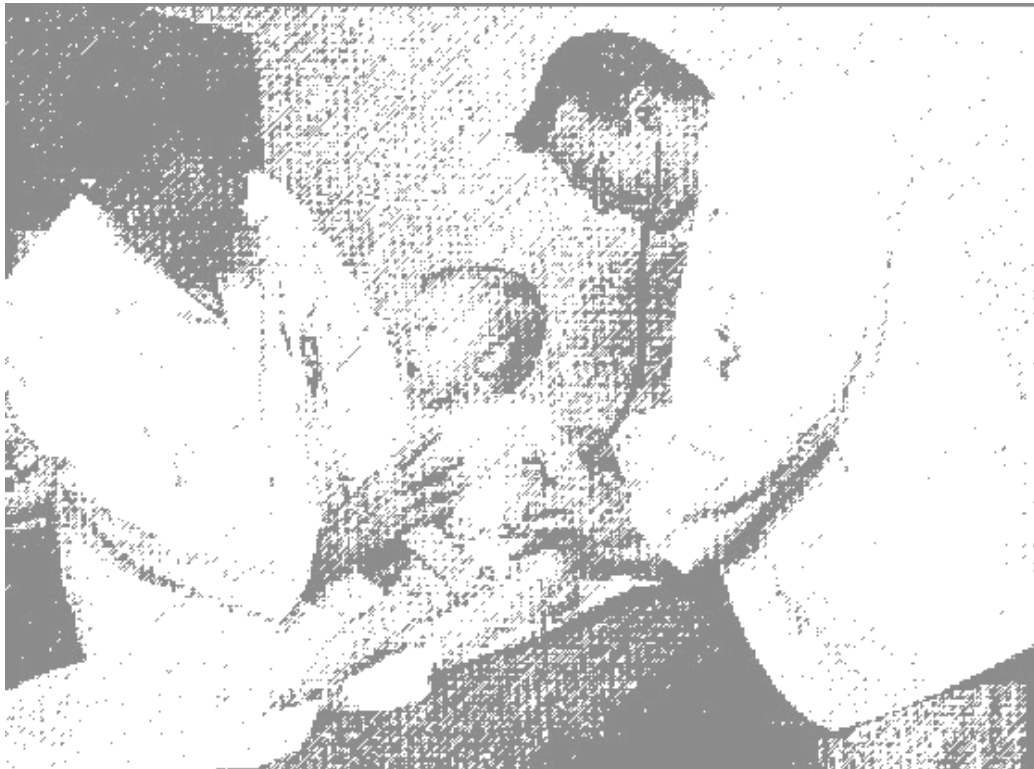
















# Teaching Tips for Tutors





**A brief guide to teaching for  
General Practitioners.**

## Contents

1. Introduction .....	Page3
2. How to use the guide .....	Page3
3. General principles .....   .....	Page4
4. History taking.....   .....	Page 6
5. Teaching a skill.....   .....	Page 8
6. Giving feedback .....   .....	Page 10
7. Teaching in the GP Consultation.  .....	Page 13
8. Teaching small groups.....  .....	Page 15
9. Lesson planning and objectives...   .....	Page 20

## Key

Important for small group teaching	
Important for core general practice teaching	

**This guide has been prepared by Dr Ann Griffin**

## 1. Introduction

Welcome and thanks for taking part in the undergraduate teaching. It is very rewarding as I am sure you will already realise. This very brief guide is aimed at giving you a few key tips to enhance the experience for yourselves and the students.

It is a very basic “starter” guide to teaching and learning in general practice and you would be more than welcome to join us on our teacher training courses (TIPS) to learn more.

By the time you have finished with this guide we hope;

- You will be able to describe the basic principles of enhancing teaching and learning in the community.
- You will know of other sources to get further information and training.
- You will have a series of activities that provide you with evidence of reflective teaching practice that you could include in your personal development plan (PDP)

## 2. How to use the guide

The guide is clearly laid out to enable you to choose the way you use it, some of you may prefer to start at the beginning and read through others may only want to pick out relevant chapters. Some chapters will be more relevant to teaching small groups, some to “core general practice” students; these will be clearly marked with symbols.

Each topic has a self-assessment exercise related to the common problems encountered by tutors and we suggest you take a few minutes to think and write down your thoughts on dealing with this. The following text should give the basic tenants of finding a solution.

If you want you can disassemble the guide and include the sections you have read and reflected on in your PDP

It is meant to be brief; if you want to know more about various issues a reference section is clearly highlighted.

This is not a tutor’s course guide.

