Residents-as-Teachers Programs in Psychiatry: A Systematic Review

Charlene M Dewey, MD, MEd, FACP1; John H Coverdale, MD, MEd, FRANZCP2; Nadia J Ismail, MD, MPH3; John W Culberson, MD4; Britta M Thompson, PhD5; Cynthia S Patton6; Joan A Friedland, MD, MPH7

Objectives: Because psychiatry residents have important roles as teachers and significant opportunities to contribute to medical student education, we set out to: identify all randomized control trials (RCT) for residents’ teaching skills programs in psychiatry and to identify the efficacy of those interventions for improving teaching skills; identify the strengths and weaknesses of the available studies across medical disciplines; and identify currently available methods for enhancing residents’ teaching skills for residents training in psychiatry.

Methods: The published English-language literature was searched using PubMed, Social Sciences Index, and PsycINFO databases, with key search words including: residents, teaching skills, residents as teachers, psychiatry, and assessments. Both RCT and controlled, nonrandomized trials of residents’ teaching programs directed to enhance residents’ teaching skills were selected and critically appraised.

Results: Of 13 trials identified and reviewed, most included residents in internal medicine. Only one included psychiatry residents and assessed their ability to teach interviewing skills to medical students. Along with other studies, this study demonstrated improvement in residents’ teaching skills. Overall, interventions and outcome measures were heterogeneous while the quality of methodologies varied. Five studies were of higher quality, representing examples of quality educational research. Several described group differences, blinding, good follow-up, and use of valid, reliable tools.

Conclusions: Only one trial exists that incorporated psychiatry residents. Significant opportunity to advance educational research in this field exists. Psychiatry residency program directors should incorporate high-quality methodologies and can benefit from the findings of trials in other disciplines.

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Clinical Implications

- Psychiatry residents serve a significant role and purpose as teachers.
- Psychiatry residency program directors should find ways to enhance their residents’ ability to teach.
- Residents-as-teachers programs can be efficacious and previously developed programs can be a guide for developing such programs.

Limitations

- More programs in psychiatry may exist that are unpublished.
- Not all residents-as-teachers program content (for example, procedural skills) will be directly applicable or require a higher level of emphasis for psychiatry residents.
- Psychiatry residency programs generally have a few residents making randomization a challenge. Program directors should collaborate to pool residents across institutions to increase the sample size.
Residents in all disciplines serve as teachers and role models for students, colleagues, and other staff. Residents work closely with medical students in particular and have considerable opportunities to teach and influence students’ knowledge, attitudes, and behaviors. Since the early 1970s, the literature on the residents’ teaching role has emphasized the need to train residents as teachers as well as to evaluate the content and outcomes of instructional programs. Overall, this literature demonstrates that residents desire to teach; residents desire to be trained as teachers and leaders; some programs are well received; and effective programs can improve residents’ teaching skills. Moreover, major governing organizations support the role of residents as teachers. The RCPSC, office of education, revised their 1996 framework for competencies to create CanMEDS. CanMEDS is part of an effort to move toward competency-based, outcomes-oriented education. The CanMEDS 2005 Competency Framework describes competencies for Canadian residents and defines residents’ scholarly role as a competency that “as teachers, they facilitate the education of their students, patients, colleagues, and others.” In the United States, the LCME and the ACGME also support residents’ roles as teachers and the development of programs to prepare residents for this role.

Psychiatry residents’ training to enhance teaching skills is currently mandated in the United States and Canada. In 1980, Callen and Roberts reported a survey of American psychiatry residents and found that most residents spent 1 to 2 hours per day teaching and that they tended to see themselves as capable teachers although they had received no formal instruction on teaching. There is little documentation about the prevalence and specific components of programs that train psychiatry residents as teachers. In one ACGME survey accredited residency programs and clinical medical specialties in the United States, 62% of psychiatry residency program directors indicated that they offered residents training in teaching skills. In this survey, lectures and workshops were the most common method for instruction; psychiatry and obstetrics–gynecology residency programs used lectures more often than other specialties. A report of one Canadian program exemplified how residents can teach medical students about personality disorders and psychotherapeutic principles. Psychiatry residents have a critical role in that they influence and shape future physicians. One committee on graduate education (2001/2002) identified several benefits to psychiatry residents becoming better teachers. Some benefits include: an improved fund of knowledge on the topics taught, improved skills for lifelong learning, and greater influence over students’ approaches to medicine and even in their specialty choices. Unique issues for psychiatry residents include: overcoming the stigma against mental illness with medical students, helping students develop empathy for patients with mental illnesses, and teaching practical skills for all students regardless of specialty choice. There is a need, however, to determine the efficacy of currently available residents’ teaching programs through a systematic review of published literature. This information can be vital in guiding psychiatry program directors and faculty educators in developing programs that can effectively enhance psychiatry residents’ teaching skills by using scientifically rigorous methods and validated, reliable assessment tools. This should ensure the best possible outcomes for psychiatry residency training programs.

