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The steep learning curve of medical education

This article focuses on the complex issues surrounding the need for adequate training in medical education for all clinicians. Many recent landmark papers, including guidance from the General Medical Council, have expressed the importance of formal training. Although the article points out that the majority of clinicians will probably not need to attend such courses, a few generic skills in teaching large and small groups may be of benefit to most. The authors call for the recognition of teaching duties in psychiatrist's contracts and discuss the wider implications of sound medical teaching for the recruitment and retention crisis in psychiatry.

Until relatively recently, the old adage of 'see one, do one, teach one' was the mainstay of the apprenticeship system in medicine. But is being an effective medical educator an innate talent – a true case of nature over nurture? Apprenticeship still continues, but recent changes in educational practice have made an increasingly structured approach necessary.

The past 10 years have seen a number of landmark publications concerning medical education. The Standing Committee on Postgraduate Medical Education (SCOPME) reports focused on improving the standards of clinical teaching (SCOPME, 1994). The World Psychiatric Association (1999) has produced an outline curriculum for undergraduates, which ties in with a similar work by the Royal College of Psychiatrists (Ring *et al*, 1999). The General Medical Council (2002) states that 'teaching and learning systems must take account of modern educational theory and research and make use of modern technologies where evidence shows that these are effective'. However, the majority of doctors teaching psychiatry, whether to undergraduates or postgraduates, in a university or clinical setting will have little formal training in these concepts. Do they need to?

Since the 1997 Dearing Report into Higher Education (National Committee of Inquiry into Higher Education, 1997), universities have been expected to provide specific courses to enhance teaching practices (including within medicine). These courses must be validated by a regulatory body such as the Institute of Learning and Teaching in Higher Education (ILTHE), and there is good evidence that such programmes improve student learning. Gibbs & Coffey (2004) showed that course participants delivered teaching that was more student-centred, better communicated, and was retained for longer.

Although we recognise that not all clinicians need to attend such courses, some generic skills may be useful to all medical teachers. As well as ILTHE-approved courses, there are a number of courses available locally (usually within the deanery) which may provide focused training. The majority of clinicians need the skills to be able to deliver teaching at some level during their medical careers. Since the introduction of the new consultant contract, teaching activities including 'training, medical education and formal teaching' are listed under the umbrella term 'supporting professional activities' (Department of Health, 2003). Consultants are encouraged to take an active part in their own job planning, and teaching duties often form a considerable part of this.

This article focuses on practical ways to improve the use of two such key teaching skills that are commonly needed by clinicians: first, how to present to a large group and second, how to arrange small group or tutorial teaching.

Presenting to large groups

Lecturing or presenting to an audience is a daunting and at times a terrifying experience for most of us. Attempting to get one's points across clearly, as well as maintaining the interest of the audience, are paramount to this process. Psychiatrists are usually asked to give presentations as part of an undergraduate or postgraduate educational course, in an academic expert capacity, or more recently during part of a structured interview process. As in most other aspects of medical training, there is no substitute for practice. We have attempted to present a few practical tips for addressing large groups, under the chronological headings: 'before presentation', 'during presentation' and 'after presentation'. These concepts have been summarised in Box 1.

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Box 1.   Summary of practical tips for presenting to large groups

Before presentation

- Effective time management is essential
- Adequate preparation and research of your audience is advisable
- Choosing your presentation format is important and dependent on many variables
- Come prepared with back-up presentations
- Allow adequate time for practice sessions.

During presentation

- Start punctually
- Tell them what you are going to tell them and then tell them
- Keep an eye on the audience and try to break talk every 20 min
- Close by summarising two or three key points

After presentation

- Collect feedback from a variety of sources
- Use these (and your own conclusions) to guide the reflective process

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Before presentation

- Allow plenty of time for preparation. A 1-h presentation will take several times that period to prepare adequately. However overpreparation can be just as risky a strategy as not allowing enough time to prepare.
- Know the physical environment. Familiarise yourself with the exact location that you are due to present in well in advance. This may involve making a prior visit to the room or auditorium. You must also make sure that you have a sound knowledge of existing 'presentation tools' such as lighting, computers and audio-visual equipment.
- Work out the context of your presentation. Where does your talk fit into the course or curriculum? Does it add anything new to the subject or present things in a different way? Getting a copy of what students have already been taught (and hence avoiding overlap) could save a lot of your own, as well as your audience's time.
- Research your audience. Who are they? What are their experiences or training in psychiatry? Speak to others who may have presented to them. What particular aspects of presentation have gone down particularly well in the past? (Brown *et al*, 1995).
- Support materials such as handouts should be devised thoughtfully. Allow plenty of space for annotation and make sure that the font is a reasonable size. Decide whether you simply want a carbon copy of the presentation or simply the highlights.
- Deciding your presentation format will depend on many variables. A Microsoft PowerPoint presentation is obviously most versatile; however it is prone to technical shortcomings and also the experience of the lecturer. Slides and Microsoft PowerPoint are the obvious choices for a larger audience, whereas an

overhead projector (OHP) may be used effectively in a smaller lecture group. An interactive whiteboard and OHP may be a good choice if you wish the audience to participate in exercises or make suggestions which can be transcribed directly, however these are much less likely to be seen well in large groups and do not aid handout production.

