

Educational Contracts: A Basis for Effective Clinical Teaching

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Abstract—An educational contract is a negotiated agreement between a teacher and a learner. It addresses four elements: needs, expectations, roles, and content. Contracts should develop and evolve via explicit negotiation between the teacher and the learner. Research to validate the concept of the educational contract and to document its utility is important to understanding effective clinical teaching.

Research to define effective clinical teaching is sparse relative to the work which has been done in nonclinical areas (1). Effective clinical teachers are usually described in terms of their personal attributes, interpersonal regard for learners, professional competence, or specific teaching skills (2-7).

A major shortcoming of this approach is that it focuses on the teacher to the exclusion of the learner. It ignores the impact of the unique needs and personality of the learner on the effectiveness of any given educational encounter. Understanding how teachers may be effective requires a more comprehensive analysis of the active, dynamic relationship influenced by both learners and teachers.

One such analysis is proposed in this article and emphasizes the interactive process by which the teacher and the learner agree on what they will do to promote effective learning. No prospective

research has been done in clinical teaching to show details of this process or to validate experimentally its impact on the effectiveness of instruction. In this article, the authors describe the concept of an educational contract and give preliminary observations of the process of negotiating such a contract in clinical teaching.

Definition

An educational contract is a personal agreement between the teacher and the learner as to what area of knowledge they will address in their time together and how they will do so.

In our society, the idea of negotiating contracts usually suggests an impersonal process of tough bargaining between antagonists leading to a written, legal document which rigidly defines rights, privileges, and responsibilities. Educational contracts differ in many ways from such contracts yet retain elements in common with them. They retain a basic interest in mutual benefits for both parties. They define expectations, roles, and responsibilities. However, they are not negotiated in a setting of mutual distrust, they are not

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rigid, and most often they are not in written form; indeed, an educational contract often exists but remains entirely unspoken.

Elements

Educational contracts have four key elements: needs, expectations, roles, and content.

A need is the discrepancy between an existing state and a desired state. In a practical sense, most educational encounters arise out of a need for: (a) information; (b) procedural assistance; (c) confirmation of a decision; or (d) confirmation of one's value as a professional. Any one or more of these needs may spark an exchange between a learner and a teacher in hopes of reducing a discrepancy between the existing and desired state of affairs.

Many encounters begin with statements that leave some question as to what is needed. Following are two examples of typical unclear statements by learners of their reasons for initiating a teaching encounter: "I have a 39-year-old white married female with a complaint of back pain." "This is a teenager with a fever that developed after she flunked chemistry."

From these, the teacher would be hard-pressed to describe the learner's needs and thus would have difficulty addressing it directly. Following are two examples of clearer statements of need: "I would like to learn how to decide whether to get lumbosacral spine radiographs on this patient with back pain" (request for information). "I want to start this patient on tetracycline. Do you think this is a good plan?" (confirmation of a decision).

Prior training may interfere with the learner's ability to express a need directly. For example, medical students are often taught to give routinely a complete presentation, beginning with the patient profile and chief complaint and then moving in order through the history of the present

illness, past medical history, social history, family history, review of systems, physical examination, laboratory findings, assessment, and plans. Faced with a mass of data, the teacher is left to decide which aspects of the case to discuss. This decision might be made based on the teacher's judgment of key issues in the patient's care, on his favorite subject, or on something that the teacher learned at a recent conference. If so, it is unlikely to address the learner's immediate need.

A person's need may not be easily stated. It may have to do with the relationship evolving between teacher and resident or may be more personal. Whatever the need, experience suggests that learners and teachers both benefit from learning to express felt needs and respond supportively to another person's expression of need.

In most relationships, people expect others to behave toward them in particular ways. These expectations include elements both of desire to have certain behaviors occur and prediction that those behaviors will indeed occur.

At the broadest level, students enter clinical instruction with expectations that the instructors will be knowledgeable and capable clinicians able to demonstrate and explain medical procedures and concepts. At the more detailed level of the individual encounter between teacher and learner, the resident might expect the teacher to demonstrate a procedure or help the learner think through the solution to a problem.

In addition, clinical instructors have expectations of residents and medical students. At a broad, general level, one attending physician may describe his expectations as follows: "I expect residents to demonstrate an interest in learning. In other words, there should be some level of inquiry. He should learn to ask a question about every patient he sees."

Another teacher may describe his expectations of residents at different levels of training: "The first year, I expect people to not have a great fund of knowledge and to be working on their decision-making skills and prioritizing skills, that is, their time-utilization skills. Second year, I expect people to start picking up some managerial skills. They need to be able to work with interns, do a little bit of teaching; their time skills should be a little bit better, and they should do more reading. In the third year, I expect them to be thinking about their future, how they're going to practice. I tend to think of them as junior faculty."

Usually, such expectations go unspoken, yet they color and shape much of the teaching/learning process. To the extent that they can be explicitly stated and differences negotiated, there should be less misunderstanding and conflict and more effective instruction.

Roles are general patterns of teaching and learning within educational relationships. Others have discussed teaching "styles" in clinical instruction (8, 9). The term "roles" emphasizes that different approaches to teaching and learning should be selected to fit into particular relationships and that both teacher and learner must agree upon their roles as a basis for effective learning. The discussion here will be limited to three teacher roles and three learner roles. They should not be interpreted as either rigid or mutually exclusive role descriptions. Rather, they are more like reference points along a continuum which individuals may adopt flexibly, depending upon the circumstances and individual needs (8).