Thus the purpose of this systematic review is to: identify all RCTs for resident teaching skills in psychiatry and to identify the efficacy of those interventions for improving teaching skills; identify the strengths and weaknesses of the available studies across medical disciplines; identify currently available methods for enhancing resident teaching skills for residents training in psychiatry; and inform the development of future educational research in psychiatry resident training programs.

Methods
We used standard methodologies for conducting systematic reviews of educational programs to enhance residents’ teaching skills. The search was conducted over a 6-month period using 3 databases including PubMed, PsycINFO, Social Science Index, the web pages of the RCPSC, and the Association of American Medical College’s Selected Bibliography on Residents as Teachers—Residents’ Teaching Skills Projects Group. In addition, directed searches of primary publications referenced in other articles, including review articles, RCTs, other trials and case reports were performed. The following key search words were used:

**Abbreviations used in this article**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
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<tbody>
<tr>
<td>ACGME</td>
<td>Accreditation Council for Graduate Medical Education</td>
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<tr>
<td>CNRT</td>
<td>controlled, nonrandomized trial</td>
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<tr>
<td>CTAF</td>
<td>Clinical Teaching Assessment Form</td>
</tr>
<tr>
<td>LCME</td>
<td>Liaison Committee on Medical Education</td>
</tr>
<tr>
<td>OSTE</td>
<td>objective structured teaching exercise</td>
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<tr>
<td>RCPSC</td>
<td>Royal College of Physicians and Surgeons of Canada</td>
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<tr>
<td>RCT</td>
<td>randomized controlled trial</td>
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<tr>
<td>RSA</td>
<td>resident self-assessment</td>
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<tr>
<td>TIPS</td>
<td>Teaching Improvement Project Systems</td>
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</table>
residents, registrars, teaching skills, residents’ as teachers, psychiatry, and assessments. Five of the authors (CMD, JHC, JWC, NJI, BMT) met regularly to determine inclusion and exclusion criteria and to select articles for critical appraisal and review. Articles selected were in English and focused on assessment of programs directed at enhancing residents’ teaching skills. Preference was given to RCTs and CNRT. Articles were excluded if major outcomes did not include assessments of teaching skills, or could not be attributed to residents alone, or were duplicated results from other publications.

All articles were read by at least 2 members of the team. Articles were scored on criteria for establishing validity of a study using and extending the standards developed by the Criteria from the Evidence-Based Medicine Working Group. These items included the presence of randomization, adequacy of method of randomization, presence of concealment of randomization, whether differences at baseline were identified, presence of blinding, drop-out rates or intention to treat analysis, and validity and reliability of outcome measures used. Each item was dichotomously scored for a maximum score of 7 points.

Results
Our search of the literature databases revealed 18 studies. Five articles were excluded based on not meeting inclusion criteria, if they were pilot studies, or repeated published work. Ten RCTs and 3 CNRTs were reviewed by the team. Based on authors’ descriptions of study participants, only one of the reviewed trials included psychiatry residents. Of the reviewed articles, 3 included internal medicine residents only, 2 had pediatrics residents only, 1 had surgery residents only, and 1 had obstetrics–gynecology residents only. All others had a mix of resident participants.

As seen in Table 1, most of the RCTs included internal medicine residents (n = 7 of 13). Training programs covered all training levels. Interventions ranged from 1- to 13-hour sessions and included: workshops, one-on-one feedback sessions, didactics, and role plays. Assessment methods were heterogeneous; one-half of the studies used RSAs, one-third used medical student evaluations, 2 used observations using videotapes, 2 used an OSTE, and 1 used an objective structured clinical examination. Most programs using RSAs used the CTAF or some adaptation of the instrument.

Table 2 summarizes strengths and limitations via the validity assessments of both the RCT and CNRT. Eight of the 13 articles cited follow-up and intention to treat (a method for incorporating all subjects in the analysis). Six studies incorporated assessment tools that were both valid and reliable. Less than one-half (n = 6) described differences at baseline. Limitations included the lack of the following: blinding of raters, description of randomization methods, and concealment of randomization. Only 4 studies described their randomization methods, one of which indicated that randomization was concealed. Notably in our review, the sample size in most studies was small; only one study used a power analysis to determine sample size.