### 3. General Principles of Teaching and Learning



**Think point;** List some principles of teaching and that you consider important. Compare your list to the one below

- **Climate for learning** - Setting the right mood is very important. Students like to feel welcome in the practice, and as many of them will have had long journeys by public transport, refreshments on arrival are always popular. Check that there are no burning issues that they would like to discuss first and consider the need to formally set ground rules.
- **OK not to know** – allowing students to see our limits of knowledge helps them voice their own limits of competence
- **Needs assessment** - Find out what students already know about the topic first. This helps to pitch the session at the right level and also aids learning. Long term retention of knowledge is thought to develop by the formation of links between new knowledge and existing knowledge networks in the brain. Activating this old knowledge in student's minds at the start helps them to make these links.
- **Aims and objectives** - Give students a clear idea of what to expect by highlighting the aims/objectives and outlining a basic structure for the sessions
- **Active learning** – it is far better to get the students actually doing, rather than telling them how to do things. Get them to see patients, present their findings, decide on what management they would choose and why.
- **Constructive feedback** – this is vital and covered on page 10.
- **Relevance** - Motivate the students to learn by explaining how relevant the skills learnt will be for them both as medical students and doctors, whatever their speciality. Remember that for students assessment is a powerful driving force
- **Summarize** - Telling them what you've told them at the end of each session is very useful to summarize what has been learnt. This is called schema refinement and helps long term recall.

- **Role modelling** – Do not forget how powerful this is. Your student will be observing you and your interactions; it is an ideal opportunity to teach correct attitudes.



**Action Point:** For your own teaching setting write down ideas you have for making your teaching more active for the students



**Key tip:** Active learning means the students are thinking. This leads to a greater chance that this new knowledge will be retained. Thinking also leads to deeper level learning.



#### Further reading

1. Hutchinson L. ABC of Learning and teaching, Educational environment, BMJ 2003:326: 810-2
2. Bednar, A.K. Cunningham, D. Duffy, T.M. & Perry, J.D. (1995) "Theory into Practice" in Instructional Technology: Past Present & Future, 2<sup>nd</sup> edition by Anglin, G.J, pp88-101
3. Kolb, D. A. (1984). Experiential learning: Experience as the source of learning and development. Englewood Cliffs, NJ: Prentice Hall.

#### 4. Taking a History



Think point: how do students in their early years a history?

Students have been given a lengthy list of questions to ask patients, including the “systems review”. It should not really come as any surprise that in a clinical encounter they spend all their time trying to remember these questions rather than talk to the patient. Asking multiple closed questions is called the “exhaustive method” of history taking, and it tires the teacher from listening to it as much as the student from performing it.



**Action point:** Write down ways you think could help improve your students ability to make a diagnosis.

In this chapter we will make a distinction between a consultation, which we see as a bigger holistic situation and gathering information. Here our aim is to focus on aiding information collection and analysis.

There are two key ways to try and improve the clinical reasoning that goes on in a history taking setting.

Firstly pattern recognition: In hospitals students tend to see rare conditions, which naturally spark more interest for them and their colleagues. They also may not have the medical knowledge to know how things present and will not link diseases with epidemiology. So in your teaching it’s really useful to get them to see very common conditions again & again. Integrating the prevalence will help “common things happen commonly”. Comparing and contrasting

medical conditions, rather than listing features of one, also aids learning.

Secondly we introduce a theory: Hypothetico-deductive reasoning. This is how experienced clinicians take histories.

It means that we ask questions, think of likely diagnosis, formulate further questions to test our hypothesis and ask again all within the consultation. Students don't, they ask, write down and come away with unanswered questions. They may miss important non verbal clues as they are concentrating so hard to remember the questions.



**Key tips:** 2 mnemonics to help you aid the deductive powers of your students

**SSSTOP** – Symptoms, severity, situational factors, time course, onset and patient characteristics.


- Let the student take the history of the presenting complaint then stop them and get them to consider the above headings.
- Get them to plan what other questions they need to ask and let them experiment and try them out

**FWWWU** – Follow Wee Willie Winkie Upstairs

- Focus – ask student to summarise findings
- Wait – let them finish their presentation
- What – ask them what they think the diagnosis is
- Why – why do they think that it is this
- Uncertain – what things have they heard that make them uncertain?



These techniques can encourage the detective behaviour.



 **Educational opportunity:** try videoing your own consultations and look at your own powers of deduction. Maybe review them with a colleague? *Don't forget patient consent!*



Further information: TIPS II course. ACME.

Administrator – Leonie Hayes, ACME, Whittington Campus,  
RF&UCMS



020 7288 3562  020 7288 3322  [l.hayes@acme.ucl.ac.uk](mailto:l.hayes@acme.ucl.ac.uk)

## 5. Teaching a Skill



**Think point:** Think about a skill you have learnt. List the things the instructor did that helped you learn.

*“Over two-thirds of academic and clinical staff had received no formal training in teaching skills”* Preston-Whyte et al 1999

In the small group setting you will be required to teach clinical examination skills, this is very likely to involve a demonstration and observing students as they practice. This sort of supervision is invaluable to them; it is not unusual for you to be the only doctor to actually watch them doing it!

