Introduction to teaching for junior doctors 1: opportunities, challenges and good practice

Doctors are expected to contribute to teaching activities and those who do should develop requisite skills. This two-part article highlights approaches to teaching for doctors in training based on sound educational principles. The first part focuses on identifying teaching opportunities, meeting logistical challenges and implementing good practice.

The Board of Medical Education (British Medical Association, 2006) described how traditionally teaching activities have been seen as the remit of medical academics, GP trainers and consultants who have been contractually obliged to provide teaching and training to those junior to them.

Medical training now requires evidence of teaching from foundation doctors upwards. For example, in order to complete successfully specialist training 2 doctors are asked about their teaching activities with evidence of feedback from students or colleagues. At specialist training interviews, specific examples of teaching experiences will often be required from the candidate. Such requests may come as a surprise if such skills have not been focused upon within the curriculum.

It is important that doctors in training know what teaching they might expect to have, know how to fulfil their teaching duties using sound educational practice and are able to critically appraise and document their activity. To meet this need, this two-part article addresses some key questions often asked by junior doctors when starting teaching. The first part will consider likely opportunities, challenges and some principles of good teaching practice.

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What sort of teaching opportunities will be available to me?

There will be many opportunities for you to teach in the clinical environment. Most teaching opportunities for foundation year doctors will be with undergraduates in the clinical environment on the wards. In addition, you may well be able to participate in formal teaching activities such as clinical skills sessions or small group tutorials. In this case make sure you know about, and complete, any appropriate training course organized by your linked medical school or postgraduate centre. As you progress through training, there may be opportunities to teach other junior doctors, nurses and other health professionals. It is important also to remember that you can teach and learn from your peers.

Most commonly, your teaching will be informal and opportunistic – offered 'in response to the clinical issues in hand' (Irby and Bowen, 2004), for example, finding teachable moments by the bedside, in ward-round and 'handover' debriefs or when reviewing patients in clinics with their investigation results. Try to get into the habit of putting aside small chunks of time for example, on a ward round or during an 'on-call' specifically for the purposes of teaching.

It is worth noting that over a period of time, good quality teaching and supervision of this kind, even for relatively brief episodes, has a greater influence on trainee competence than seeing large numbers of patients unsupervised (Irby and Wilkerson, 2008). If you adopt a student-centred approach, these episodes can be invaluable for learners and this article illustrates key principles for using these short periods of time effectively. It is also important to keep a record of these events for your required documentation.

Learners do not simply acquire clinical reasoning and skills while observing your practice, these teaching encounters also provide an opportunity for students to learn 'professional' behaviour (Prideaux et al, 2000). Much has been written about the concept of the 'hidden' curriculum. Certainly, you will model (Bandura, 1977) and students will learn appropriate verbal and non-verbal communication by observing your exchanges with patients and colleagues when handing over or presenting cases. More broadly, learners will learn non-formally about the culture and organization of medicine by participating with you across the spectrum of your workplace activities (Lave and Wenger, 1991).

What are the likely challenges and how might I overcome them?

A potential hindrance faced by many new teachers is self doubt. Teaching can be an unnerving prospect when you have only just recently qualified with possibly limited work experience. A question frequently asked is 'how do I know I'm doing and saying the right thing?'

Let's start with your clinical knowledge. One of the exciting but daunting things about medical education is that as new evidence emerges, perceptions, treatment and management strategies may change. As a junior doctor delivering teaching you are not yet a specialist in a particular field and therefore may not be up-to-date with the latest developments or guidelines. Be honest in acknowledging the limits of your own knowledge and use teaching as a way to develop your own expertise, for example, by agreeing to look up any pointers for clarification with your learners (Dent, 2005).

Remember that learners will bring insights and observations to the clinical situation which can enhance your practice. It is worth bearing in mind that journal club presentations and weekly case discussion meetings will improve your knowledge base but are also a form

of teaching and can be included in your portfolio of evidence.

In terms of developing confidence as a teacher feedback can really help you overcome your concerns. Obtaining feedback from your students, peers and seniors will help build your confidence and also provide the multi-source feedback you may require as evidence. The second part of this article offers some suggestions for how best to collect this feedback.

However, it is the tension between service delivery and education that will likely present your greatest challenge. The modern time-constrained clinical environment (Irby and Wilkerson, 2008) is not in many ways an easy place to teach and learn. For example, the 4-hour target will make teaching in accident and emergency departments difficult. These time pressures are compounded by the increasing numbers of medical students in some hospitals and, owing to shift work, the decreasing number of junior doctors on a day-to-day basis. Such organizational and cultural changes may be beyond your control, but they do flag up the importance of finding and using short teachable moments in the most effective way possible.

Other obstacles will always remain such as the challenge of recruiting patients who are not too unwell (British Medical Association, 2006) or able to provide consent and negotiating around protected meal and rest times. Since there is no immediate solution to these problems you need to think through contingency plans with 'back-up' patients who are willing to step in should the planned patients be unavailable.

Teaching in busy, complex hospital environments (sites of hot action according to Beckett and Gough, 2004) presents difficult logistics but it is not impossible and the learning that does take place is often highly relevant and greatly valued by trainees and students (White et al, 2005).

How can I implement good practice as an educator?

