

Organizational steps to support medical educators

Longstanding threats to the education mission in medicine continue to undermine educators, organizations and systems. The global COVID-19 pandemic has highlighted these threats and amplified pre-existing strains on the medical educator workforce. The disruptions caused by the pandemic will continue to impact educational systems even as pandemic conditions improve. In addition, the attrition of medical educators has far-reaching implications for health care systems nationwide.

Since educational efforts have traditionally been undervalued by health care organizations, there is risk that individuals under stress will abandon educational roles.

Such response is doubly unfortunate since well-being is highly associated with a sense of purpose in one's work and many derive tremendous satisfaction from educational activities. Concurrently, the disruption of the pandemic propelled important educational innovations—ones that we should consider sustaining or developing further.

It is imperative to preserve the capacity for creativity among educators and avoid reversion to historical practices out of sheer exhaustion and change fatigue. This is not an issue of individual resilience. Health care organizations and educational institutions must take action to avoid mass abandonment of educational duties and loss of educational leaders.

The following list of challenges and associated recommendations emerged from the vision and collaborative work among members of the [AMA Accelerating Change in Medical Education Consortium](#) and the [AMA Council on Medical Education](#):

Key threats to the education mission during sustained disruption

Disruption of the clinical learning environment

- Operating in strained clinical systems impairs educators' ability to engage in teaching, direct observation and provision of feedback to learners.
- Physicians who are over-extended and under-supported cannot serve as inspiring role models to students, resident physicians and fellows.
- Resident physicians have experienced clinical service demands that altered their own education and training and impact their pathway to specialty certification and independent practice. Such disruption makes it difficult for residents to fulfill their critical role in educating and serving as role models for medical students.



Repeated redesign of the educational program

- Educators have been called upon to urgently redesign educational programs while simultaneously dealing with constant changes in workflows.
- Conversion to virtual and hybrid settings has required educators to learn new skills and evaluate tools while addressing competing organizational and personal demands.
- Administrative burdens related to educational programming have not been adjusted to offset competing demands, and in some cases administrative support has been reduced due to staffing limitations.

Cognitive and emotional load on educators

- Educators have faced greater cognitive load in all daily routines (disruptions to clinical, classroom and home activities), making it difficult to continue to juggle multiple roles.
- Educators bear responsibility for learner well-being and have experienced an added empathic burden as learner well-being has been compromised.
- Learner anxiety and frustration with alterations to training and career progression have compromised relationships between learners and educators; yet such relationships are important motivation for engaging in educational duties.
- Increased awareness of chronic health inequities highlighted the imperative to combat structural racism in educational programs. Educators need time and resources for personal reflection, developing individual and organizational competency, and redesigning educational systems. This challenge places an even greater burden on educators who themselves identify with historically marginalized groups.

Organizational gaps

- Historically, key activities to support medical education are not sufficiently valued or protected by organizations.
- The medical education system lacks educational surge capacity.
- Medical educators function at the intersections of systems. Each educational program interacts with associated health system(s), accreditors and licensure systems that are also in flux. This places constraints on the educator's influence and creates tension.
- Career development among educators is languishing as they strive to meet the many challenges presented by recent disruptions.
- Well-being efforts appropriately focus on learners and on health care providers; however specific programming to support the unique needs of educators—and the diversity of needs among educators—is commonly neglected.



Identifying organizational strategies

In developing organizational responses to the many challenges, it is important to recognize that education is not limited to delivery of content. Critical educator roles also include direct observation and assessment of learner progress, coaching and mentoring. The broad continuum of educator roles ranges from informal to more structured duties—from “frontline” clinical supervisors in the workplace (including resident physicians); to educators who contribute with intermittent small group facilitation, lectures or mentoring; to those with formally appointed roles in teaching, assessment and advising. Finally, administrators charged with oversight of curricular and assessment programs require support from the leadership of both the educational institution and their associated health system(s) to implement necessary changes.

Given this breadth of educator roles, the potential actions to support them are equally broad.

Recommendations:

1. Monitor and support well-being of educators as well as learners

- Explicitly assess and monitor educator well-being.
- Establish organizational well-being efforts that specifically consider the context of educators. Read [AMA STEPS Forward: Creating a Resilient Organization](#).

2. Refine workflows to support educational interactions

- Design clinical workflows and spaces that support inclusion of the education mission.
- Identify systems issues that create constraints on individual educators' efforts.
- Empower educators, administrators and learners to propose adjustments to workflows.
- Solicit input from resident physicians—who are simultaneously learners, educators and role models.
- Foster an environment of shared learning, facilitate positive communications and promote co-production of solutions between educators and learners.

3. Protect time for educational activities

- Provide appropriate protected time and remuneration for educational roles.
- Alleviate administrative burdens on educators and eliminate non-essential tasks.
- Provide adequate educational administrative staffing.
- Leverage shared online or commercial resources as appropriate rather than generating new institutionally based materials or solutions.

4. Provide ongoing training

- Provide frontline clinical supervisors tips for efficiency in workplace-based education practices:
 - Reduce focus on delivery of content and encourage more direct observation of encounters with patients, discussion of clinical reasoning and provision of feedback.
 - Encourage educational huddles to set priorities with learners.

- Provide faculty development in efficient workplace-based tools, such as one minute preceptor. View the [AMEE Guide no. 34: Teaching in the clinical environment](#).
- Reduce educator burden related to evaluations of learner performance by soliciting focused feedback in a timely manner and monitoring total requests on the individual educator.
- Provide training for educators in tools for remote education, simulation and for engaging learners in remote care settings. Read the [AMA Telehealth Clinical Education Playbook](#).
- Support educator involvement in professional development programs.

5. Nurture educator career advancement

- Remunerate for educational roles (e.g., protected time, merit pay, inclusion in annual evaluations)
- Provide reports of educators' activities to department chairs or other relevant supervisors
- Provide regular reviews of each educator's progress regarding promotion and tenure and provide appropriate mentoring.
- Create mechanisms to acknowledge the work of educational design (and redesign) in promotions and tenure evaluations as scholarly teaching and/or institutional service.
- Provide centralized support for scholarly work in education, such as amplifying opportunities to submit for presentations and grants, hosting writing huddles, and supporting travel to educational conferences.
- Amplify a view of the education mission as a critical factor in organizational success and showcase educational contributions across the organizational community.

6. Build educational surge capacity

- Inventory individual educator's tasks to create flexibility and consider re-distribution as indicated.
- Engage more educators across the program.
- Create a deliberate succession plan for key educational roles.
- Consider opportunities for near-peer teaching and assessment and for multi-media approaches that support self-directed learning and assessment.
- Offset the burden of developing educational materials and tools by using open source or vendor solutions as appropriate.
- Actively leverage technologic solutions to administrative and educational tasks.

7. Advocate for systems change, locally and nationally

- Encourage all stakeholders to apply [systems thinking](#) to the educational process and engage learners in co-production of educational redesign.
- Strengthen relationships between the educational institution and associated health system(s) to facilitate shared problem solving and align communications.
- Implement [value-added roles](#) for learners.
- Advocate for appropriate adjustments in accreditation processes and assist leaders of educational programs to follow evolving recommendations and requirements.