As seen in Table 2, the total validity scores for articles reviewed ranged from 0 to 7 for the 10 RCT and the 3 CNRT trials. The study by Naji et al, the second-highest rated study, was the only study to include psychiatry residents. The primary purpose was to assess residents’ ability to teach interviewing skills to medical students. This study utilized a complex study design. Psychiatry residents (n = 24) were randomly assigned to each of 4 intervention groups, with 1 control group. Medical students were also randomly assigned to the 4 groups and students not fitting into any group served as the control. The 4 interventions consisted of experiential supervised, experiential unsupervised, didactic supervised, and didactic unsupervised. Experiential groups (supervised and unsupervised) consisted of residents who were able to self-assess their performance on taped interviews and received feedback on the taped interviews in a feedback session. Supervised groups (experiential and didactic) had supervisors to provide feedback during the sessions. Pre and post interviews were evaluated by trained raters blinded to training conditions. Discrete behaviours assessed included purpose of interview (present or absent), handling emotional topics, and amount of key information obtained (5-point rating scale). They concluded that students taught by experientially trained resident teachers performed better, whereas supervision alone did not exert significant improvement on student behaviour.

Of the remaining studies, the RCT by Morrison et al was assigned the highest possible validity rating (7 out of 7). It consisted of a 13-hour teaching intervention that included feedback about their teaching skills with an OSTE as one of the primary assessment methods. The strength of this study was its comprehensively designed methodology (description of randomization methods, concealment of randomization, and blinding of raters). Results of this study indicated that residents’ teaching skills improved significantly in the experimental group, compared with the control group.