Clinical teachers adopt three basic roles: expert, model, and facilitator. When serving as an expert, the teacher provides detailed, authoritative information or answers without necessarily demonstrating the thought process or skills used to obtain

them. As model, the teacher demonstrates the skills and thought processes of a good clinician. He is an "open book" which learners may watch and imitate. When serving as a facilitator, the teacher focuses attention on helping the learner acquire information, analyze it logically, ask pertinent questions, and develop reasonable plans. The facilitator guides the learner to do the actual work.

Learners may also adopt three basic roles: dependent, competitive, and participant. In a dependent role, the learner follows structure and guidance provided by the teacher. In a competitive role, the learner seeks to outperform other learners and, perhaps, teachers in order to gain recognition and esteem. The participant learner works in a collaborative way with others and is confident of his own skills and knowledge but willing to accept others' input.

The teacher's decision to adopt a particular role should be made in response to a diagnosis of the learner's current role, developmental stage, circumstantial constraints, and needs.

For example, a learner may want a clinical preceptor to help him think through a problem without providing direct answers to questions (facilitative role). If the teacher plays an expert role at this point, perhaps lecturing to the student, both teacher and learner are likely to feel frustrated and be less effective. In most structured relationships, such lack of agreement about role expectations is as important a source of conflict as is deficient role performance (10). A clear educational contract can help prevent this problem.

The need for clarification of roles in clinical training is well documented in counseling psychology (11), education (12), and medicine (5). It is also clear that clinical teaching roles change over time, generally from directive to nondirective.

The aspect of contracts which usually

receives the most attention in clinical teaching is the content of the educational transaction. The literature on principles of adult learning consistently shows that people learn best what they are ready and motivated to learn, when they are involved in setting goals and deciding on relevant content, and when they generally participate in decisions affecting their learning (13). Unfortunately, observation of clinical education shows frequent examples of teaching far removed from stated interests of learners, and this suggests that the content of teaching is seldom the result of a negotiated agreement between teacher and learner but rather tends to be decided by the teacher.

This is not to say that teachers should not have input to deciding the focus for teaching encounters; clearly, they should. Ample research documents that students and residents expect clinical instructors to set clear goals (6), establish a schedule (6), and provide direction (4). However, a mutual agreement regarding the content and its sequence and emphasis is important (2).

Negotiation

In the ideal case, a contract is developed at the beginning of each teaching encounter. This need not be a long or complex process. Rather, a simple, brief exchange of thoughts about needs, expectations, roles, and content may take only one or two comments.

Indeed, there are teaching situations where no negotiating is necessary. For example, a third-year resident might approach a faculty member to ask what references the teacher would use to calculate a drug dosage. This is a request for specific limited content and for role-modeling by the teacher. A simple statement of the title of a pharmacology text will satisfy both aspects of the request without negotiation.

If the teacher is unwilling to meet the request directly, he should say so and offer

an alternative combination of content and role which he is willing to provide. However, experience suggests that teachers seldom negotiate roles and content explicitly. In the above example, it might be more common for the teacher to begin instead a discussion of differential diagnosis (wrong content) or ask the resident to decide for himself what reference to use (wrong teaching role). Either of these might be "better" teaching than what the resident initially requested. However, either is also likely to generate frustration for both teacher and learner as well as less effective education, unless they both agree to the change after reviewing their needs and their roles as well as the proposed teaching content.

Evolution

Specific learners may want to learn in any of the three roles and may want any of the three teacher roles, depending on the content to be learned, the urgency of the clinical situation, amount of time available for learning, and other factors. The sensitive teacher may identify and respond flexibly to these, quickly negotiating a new contract for each encounter.

As teacher and learner get to know each other, such negotiations may occur less often. However, over the weeks, months, or even years of training during which the teacher and learner may have contact, the relationship between them may progress through phases of development. In the beginning, both people will be concerned with the unknown: Who is this other person? What will he expect of me? What can I expect of him? These concerns will be present whether or not they are expressed. Explicit contracting merely makes resolution of them more efficient and direct rather than haphazard and indirect.

As the teacher and the learner work together in a variety of learning encounters, their patterns of communicating and

their expectations for each other will emerge. They will form clear impressions of each other and their time together, how productive the time is, how it is or is not serving the needs of each, and what demands they can legitimately make upon each other.

If the teacher and the learner have explicitly dealt with roles, expectations, and ways of communicating with each other, they will agree on the issues that govern their teacher-learner relationship, and they will be more productive in their time together. Experience suggests that such openness is rare. More often, when learners and teachers develop impressions of what they expect of each other, these impressions dictate when and where they will initiate contact. For example, if a learner wants a quick, practical, expert answer to a question, he will choose to ask the question of a teacher "known" for reliably providing such brief responses. That such strategies are consciously applied may be confirmed by just a few moments spent listening to learners or teachers talking about each other.

Even if the teacher and the learner do develop an openly negotiated relationship, periodic review of their contract can be useful to both (13). For example, as a resident becomes more confident and less dependent on the expertise of the attending physician over several years of his residency, the relationship contract may move in the direction of independent learner and facilitative instructor. While this may be the most common pattern, residents will start at different points and will differ in their progress. Thus, a particularly mature resident may start the first year with only occasional needs for an "expert" role from the instructor and rapidly progress to a level of competence where the instructor need provide only a facilitative role.

Finally, it is part of the teacher's respon-

sibilities to encourage an appropriate degree of independence for learners. Some learners may wish to give up their dependent role before they are competent to do so. Others may ask the teacher to serve as expert when it would be better for the teacher to facilitate the learner developing his own expertise. Periodic renegotiation of the overall contract for the relationship can enable smooth progress toward appropriate independence for the learner.

Research Directions

Little work has been done in clinical teaching settings to document the process of developing and using educational contracts or to show their value in clinical instruction. Such research will be important in promoting excellence in clinical teaching.

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