- Presentation formats should be interesting and clear. Make use of colours, highlighting and illustrations. Use a light slide background and stick to black or blue colouring for text. A font size equivalent to less than 20 is unlikely to be seen by most medium-sized audiences, and will be illegible on handouts.
- Whichever format you choose, come prepared with back-ups. If you plan to present using Microsoft PowerPoint, make sure that you bring a spare disk. It is also advisable to have a 'reserve' presentation (and acetates) adapted for an OHP.
- Think of interesting anecdotes that can be used in the lecture. As well as being far more likely to be remembered by audiences than much of the talk, anecdotes often help illustrate difficult concepts and break up the monotony of a long delivery.
- Allow at least one full practice run-through beforehand and several briefer practices. Presenting in the same environment that the talk will be given is best of all, however presenting to a group of colleagues or even to the mirror at home can also confer benefit (Cantillon, 2003).

During presentation

- Get started punctually and keep rigidly to your timing. A 1-h slot should allow at least 10 min for questions and discussion, the so-called 50-min hour. A good pace to aim for is 3–5 min per detailed slide.
- Break the ice by chatting informally to early attendees and asking them directly about their course/lecture experiences.
- Tell them what you are going to tell them, and then tell them. Letting the audience know what the presentation title is, who you are and your background are essential. They will also need to know the context of the talk, its layout and its length.
- Keep an eye on the audience. Glazed eyes and non-participation are not good portents. Encourage as much interaction as possible. This may be in the form of asking them 'how they are' or 'if they can follow the lecture'. It may also involve allowing them to ask questions throughout your talk.
- Evidence shows that audience interest will wane if you talk 'at them' non-stop for more than 20 min. Break long, theoretical presentations up with 'refresher sessions'. For example, this could involve dividing the audience up into small groups and asking them to perform tasks. 'Brainstorming' a particular topic, where the audience is asked to comment or suggest an idea that can contribute to the wider discussion, is another useful activity (MacManaway, 1970).
- Sum up a lecture in two or three take-home messages. As well as allowing time for questions,

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provide your contact details and a focused further reading list (including website addresses).

After presentation

- Collect feedback from as many sources as possible including the audience and any peer-observers. This may be verbal and informal, or structured and written on pre-prepared forms. This process is essential for reflection.
- Reflect candidly upon your experience, taking into account all the objective evidence. Take a few minutes after the lecture to note down the positive aspects, the negative aspects and your suggestions for the future. It is only through completing this process that future improvement is possible.

Teaching small groups

Balanced styles of teaching which incorporate small-group teaching as a central component have been recommended for medical undergraduates (General Medical Council, 2002). This type of teaching is said to allow clinicians to develop the skills of enquiry and reasoning (Quality Assurance Agency for Higher Education, 2002).

As psychiatrists, most of our small-group teaching is in the form of 'bedside teaching', or one-to-one teaching in out-patient clinics or ward rounds. Many of the generic skills that are important in teaching larger groups also apply to tutorials. These include good time-keeping, attention to structure and maintenance of participant interest through interaction. There are other skills however that are more specific to small-group teaching. These can be summarised as follows and are highlighted in Box 2.

- Get to know your students and allow them to get to know one another. A small amount of time spent at the beginning of a session or placement goes a long way in enhancing their, as well as your own, experience of teaching. Simple measures such as providing name badges or asking the students to introduce one another by name and give an amusing fact about themselves can help act as 'ice-breaking' tools.
- The presentation format may change in small groups. Obviously in one-to-one tutorials the teaching will be primarily aural. However in small groups, one may choose to make use of the OHP, interactive

whiteboard, or flip charts. These are simple to use and any tasks that are given to the small groups can be prepared using these formats.