There were 4 other relatively strong studies as judged by the total validity score (4 out of 7). Furney et al used power analysis, had good follow-up, and described the method of randomization. In this case, a random number generator was used; however, it was not noted whether randomization was concealed. Their intervention was a 1-hour session incorporating lecture, role play, and group discussion. Their assessment instrument was a 14-item, 5-point rating scale administered both to residents for self-report and to medical students for evaluation of residents’ teaching skills. Limited
<table>
<thead>
<tr>
<th>Learner type</th>
<th>Authors</th>
<th>Study type</th>
<th>Experimental and control subjects</th>
<th>Training level</th>
<th>Assessment methods and tools</th>
<th>Intervention</th>
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<tbody>
<tr>
<td>Pediatrics</td>
<td>Jewitt et al&lt;sup&gt;17&lt;/sup&gt;</td>
<td>RCT</td>
<td>27, 26</td>
<td>PGY 1–3</td>
<td>RSA; PP Faculty, peer, and student evaluations</td>
<td>2 half-day workshops and two 1-hr instructions</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>Greenberg et al&lt;sup&gt;18&lt;/sup&gt;</td>
<td>RCT</td>
<td>27, 26</td>
<td>PGY 1–3</td>
<td>RSA; PP</td>
<td>8 hrs, total (2 half-day) workshops; 1 hr of group consultation and feedback</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>Naji et al&lt;sup&gt;19&lt;/sup&gt;</td>
<td>RCT</td>
<td>n = 24 registrars n = 287 students</td>
<td>8 senior and 16 other ns registrars</td>
<td>RSA with blind raters and videotaped patient interviews; PP and student’s interviewing skill; PP</td>
<td>Training and feedback sessions lasted at least 1 hr</td>
</tr>
<tr>
<td>Obstetric–gynaecology, family medicine, internal medicine</td>
<td>Edwards et al&lt;sup&gt;20&lt;/sup&gt;</td>
<td>RCT</td>
<td>12, 9</td>
<td>PGY 1 Cohort&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Observation with trained raters (videotapes) RSA (CTAF)&lt;sup&gt;b&lt;/sup&gt; MS evaluations</td>
<td>Half-day session in year 1 and in year 2 workshop and critique</td>
</tr>
<tr>
<td>Internal medicine</td>
<td>Snell&lt;sup&gt;21&lt;/sup&gt;</td>
<td>CNRT</td>
<td>9, 5</td>
<td>PGY 3–4&lt;sup&gt;c&lt;/sup&gt;</td>
<td>Checklist; PP RSA; PP scales adapted from CTAF; PP</td>
<td>Evening seminar series: five 3-hr sessions</td>
</tr>
<tr>
<td>Internal medicine</td>
<td>Spikard et al&lt;sup&gt;22&lt;/sup&gt;</td>
<td>CNRT</td>
<td>22, 22</td>
<td>PGY 2–3</td>
<td>MS evaluations; PP RSA; PP</td>
<td>3-hr workshop</td>
</tr>
<tr>
<td>Internal medicine, pediatrics</td>
<td>Bing-You et al&lt;sup&gt;23&lt;/sup&gt;</td>
<td>RCT</td>
<td>14, 14</td>
<td>PGY 2–3</td>
<td>CTAF residents and MS team interviews (focus groups)</td>
<td>Summary of ratings versus no feedback</td>
</tr>
<tr>
<td>Surgery</td>
<td>Dunnington and DeRosa&lt;sup&gt;24&lt;/sup&gt;</td>
<td>RCT</td>
<td>30, 32</td>
<td>PGY 1–4</td>
<td>5-station OSTE RSA MS evaluations</td>
<td>2 sessions, 10.5-hr course</td>
</tr>
<tr>
<td>Internal medicine</td>
<td>Furney et al&lt;sup&gt;25&lt;/sup&gt;</td>
<td>RCT</td>
<td>28, 29</td>
<td>PGY 2–3</td>
<td>RSA; PP MS and PGY 1 evaluations (Both adapted from SFDP-26)</td>
<td>1-hr session</td>
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<tr>
<td>Obstetric–gynaecology</td>
<td>Mass et al&lt;sup&gt;26&lt;/sup&gt;</td>
<td>RCT</td>
<td>n = 24&lt;sup&gt;d&lt;/sup&gt;</td>
<td>All levels</td>
<td>MS evaluations RSA; PP</td>
<td>Written and (or) oral feedback from student evaluations, teaching awards and pins</td>
</tr>
<tr>
<td>Unknown</td>
<td>Thomas et al&lt;sup&gt;27&lt;/sup&gt;</td>
<td>CNRT</td>
<td>6, 6, 0&lt;sup&gt;e&lt;/sup&gt; 22, 11, 9&lt;sup&gt;f&lt;/sup&gt;</td>
<td>PGY 1–2 MS–4</td>
<td>MS PE skills (OSCE)&lt;sup&gt;g&lt;/sup&gt;; PP RSA</td>
<td>Residents trained by experts</td>
</tr>
<tr>
<td>Internal medicine, family medicine, pediatrics</td>
<td>Morrison et al&lt;sup&gt;28&lt;/sup&gt;</td>
<td>RCT</td>
<td>33, 29</td>
<td>PGY 2</td>
<td>8-station OSTE; (SFDP)</td>
<td>13-hr curriculum, 1 hr twice monthly for 6 months</td>
</tr>
<tr>
<td>Internal medicine, surgery</td>
<td>D’Eon&lt;sup&gt;29&lt;/sup&gt;</td>
<td>RCT</td>
<td>8, 8</td>
<td>Unknown</td>
<td>Observation with trained raters (videotapes; PP)</td>
<td>TIPS workshop; 1 day/week over 2 weeks for a total of 2 days</td>
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<sup>a</sup>Study assessed medical students’ PE performance on an OSCE pre-post clinical rotations with residents trained by experts.
<sup>b</sup>Measured but not reported
<sup>c</sup>Canadian hospital, third- and fourth-year residents
<sup>d</sup>The PGY 1 cohort was followed with repeated measures during their PGY 2 and 3 years
<sup>e</sup>This study consisted of MS randomized into 3 groups of residents, 2 experimental groups and 1 control group. RMOs were trained in PE skills for the eye, leg, and the hand. There were no RMOs in the control group.
<sup>f</sup>The students were assigned to 2 experimental groups and 1 control group.
<sup>g</sup>The total number of residents in this study was 24. The program consisted of 3 groups, 2 experimental, and 1 control, but the number of participants in each was not provided.

CTE = clinical teaching effectiveness; EV = evaluations; MS = medical students; ns = not specified; OSCE = objective structured clinical examination; PE = physical exam; PGY = post-graduate year; PP = pre-post assessments; RMO = resident medical officer; SFDP<sup>g</sup> = Stanford Faculty Development Program form-26;
validity and no reliability analysis for the instrument were provided. Although the intervention and control groups did not score significantly differently on overall teaching effectiveness, 5 of the 14 items showed significant improvement with the intervention group doing better than the control.

