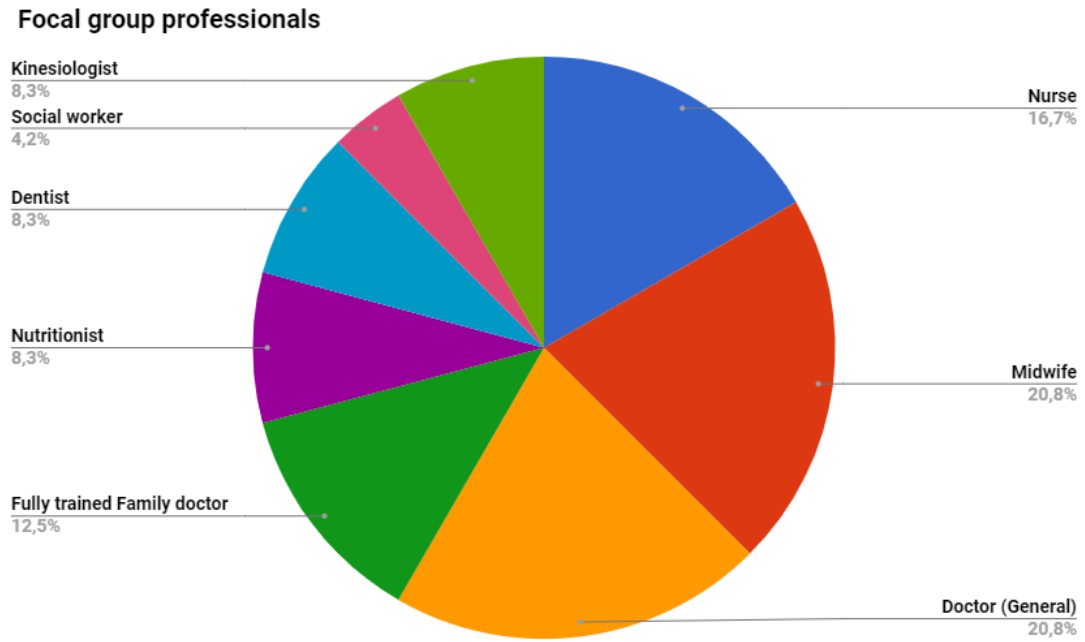
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**Table 1**

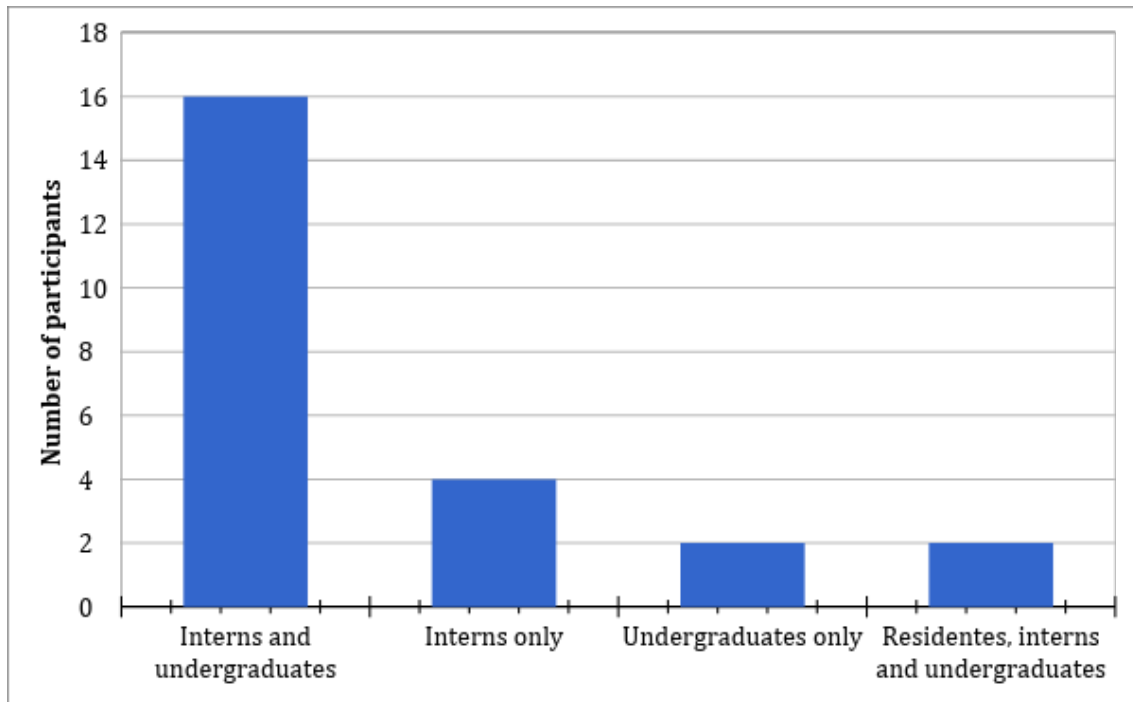
**The ten domains of competence of a clinical educator and the percentage of respondents who considered the domain to be important for training PHC teachers**

