VIEWPOINT

Trust Between Teachers and Learners

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Viewpoint

In health care, the ability to earn and give trust is an important human act. It requires individuals to put their own welfare in the hands of another and have confidence that their vulnerability will be reciprocated with something important to them. While trust between patients and their physicians is well established as a keystone of care, the essential nature of trust between physician teachers and their peer or more junior learners has become a more central concern of health professions educators.

Medical education has been progressively evolving from a model that was designed primarily to transmit information to a model that is designed to generate skill and behavioral changes.[1,2] Developing and maintaining the cognitive and psychomotor skills necessary to provide effective clinical care requires deliberate practice and feedback. Performance only improves when the feedback is absorbed and acted on, and feedback requires the learner to trust the expertise and integrity of the person delivering that feedback. In medicine, this process relies heavily on personal relationships because the sophistication of the skills being taught and evaluated is not always reliably assessable.

Teachers must trust their learners. The trust of teachers is won when learners attend, engage, respond, and appreciate the teachers and their volunteerism. It takes time and repeated exposure for trust to be optimally developed, which implies both available time and longitudinal engagement that is increasingly absent.[3] In contrast, trust is easily lost if learners do not attend or are ambivalent, distracted, resistant, dismissive, defensive, or unresponsive.

Teachers make trusting judgments about their learners all the time. Teachers must progressively relinquish control and supervision to their learners, attending to the safety of their shared patients. Based on the level of trust, students should progress from observing patient care, to performing it under continuous and direct supervision, to performing with indirect supervision with the teaching physician within close proximity to supervision from a distance; ultimately, the learner would be able to supervise others.[4,5]

Students, residents, and peer-learners must learn to trust their teachers. The level of trust in a teacher is associated with the engagement in the learning process. Teachers create trust by establishing and demonstrating their own competence and professionalism, showing interest in the learners, and providing meaningful feedback that helps learners grow. Reciprocally, educators who harass or otherwise lose their learners' trust may continue to teach but will be unlikely to create effective learning. Trust that is eroded or lost can be impossible to recover.

Trust is mutually reinforcing.[6] The stages of entrustment between teachers and learners apply as readily to faculty as they do to students. The stages typically include an initial presumptive trust based on an individual's credentials before a relationship has been developed, to an early entrustment based on first impressions and experiences together, to a grounded trust based on longer experience and observation.

Trust is generated when there is bilateral openness and humility, aligned with shared objectives.[6] Placing teachers in a role in which they are a summative assessor can mitigate learners' willingness to be open and honest. Trust between the teacher and student can be endangered if it is not clear whether performance assessment in a learning activity will be used for a summative decision about competence of the student that will be shared with others or whether it is formative, confidential, and intended to facilitate the learner's personal growth. Feedback should be directed at student behavior and not as a judgment of character to avoid shaming, which can meaningfully abrogate trust.

Learners and teachers must also learn to have trust in the institution and its learning environment. In this situation, trust is strongly affected by institutional policies and resources. Humans want to connect and to belong. In a culture of trust, responsibilities and urgencies remain, but participants work with the confidence of knowing that colleagues, including educators, will support learners as they work. Educators thrive when they feel that their work aligns with the mission and values of the organization and when their work in teaching and learning has a direct line to the outcomes that are appreciated and recognized.

Issues that can interfere in the formation and maintenance of that trust include the quality of support staff, equipment, crowding of the facility, or institutional policies related to access to care. Standards of supervision, quality and patient safety, work hours, care transitions, and professionalism, in addition to other components of the learning environment, can facilitate or hinder the trust relationships between teachers and learners. Faculty may be constrained by institutional policies in their ability to entrust students with activities that will stimulate learning. Trust in the learning environment involves dynamic relationships among teachers, learners, institutions, and patients. When educational and clinical goals are aligned, the organization thrives: faculty and learners who feel supported and learn productively together perform better and more cost-effectively. Mismatch between stated institutional goals and behavior can nurture or threaten trust in the institution. This is most apparent when an organization's actions are discordant from stated

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values, such as an expressed commitment to access, quality, improvement, community, or diversity.

While trust may be difficult to quantify, its importance should not be underestimated. Trust can be actively nurtured and easily lost. By considering how systems, processes, and culture create and maintain trust, we can optimize both learning and care quality. Reflect-

ing on the culture of trust within the learning environment can illuminate institutional strengths and challenges. Every physician, as learner, educator, or both, can respond to those issues and in doing so, help ensure that the future health workforce builds trusting relationships with institutions, colleagues, health team members, patients, and the public, and flourishes in the medical profession.

REFERENCES

1. Pratt DD, Arseneau R, Collins JB. Reconsidering "good teaching" across the continuum of medical education. *J Contin Educ Health Prof*. 2001;21(2): 70-81. doi:10.1002/chp.1340210203

2. McMahon GT. Advancing continuing medical education. *JAMA*. 2015;314(6):561-562. doi:10.1001/jama.2015.7094

3. Hirsh DA, Holmboe ES, ten Cate O. Time to trust: longitudinal integrated clerkships and entrustable professional activities. *Acad Med*. 2014;89(2):201-204. doi:10.1097/ACM.0000000000000111

4. ten Cate O. Trust, competence, and the supervisor's role in postgraduate training. *BMJ*. 2006;333(7571):748-751. doi:10.1136/bmj.38938.407569.94

5. Ten Cate O, Hart D, Ankel F, et al; International Competency-Based Medical Education Collaborators. Entrustment decision making in clinical training. *Acad Med*. 2016;91(2):191-198. doi:10.1097/ACM.0000000000001044

6. Sklar DP. Trust is a two-way street. *Acad Med*. 2016;91(2):155-158. doi:10.1097/ACM.0000000000001046