Role modeling in clinical practice: A whirlpool around master and apprentice in lifestyle interventions for obesity in general practice

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Chapter 9

Summary
Chapter 2 Both patients and government expect the General Practitioner (GP) to treat obesity. Previous studies reported a negative attitude of GPs towards this task. Little is known about the attitude of GP trainees. To assess the attitude and other factors that influence the willingness and ability of GP trainees to provide lifestyle interventions for overweight patients, we performed a qualitative study using focus groups, consisting of first- and third-year trainees, GP trainers and teachers.

The data showed that first-year trainees lack knowledge and a positive attitude. Third-year trainees, although trained in motivational interviewing techniques, lack specific knowledge and feel cheated when discussing eating habits. Trainers are despondent as they rarely observe long-lasting results. Teachers warn the trainees not to have high hopes. The trainers and trainees fear ruining the relationship with their patient.

Chapter 2 concludes that trainees do not feel more competent in treating overweight patients successfully over the course of their GP specialty training and GP trainers are not convinced of the success of the treatment of overweight patients. Therefore it could be equally important to reflect on the GP trainer as a role model as to concentrate on the education of the trainee.

Chapter 3 Medical trainees (interns and residents) and their clinical trainers need to be aware of the differences between positive and negative role modeling to ensure trainees imitate and trainers demonstrate the professional behavior required to provide high-quality patient care. Therefore we systematically reviewed the medical and medical education literature to identify the attributes that characterize clinical trainers as positive and negative role models for trainees.

We divided the found attributes of role models into three categories: patient care qualities, teaching qualities, and personal qualities. Positive role models were frequently described as excellent clinicians who were invested in the doctor-patient relationship. They inspired and taught trainees while carrying out other tasks, were patient, and had integrity. These findings confirm the implicit nature of role modeling. Positive role models’ appearance and scientific achievements were among their least important attributes. Negative role models were described as uncaring toward patients, unsupportive of trainees, cynical, and impatient. These identified attributes may help trainees recognize which aspects of the
clinical trainer’s professional behavior to imitate, by adding the important step of apperception to the process of learning professional competencies through observation.

Chapter 4 With the identified attributes from chapter 3, we developed and validated an instrument to assess clinical trainers as role models: the Role Model Apperception Tool (RoMAT). This instrument consists of 17 attributes characterizing a role model, to be assessed using a Likert scale. In 2012, general practice (GP) trainees, in their first or third year of post-graduate training, who attended a curriculum day at institutes in Amsterdam, Nijmegen, Maastricht and Leiden, completed the RoMAT. On the data that were generated we performed a principal component analysis, and we tested the instrument’s validity and reliability. The RoMAT demonstrated both content and convergent validity. Two components were extracted: “Caring Attitude” and “Effectiveness.” Both components had high reliability scores (0.92 and 0.84, respectively). Less experienced trainees scored their trainers significantly higher on the Caring Attitude component. The RoMAT proved to be a valid, reliable instrument for assessing clinical trainers’ role-modeling behavior. Both components include an equal number of items addressing personal (Heart), teaching (Head), and clinical (Hands-on) qualities, thus demonstrating that competence in the “3Hs” is a condition for positive role modeling.

Chapter 5 We used the RoMAT to establish whether a ‘teach-the-trainer’ course leads to improvements in the role model behavior of the clinical trainers. Therefore, we performed a controlled intervention study with GP trainers and GP trainees from four training institutes in the Netherlands. Clinical trainers in the two intervention institutes received two 3-hour training sessions on weight management, focusing on knowledge and attitudes towards obesity, and on conveying the correct professional competency as a positive role model for trainees. This was measured using questionnaires on knowledge and attitude of the trainers and their trainees, and using the RoMAT, completed by the trainees for their trainers. As a result of the educational intervention GP trainers showed an increase in knowledge and several characteristics could be identified as being related to positive role model behavior. Also a small correlation was found between trainers with better role model behavior on the “Effectiveness” component of the RoMAT and trainees with the highest scores on attitude.
However, this teach-the-trainer course in which knowledge, attitudes, and role modeling were integrated and that improved the knowledge of clinical trainers, did not result in a measurably better professional outcome for the trainee, maybe due to a more objective level of assessment.

Chapter 6 Continuing Professional Development (CPD) and Faculty Development (FD) courses have been designed in the expectation that a cascade effect will occur: conveyance of information from course to clinical trainer to daily practice and/or to trainee by means of role modeling. To gain insight into factors encouraging clinical trainers to incorporate what they have learned in CPD/FD into their role model function and factors influencing conveyance from master to apprentice, we conducted a qualitative study using semi-structured interviews with GP trainers and their trainees. Twenty-four GP trainers who completed a CPD/FD course, and sixteen of their trainees participated. Analysis of their statements enabled identification of factors that affect amplification of the competences of the clinical trainer and awareness of being a role model, applicability in training practice and conveyance to the trainee. As a result of interaction between trainer, trainee and patient, conveyance of competences from master to apprentice seems to be better represented by a whirlpool than a cascade with steps, functioning as filters, declining the effectiveness of CPD/FD courses. These filters are influenced by different factors and interactions. Using these filters as turning-points for improvements around the whirlpool could increase the effectiveness of CPD/FD.

Chapter 7 We also used the RoMAT to assess changes in role model behavior of the clinical trainer after giving personal feedback. First year GP trainees at two institutes for GP specialty training in the Netherlands were asked to complete the RoMAT for their clinical trainers. The RoMAT was scored before and after the trainers received their personal scores combined with the mean score of their peers. The trainers were divided into three performance groups: below average, average and above average. After the personal feedback only the group of trainers with the lowest scores showed an improvement on the Effectiveness component of the RoMAT. This pattern was confirmed by the number of trainers shifting from the group with below average performance to the average and above average performance groups.
This study showed that giving feedback to clinical trainers did result in better scores on role model behavior. This outcome seems to indicate that trainees are able to use the RoMAT to distinguish between positive and negative role modeling, and that the role model behavior of the clinical trainer can be improved.