<b>Domain of Competence for clinical educators</b>	<b>% Respondents considering domain as important for PHC teachers</b>
Leadership	92
Running tutorials/small group seminars	92
Curriculum	92
Giving feedback	92
Teaching Procedural skills	88
Preparing educational material	87
Teaching communication skills	86
Evaluation	84
Clinical Observation	83

**Figure 1 Professionals who participated in the focus groups**



**Figure 2: Types of students taught by the participants of the focus group.**



### **The Role of the Teacher in Primary Care**

*"the important thing is how we work in PHC – it's really different from working in the emergency department or on the wards, there are things that they don't teach you . . . all the teamwork that goes on like, I send the patient to see the nurse and the nurse sends the patient back to me and then I might send the patient to physio , all this goes on every day and they don't teach it, so that's what I focus on" Person 5 Group 1*

*"it's different if you are in a clinic that has everything or if you are in a public PHC where what you do is play about with what you have and how you make things do .. if you don't have enough sticky-tape you have to find ways to save it, so I think that in the end the problem is that they (the students) don't come adapted to the reality, like they come in a little bubble, so we have to bring them down to earth". Person 6, Group 1*

*"I think that our biggest problem is getting the student to adapt to the reality of the patients and sometimes they are really shocked when they say for example they want to crown a tooth and you have to say that if the patient hasn't got the money, we have to take the tooth out and they look at you funny . . . Person 4, Group 1*

### **The challenges faced by teachers in PHC**

*"she always seemed to be hiding things from me or telling lies and in the end it felt like I couldn't take anymore, like I didn't want to see her again, I just wanted them to swap her for another student" Person 5 group 2*

*" I think one really important and difficult thing is the whole thing of evaluation, because personally I think that in the Chilean society we are all used to concentrate on the bad side, I mean when we are trying to evaluate we look for the errors, what the student did wrong and with that we tend to give the student a label, like he's lazy, or always late, or hopeless at hands-on activities. If we don't take care the label sticks for their whole rotation and in the end the student gets a bad grade because of that first bad impression. So I think it's really important to give a bit of time to the whole subject of evaluation and to try and work on this aspect and how we can change that first bad impression to be something to work on during the whole rotation. It can't be that the rotation is just to pick up things they can't do and that's all". Person 7, Group 2*

*"The way we have to evaluate our interns just doesn't fit in with our reality and for years we have asked the university to change it, but it seems like the university teachers who make the decisions don't have much clinical experience, at least in the school of nursing. So we have sort of got tired of fighting the system and we tell the students that we are kind of adapting the evaluation and so I put "not observed" and then specify what I have actually seen. I've actually*



*dared to change the form and so far they haven't said anything, but it shouldn't be like that".*  
Person 8, Group 1

**Intuitive teaching: how do the teachers manage?**

*"I think that we are all learning, I mean we all do the best we can basically using our intuition, but really I don't have the skills yet"* Person 2, Group 2

*"I like getting feedback from my students, sometimes they don't do it because you are the one that gives them their mark, so they are not likely to say "Doctor, you were really boring" or sometimes they tell you after you have given them their marks. I like it, maybe afterwards, yes I think that's the right time, they are not going to tell you before, that's what I would like"*  
Person 2 Group 2

*"And another thing that's really important is how to take on board what the students say about me as a teacher".* Person 7, Group 2

*"...My style is really authoritarian and I've begun to realise that that's not always the best way although I had always thought so, because that's the way we were taught".* Person 1, Group 1

*"I always read what the students write at the end of their rotation and that's how I go changing the introduction that I give them, because sometimes they come with certain expectations that don't get fulfilled"* Person 8, Group 1.

*" . . . I put a stool beside me first, and tell them to look and listen, then the next day I say "you go and call the patient", then the next day - I'll examine and you write - and the next - you examine and tell me what to write - and the next -do everything. Do you get it? there are various steps involved.* Person 7, Group 2



**Table 1**

The ten domains of competence of a clinical educator and the percentage of respondents who considered the domain to be important for training PHC teachers

Domain of Competence for clinical educators	% Respondents considering domain as important for PHC teachers
Leadership	92
Running tutorials/small group seminars	92
Curriculum	92
Giving feedback	92
Teaching Procedural skills	88
Preparing educational material	87
Teaching communication skills	86
Evaluation	84
Clinical Observation	83