Although much of your teaching may be brief and informal that does not mean that it cannot be of high quality. Key principles drawn from educational theory can be used to inform your practice. Much modern educational practice is informed by constructivist thinkers (Cohen and Dennick, 2009) who see learners as being at the heart of the educational process, active in their own learning.

Translated into principles for teaching, this means that you should start with the learners' perspective. It is sound practice to begin by ascertaining the level of your students' or trainees' existing knowledge (Dent, 2005) and consequently, what they can reasonably be expected to learn. This is especially critical if you are going to provide effective teaching in a small time span. It is useful to see your role as helping them to build upon their existing knowledge while presenting them with appropriate challenges (Bandura, 1977). Be guided by Harden and Crosby's (2000) words that 'a good teacher can be defined as a teacher who helps students to learn'.

If you do have some planning time, say for bedside teaching, consider creating a mental 'road map' of the teaching points you wish to cover (Ramani, 2003). You will still need to elucidate your learners' needs but have in mind some specifics – history taking, the system you want to cover and so on. In time you will find you develop 'illness scripts' which cover three to five key points and common errors made by learners.

You may choose to teach such content didactically but consider making more use of questioning. Much has been written about questioning techniques as a form of teaching (e.g. Lake et al, 2005). They suggest that you think in terms of a scale which starts with factual recall questions, to which some clinicians are inclined, and extends to questions that promote higher order skills. Try using the upper ends of the scale – questions such as 'what might happen if…?' and 'what do you remain uncertain about?' It is possible to be quite challenging and thought provoking without being intimidating or humiliating.

The same principles apply even if your teaching is impromptu, arising from treating a patient with particular signs and symptoms. Again, begin by diagnosing your learners' needs through questions such as 'have you seen this before?' Then build a teaching strategy on the responses you receive to your questions. Remember to pitch questions according to your learners' stage of training, allow time for answers and avoid answering your own questions where possible.

Teaching is very much about practicalities and if you do have time for some planning as well as your road map of key objectives, think about rough timings and your 'resources' – willing and available patients. Never forget the key role of the patient. If you do involve a real patient, brief him/her as to the purposes of teaching (Dent, 2005) and draw him/her in as actively as possible since there is a great deal we can all learn from patients:

> **'...not only can patients tell their stories and show physical signs, but they can also give deeper and broader insights into their problems' (Spencer, 2003).**

The patient may even help offer feedback to the students or trainees. Also identify other members of the clinical team who may be willing to offer their specialist expertise and possibly some teaching space – maybe a room for following up discussions. Keep a record of any lesson plans you produce.

Certainly as teacher you have responsibility for the content and overall shape of the teaching session but for learning to take place students need to be as active as possible. This may be achieved by them responding to your probing questions, but you should also allow them to practice skills and give them feedback. Students require feedback if they are going to learn and improve. Constructive feedback from yourself as a clinical teacher, based on your first-hand observation of performance, will be perceived as useful and credible. Such feedback should avoid global judgments of 'that's fine' but rather be specific, based on the evidence of what you have observed and should help learners identify strengths as well as pointers for improvement (Irby and Bowen, 2004).

Most importantly, try to identify how such improvement may be achieved, i.e. through further practice, research or additional experience. It is useful, wherever feasible, for students or trainees to have the opportunity to implement any suggestions as soon as possible.

Other techniques to promote active learning include 'hot seating' where you may hand over to the student in the middle of a consultation, or 'hot review' where you discuss a case immediately after the student has seen it encouraging students to reflect and thus learn from what they have

just practiced, heard or observed (Kolb, 1984). Ask them about matters which have puzzled them (Aygris and Schon, 1974), to draw parallels and distinctions between cases and identify how their new knowledge may be applied in future settings. These activities may occupy little time, but prove extremely useful.

In all aspects of his/her practice, the good teacher should be concerned with creating a conducive educational environment (Genn, 2001). As a trainee, there will aspects of the clinical environment beyond your control but there are ways you can make a difference. Demonstrate your genuine enthusiasm (Gibson, 2009) for teaching by establishing your learners' needs, listening to their concerns but also by transmitting your interest in your subject. Think about creating joint agendas, for example by preparing for bedside teaching by asking 'What are we hoping to accomplish at the bedside?' This type of collaborative approach to learning helps to build rapport and remember that such 'emotional intelligences' are the hallmark of an excellent educator (Hesketh et al, 2001).

Conclusions

Recent changes to medical training have resulted in a more targeted approach to assessing the teaching competencies of junior doctors. In the authors' view, this is a positive step in recognizing a skill that is expected and already practiced by many doctors so vital to the future progress of medicine. In meeting the challenge of developing and demonstrating their teaching skills, junior doctors have the potential to improve and increase the amount, and quality of teaching, which in turn may lead to an overall better service for doctors and patients.

The second part of this article will focus on collecting feedback on your teaching and the opportunities available to develop your expertise. **BJHM**

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KEY POINTS

- Keep a log of all your teaching both formal and informal, i.e. topic, date, who is being taught, reflective comments.
- Find out about any available or requisite teacher training at your associated medical school or postgraduate centre.
- Identify informal teachable moments – be opportunistic.
- Identify your learners' needs and pitch your teaching accordingly.
- Use questioning as a method of teaching and use questions which promote higher order thinking.
- Involve patients as equal partners in your teaching.
- Make students as active as possible in the learning process through responding to questions, practising skills, acting upon feedback.
- Seek to create a comfortable, collaborative learning environment.

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