- Encourage participants to bring their own subjective experiences into the teaching groups. Base your teaching around their examples. This tends to work particularly well when discussing clinical scenarios.
- As psychiatrists, we should be better able to pay attention to the group dynamics. You can discourage the formation of 'cliques' for example, by allocating groups randomly. Group boundaries and acceptable and unacceptable behaviour should be made clear from the start. Behaviour such as favouritism or bullying within groups should not be tolerated. Whereas punctuality and expecting each group member to contribute equally should be rewarded.

Conclusion

Although most clinicians will probably not need to obtain a postgraduate qualification in teaching, use of a few generic skills for teaching large and small groups may be of benefit. Many clinicians have a recognised regular teaching commitment in their contracts. It is important that teaching activities are encouraged in our professional roles, as this will both enhance our teaching efficacy as well as the students' experience of psychiatry. Good teaching may have far-reaching consequences for the whole of medicine, and not least for psychiatry. The incorporation of good evidence-based teaching methods may be partiuclarly relevant, given the problems of recruitment and retention (Pidd, 2003) currently facing our speciality. It is notable that students often interested in the psychosocial aspects of patient care on entry to medical school seem to lose interest in these areas as graduation approaches. It is felt that positive, focused and well-delivered psychiatry teaching at an undergraduate level could do much to attract medical students into the specialty at its 'coalface' and stem the drain into other medical specialties. The learning curve for psychiatry teaching is it seems just as steep as ever.

Declaration of interest

None.

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Box 2.   Summary of practical tips for small-group teaching

- Use ice-breaking techniques to help students become familiar with group-working
- Have a clear purpose and goal for the session
- Pay attention to group dynamics and set boundaries early
- Encourage participants to bring their own subjective experiences to the group
- Make use of different teaching formats such as whiteboards or overhead projectors

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Review of on-call duties of non-consultant hospital doctors in a rural Irish psychiatric unit

The European Working Time Directive is a welcome challenge to traditional out-of-hours medical working practices, and aims to safeguard both doctors' and patients' health and safety. Its implementation is delayed in the Republic of Ireland because of ongoing medical union negotiations. Implementation of the directive will mean examination of on-call rotas, training requirements, and the organisation of cover. Local data determining clinical workloads after hours are the starting point to identify areas of concern and to implement appropriate solutions in individual locations.

We examined the out-of-hours calls of non-consultant hospital doctors (NCHDs) from 17.00 h to 09.00 h on weekdays and all day at weekends over a 4-week period, representing a total of 512 h. After midnight, the number of calls to doctors was less than a sixth the number before midnight (10 *v.* 64%). The majority of calls (68%) were for patient assessment and review, but a significant proportion related to non-medical work such as phlebotomy (8%) and filing (1%), and non-urgent work, such as the rewriting of prescriptions and the charting of medica-tion (16%). Of all calls, 88% were appro-priate to the skill level of the doctor contacted, however 9% required less skill and 2% were judged to be non-medical. Only 1% of calls were from general practitioners.

The restricted access of NCHDs to clin-ical supervision and training opportunities with shift working could be mitigated by high quality training in the evening and a reduction in time spent on non-training tasks. The new models of working are an opportunity to improve coordination of care between medical, nursing and other staff. Resources must be focused on the correct solutions, not just recruitment of additional medical staff. Above all, current available services and quality of patient care and safety must not be compromised.

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Training of senior house officers

In their recent paper Callaghan *et al* (*Psychiatric Bulletin*, February 2005, **29**, 59–61) showed that senior house officers (SHOs) in psychiatry usually valued on-call periods as a learning experience. However, the European Working Time Directive regulations regarding hours worked and rest requirements are now well and truly upon us and this has caused concern regarding the training of SHOs in other specialties (Mayor, 2005).

In Nottingham, SHOs in psychiatry previously worked a high intensity shift pattern that did not adhere to European Working Time Directive regulations. Measures implemented to ensure adher-ence to the new regulations included the appointment of psychiatric nurses to work specifically at night as the first point of call for anyone referring to the psychiatric SHO. Initially SHOs were involved with the majority of the assessments but over time the nursing team's experience has increased and they are now proficient in managing almost all of the referrals inde-pendently. As a consequence, SHOs are now finding that their participation in acute decision-making, risk assessment and devising management plans has reduced significantly.

The movement of specialist nurses into the role traditionally fulfilled by SHOs should not act as a barrier to training. Additional measures need to be intro-duced to ensure SHOs remain exposed to acute psychiatric cases. Possibilities include nursing teams providing direct training and a more comprehensive trainee's logbook where emergency cases seen are recorded. This would also be a step towards workplace assessment for doctors in training which is emphasised in Modernising Medical Careers (Depart-ment of Health, 2002).

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Psychiatry and the pharmaceutical industry

We read with interest the editorial 'Dancing with the Devil? A personal view