Edwards et al\textsuperscript{20} was also assigned a relatively high validity score. They did not describe their method of randomization; however, raters were blinded and group differences were described at baseline. They did not conduct a power analysis and had smaller numbers in each group with a substantial drop-out rate. Their intervention consisted of instruction and feedback sessions with critique. Their outcome measures were multifactorial, including observations (videotapes), RSAs, and medical student evaluations. After the intervention, few differences were noted between the experimental and control groups, but the residents did attempt to incorporate their new skills. Thus the authors concluded that teaching skills can be improved by instruction.

D’Eon’s study\textsuperscript{29} also scored 4 out of 7 points. They implemented a program called TIPS and used a randomized controlled experimental method with third party observations (videotapes), RSAs, and medical student evaluations. After the intervention, few differences were noted between the experimental and control groups, but the residents did attempt to incorporate their new skills. Thus the authors concluded that teaching skills can be improved by instruction.

The 3 CNRTs had validity scores that ranged from 0 to 4. Only one study described group differences at baseline and described the adequacy of follow-up. None of the studies, however, blinded raters. The Spikard et al\textsuperscript{22} article was the strongest of these 3 studies. Two important strengths were that it incorporated a power analysis and had a low drop-out rate. The intervention consisted of a 3-hour workshop on teaching skills using RSAs and medical student evaluations. A 9-item, 9-point rating scale with adequate psychometric properties was used to assess learning climate, ability to provide feedback, and overall teaching effectiveness. They also discussed group differences at baseline. The intervention group improved learning climate and their ability to provide feedback was comparable to the control group, as was their increase in confidence and learner-centred approaches. Overall teaching scores were not rated differently, however, and a potential for confounding factors was identified.

\begin{table}[h]
\centering
\begin{tabular}{|c|c|c|c|c|c|c|c|c|c|}
\hline
Study & Randomization methods & Concealment of randomization & Group differences at baseline & Blinding of raters & Follow-up and ITT & Instrument validity & Instrument reliability & Total score \\
\hline
RCT & Morrison\textsuperscript{28} & 1 & 1 & 1 & 1 & 1 & 1 & 7 \\
& Naji et al\textsuperscript{19} & 1 & 1 & 1 & 1 & 0 & 1 & 5 \\
& Edwards\textsuperscript{20} & 0 & 0 & 1 & 1 & 0 & 1 & 4 \\
& Furney\textsuperscript{25} & 1 & 1 & 1 & 0 & 1 & 0 & 4 \\
& D’Eon\textsuperscript{29} & 0 & 0 & 1 & 1 & 0 & 1 & 4 \\
& Dunington\textsuperscript{24} & 0 & 0 & 0 & 0 & 1 & 1 & 1 \\
& Bing-You et al\textsuperscript{23} & 1 & 0 & 0 & 0 & 1 & 0 & 2 \\
& Mass\textsuperscript{26} & 0 & 0 & 0 & 0 & 1 & 0 & 1 \\
& Jewitt\textsuperscript{17} & 0 & 0 & 0 & 0 & 1 & 0 & 1 \\
& Greenberg\textsuperscript{18} & 0 & 0 & 0 & 0 & 1 & 0 & 1 \\
\hline
CNRT & Spikard\textsuperscript{22} & 0 & 0 & 1 & 0 & 1 & 1 & 4 \\
& Snell\textsuperscript{21} & 0 & 0 & 1 & 0 & 1 & 1 & 2 \\
& Thomas\textsuperscript{27} & 0 & 0 & 0 & 0 & 0 & 0 & 0 \\
\hline
Total & 4 & 1 & 6 & 4 & 9 & 7 & 8 \\
\hline
\end{tabular}
\caption{Validity assessments of RCT and CNRT of residents’ teaching skills programs}
\end{table}

\textit{ITT} = intention to treat
Discussion

Our primary purpose was to identify and appraise controlled trials on residents’ teaching skills programs in psychiatry. We found one documented study of a psychiatry residents' teaching skills program to enhance teaching skills and no other controlled studies with psychiatry residents met our inclusion criteria. The published study was of relatively high quality and was primarily concerned with residents’ teaching interviewing skills to medical students. The findings supported that residents can be trained to become more effective teachers.

Discussion

In Review

Based on the dearth of published studies in psychiatry, psychiatry programs should publish and share data and outcomes from their current or previously developed programs. It is important to gain insights from residency programs in all disciplines that have previously developed or conducted research in this area. Despite the priority given to this area of research by the RCPSC, LCME, and ACGME, more studies are needed to assure that residents’ teaching skills can be enhanced in all residency specialty programs. In addition, many of the studies were limited in sample size and power. This is a particular challenge for small psychiatry residency programs. We suggest that psychiatry residency program directors consider conducting multicentred trials to increase the size of their samples and thereby increase statistical power.

