Shared Goals, Togetherness, Accountability, and Embracing Love
Stephen A. Wilson, MD, MPH

The purpose of medical education is to improve patient care. Whether expressed and operationalized through precepting, direct observation, competency and milestones assessment, feedback, mentorship, remediation, or lectures, the purpose is to improve the quality of care patients receive. This is facilitated by shared goals, being all in together, accountability, and embracing love.

Shared Goals
Shared goals are the target and guide for success, and they come from shared vision. The Society of Teachers of Family Medicine’s (STFM) vision is “to become the indispensable academic home for every family medicine educator,”¹,² which is supported by its mission of “advancing family medicine to improve health through a community of teachers and scholars.”¹,²

Core values describe who we are and how we will conduct ourselves while strategically acting to execute our mission to achieve our vision. STFM has six core values: Relationships, Excellence, Diversity, Integrity, Openness, and Nurturing.¹,² My personal description of these values is:

- **Relationships** – Get to know each other; work together
- **Excellence** – If a job is worth doing, it is worth doing well
- **Diversity** – All are welcome and sought after
- **Integrity** – A unified, sound construction in which the whole is greater than the sum of its parts
- **Openness** – “Come on in”; receptive, transparent accessibility
- **Nurturing** – Encouragement and edification

All in Together
Vegetable, Cream of Mushroom, Tomato, Chicken Noodle–labels are helpful, when they are on soup cans. They succinctly describe the essence of what is inside and what can be expected when opened. Labels are not so helpful, or easy, for people; people are much more complicated than soup.

Labels can be half right, half wrong, limit thinking, and impede abilities to relate and work together. Labels can hinder shared goals, whether creating or achieving them. Demeaning by labels is a roadblock to togetherness.

The fact that some people do not think like us or draw the same conclusions does not mean the essence of who they are can be summarized by a label. Should a brilliant PhD electrical engineer be labeled as “anti-science” for how he voted in the 2016 United States presidential election? To him, anti-science is a code word for stupid. He is not stupid. He could be justified in questioning medical science’s inconsistent positions on estrogen therapy, cancer screenings, and various dietary and medication recommendations. Different disciplines and doctors offer alternative facts: one says his mother’s breast cancer screening should start at age 40 years, another at 50; one says his father should pursue prostate cancer screening, another says not to do so. He is less likely to be open to different perspectives if he has been shamed with a label.

Family medicine is all in together to improve patient care. We cannot afford to quibble about who is a “real family doctor,” labeling each other based on how we apply our various giftings and talents: “academic,” “researcher,” “university-based,” “full-scope,” “community-based,” “educator,” “real family doctor.” Let us take care not to turn descriptors into labels as we work to improve patient care for all patients.
Accountability

Accountability is the glue that ties commitment to the results. Part of our accountability to learners and patients is to be skilled and excellent at our craft.

“Clinician-educators” are now expected to be “Clinician-Educators,” with an expanded emphasis on educator knowledge and skills. We are no longer people who go into practice then become medical educators drawing upon attained knowledge, experience, and wisdom. With the advent of competency-based education, even more is expected. Like other specialists, excellent medical educators acquire additional knowledge, skills, and attitudes. The STFM Residency Faculty Fundamentals Certificate Program offers training in some of the basic skills necessary to become competent family medicine educators:

1. Accreditation Council for Graduate Medical Education (ACGME) Program Requirements
2. Competencies, Milestones, and Entrustable Professional Activities (EPAs)
3. Structure and Funding of Residency Programs
4. Billing and Documentation Requirements
5. Recruiting and Interviewing Residents
6. American Board of Family Medicine (ABFM) Rules and Requirements
7. Scholarly Activity
8. Writing for Academic Publication
9. Curriculum Development
10. Didactic Teaching Skills
11. Clinical Teaching Skills
12. Assessment and Evaluation
13. Giving Feedback
14. Residents in Difficulty: Academic and Behavioral Problems
15. Direct Observation

There should be medical-educator Continuing Medical Education (mCME), with set expectations. For physicians, mCME could count toward ABFM requirements. ABFM Self Assessment Modules are now Knowledge Self Assessments (KSA). There could be KSA on medical education, and Clinical Self Assessment Activities could be reconstructed to be Teaching Self Assessment Activities, each contributing to ABFM recertification. This would promote the further excellence and standards of family medicine education, which would advance the missions of both STFM and ABFM.

Other potential sources of mCME already exist. Two are STFM initiatives (Teaching-Physician.org and Faculty Development Delivered), and one is an Association of Family Medicine Residency Directors and STFM collaboration (Residency Curriculum Resource).

We are not teachers by accident or because there was an alignment of open position and job need. We are teachers by choice, by passion, by skill. Our learners must achieve competencies. Should we as well? Should we start to consider a certificate of added qualifications (CAQ) process? A CAQ can set expectations, decrease variance, increase shared language, provide recognition, promote continued growth in skills, and encourage scholarly activity. While adding a CAQ option has advantages, it will be necessary to identify potential negative unintended consequences so they can be adequately mediated and minimized in order to improve medical education and thereby patient care.

Embracing Love

Is it better for a person to say the right things or to do the right things? In “Sustaining Family Physicians in Urban Undeserved Areas,” Anne Getzin illustrates that love is necessary. Love is not a feeling. It is the expressed action of the amalgamation of heart and brain: love is a verb.

There are four main Greek words for love: 1) Éros – lust, romance; 2) Philia – brotherly love; 3) Storge – familial affection; and 4) Agápe – unconditional, selfless love. Agápe is the word translated “love” in the following excerpt.

Love is patient. Love is kind. It does not envy, it does not boast, it is not proud. It does not dishonor others, it is not self-seeking, it is not easily angered, it keeps no records of wrong. Love does not delight in evil but rejoices in the truth. It always trusts, always hopes, always perseveres.

This type of love is quietly, persistently powerful.

Striving for this type of love:

- Seeks to understand;
- Recognizes there can be understanding without acceptance;
- Increases our patience and understanding of the autistic child’s parent, whose fear and anxiety of the autism she sees causes her to be overwhelmed by unsubstantiated case reports and non-expert opinions of diseases she has never seen;
- Allows forgiveness;
- Seeks forgiveness;
- Fosters humility—“I am not right all the time”;
• Provides information to stimulate thinking and change, while avoiding shaming;
• Values and seeks the good of others;
• Helps us prioritize patient care decisions, e.g., resources for expensive new treatments vs ensuring access to basic health care for all;
• Fuels us when we are tired;
• Checks us when we feel slighted;
• Provokes joy; and
• Lowers the threshold for gratitude.

When we look into the eyes of a child with cancer or a person with schizophrenia, can we help but think that a chromosome here, a gene there, and our places could be reversed? This gratitude fuels appreciation and fosters a love that nudges, encourages, and challenges us to want to continually improve patient care.

Shared goals, being all in together, accountability, and embracing love can help us better achieve the purpose of medical education.

CORRESPONDENCE: Address correspondence to Dr Wilson, Director, Faculty Development Fellowship and Medical Decision Making, Education, University of Pittsburgh UPMC St Margaret Family Medicine Residency, 3937 Butler St, Pittsburgh, PA 15201. 412-784-7672. Fax: 412-621-8235. wilsons2@upmc.edu.

References
12. I Corinthians 13:4-7 (NIV)