We stress the importance of using validated and reliable assessment tools. A range of outcome measures and assessment instruments were used in the trials we appraised. Validated instruments included the OSTE, CTAF, and Stanford Faculty Development Program Form-26. While the OSTE is a comprehensive, validated, and objective measure of resident teaching skills, it is also cumbersome, expensive, and time-consuming to administer and analyze, but should be considered the gold standard of assessment. The CTAF, a multidimensional scaled instrument, was used by 3 of the programs reviewed. It is relatively easy to administer, consists of 9 items scored on a 6-point rating scale, and includes a single global rating of teaching effectiveness. More recently, 3 additional instruments have been created to evaluate clinical teaching: the Clinical Teaching Effectiveness Instrument, 32 the Resident Leadership Scale, 34 and the Personal Teacher Identity Scale. In the articles we appraised, the range of outcome measures used impedes comparisons between programs and impedes the determination of utility of the results across programs.

Residents-as-teachers programs in other specialties provide a model for the development of residents-as-teachers programs in psychiatry. These programs varied in scope and format, perhaps owing to individual needs and limitations of the training programs and institutions in which they were conducted. Thus residents-as-teachers programs must be tailored to fit the needs of a specific context, level of learner, and specialty of training. We would propose, however, that a core set of general teaching concepts should be included in most residents-as-teachers programs, such as leadership, evaluation and feedback, bedside teaching, and small group teaching skills. In addition, 3 of the programs used feedback as one of the primary interventions for resident teaching skills. Collectively, these studies demonstrated an improvement in resident teaching behaviours and confidence. Feedback, either as a primary intervention or in combination with other interventions, warrants further consideration in research and program development. Thus program developers may consider providing residents with continuous feedback (written or verbal) from medical students, faculty, and colleagues on their teaching skills. Potential mechanisms for providing residents with continuous feedback are to add assessment items to the students’ evaluation forms or make teaching skills part of residents’ core competencies.

Our study was limited by only having access to published programs; more published and (or) unpublished programs might exist. We can learn from individual programs regarding their challenges in developing and assessing residents’ teaching programs in psychiatry. As noted, however, there are also few descriptions of individual programs in psychiatry. Psychiatry residency program directors should be surveyed to determine how many residency programs provide residents-as-teachers programs, how and under what circumstances those programs are conducted, and what are the outcomes. As a general rule, to ensure success of a residents’ teaching skills program, we suggest using proper curriculum design methods including conducting a needs assessment, developing objectives and outcome measures, and some form of program evaluation.

Conclusions

In conclusion, these results suggest that residents-as-teachers programs can confer benefit on residents’ teaching skills. Nevertheless, there is a paucity of evidence especially concerning psychiatry residents-as-teachers programs. We emphasize the important goal of further developing rigorous research on this topic area.
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Résumé : Les programmes de résidents-enseignants en psychiatrie : une étude systématique

Objectifs : Parce que les résidents en psychiatrie tiennent d'importants rôles d'enseignants et ont des occasions significatives de contribuer à la formation des étudiants en médecine, nous avons entrepris : d'identifier tous les essais randomisés contrôlés (ERC) pour les programmes d'aptitudes à l'enseignement des résidents, et de déterminer l'efficacité de ces interventions pour améliorer les aptitudes à l'enseignement; d'identifier les forces et les faiblesses des études disponibles dans toutes les disciplines médicales; et de repérer les méthodes actuellement offertes pour améliorer les aptitudes à l'enseignement des résidents en psychiatrie.

Méthodes : La documentation publiée en anglais a été recherchée à l'aide des bases de données PubMed, Social Sciences Index et PsycINFO, avec des mots clés de recherche incluant résidents, aptitudes à l'enseignement, résidents comme enseignants, psychiatrie, et évaluations. Les ERC et les essais non randomisés contrôlés des programmes d'enseignement aux résidents destinés à améliorer les aptitudes à l'enseignement des résidents ont été sélectionnés et ont subi une évaluation critique.


Conclusions : Il existe un seul essai qui incorporait les résidents en psychiatrie. Il y a une occasion significative de faire progresser la recherche en ce domaine. Les directeurs de programme de résidence en psychiatrie devraient incorporer des méthodologies de grande qualité et peuvent bénéficier des résultats d’essais dans d’autres disciplines.