The old adage “see one do one teach one” can be expanded. Below are a few tips.

**Why** examine: illustrate what important positive and negative findings you are looking for and how they affect your working diagnosis

**Find out** what they can do already and how confident they feel about this, you can increase or decrease the challenge of the situation accordingly

**Demonstrate** – and talk your way through it

**Chunks** – break down complex examinations into smaller parts

**Practice**, practice, practice, to ensure transferability of the new skill by practising in different situations and with different problems

**Feedback** and correct any errors

**Reconstruct** – bringing back of the smaller chunks into the whole picture.





**Action point:** List what a good teacher would do when teaching a skill and compare it to our list

### The Good teacher

- Tells them why a skill is useful
- Performed it from beginning to end
- Talked their way through linking anatomy and physiology
- Broke it up into smaller bits
- Gave everybody a chance to practice and get constructive criticism
- Provided many opportunities for practice
- Encourages critical thinking about interpretation of signs



**Educational opportunity:** It may have been a while since you performed a clinical examination in the same way as an undergraduate. It may be a good idea to watch one of the videos on clinical examination available for hire from the department or get another colleague to watch you.



### Further reading

Dent J. Harden R. 2001. A practical guide for medical teachers. Churchill Livingstone Chapter 8;pp 93-97

Teaching medical students in primary and secondary care 2003  
Hartley S. Gill D. Carter F. Walters K. Bryant P. Oxford University Press

## 6. Feedback



**Think point:** think back on the last time somebody criticised you. What were the things that would have made you consider a change in your behaviour and what aspects would have you dismissing all that person had to say?

The aim of feedback is to improve a students' performance. If a student is upset by the manner in which feedback is offered then s/he will not be in a psychological state to benefit from it. There are some general principles for giving feedback which have been listed below.

### General principles for facilitating feedback

- ***Address the behaviour and not the person:*** there is no point criticising things that can not be changed.
- ***Constructive rather than destructive:*** criticisms should be constructive and phrased as areas for improvement or targets they can work on for next time
- ***Consider the positive before the negative:*** it has been shown that feedback is more effective if the student leaves feeling generally good but with some specific ideas for improvement. Therefore it is important to focus on positives as well as negatives. One approach is the 'criticism sandwich' where you start with comments on what went well, followed by some areas for improvement and end with some overall positive comments.
- ***Specific rather than general:*** it is especially valuable to give students specific examples of where they did particularly well or could improve, rather than general comments.
- ***Allow the student to start first:*** most of the time students will know where they went wrong but will struggle to find parts where they did well. It makes your job a lot easier, and more comfortable for the students if you allow them to give their own feedback on their performance first.
- ***Consider the timing:*** generally the sooner the feedback is given the better.



**Action point:** Your student is having difficulties in communicating with patients because they are using too much jargon. Outline using the principles of feedback, how would you deal with this?



**Key tip:** Your feedback is essential to promoting and shaping learning. It is probably the most important aspect of the course.



**Educational opportunity:** The “Rules of Feedback” can be applied anywhere, at home, at work, at play. Try them out



Further reading:

1. Gordon J. ABC of learning and teaching in medicine: One to one teaching and feedback. BMJ 2003;326:543-5
2. <http://www.clinicalteaching.nhs.uk/site/Docs/PACS-1-Guidelines-for-Feedback.pdf>
3. <http://www.clinicalteaching.nhs.uk/site/ShowModule.asp?l=next&SlideID=6110>

## 7. Teaching in the General Practice Consultation



**Think point:** How can you teach and see patients in the surgery setting? What problems can you envisage?

Sitting in observing with the doctor is a very passive experience and little learning will occur. It is important to balance your need to provide a clinical service with active teaching.

Compare your list to ours – we have added a few tips that may solve these problems

Problem	Tip
Passive experience	<p>If you have the room space, get the student to make the initial assessment of the patient. They will need supervision and feedback</p> <p>Make use of the student, get them to do blood pressures, listen to heart sounds, look up drug doses etc.</p> <p>Ask them what they would do next/what are they thinking etc and try to avoid “give me 12 causes of atrial fibrillation”</p> <p>Book “student surgeries” so patients know they are seeing the student first Get them to take your surgery whilst you observe them</p>
Unplanned	<p>Find out what they want to learn, their current level of ability and plan a timetable accordingly</p> <p>Opportunistic teaching – much of the clinical content will be unplanned, try and set a few objectives in advance with the student for example to look at the range of morbidity, prescription rates, the common presentations of the upper respiratory tract infection etc</p>

Unfocused	<p>Get them to take longer more formal histories with patients that illustrate good learning point</p> <p>Try and provide aims and objectives but not too many of them</p>
Conflict between teaching and seeing patients	<p>Try to book fewer patients in total or give yourself longer appointment times. Try to promote reflection and discussion remembering it does not have to be done immediately. The student could keep a log of queries.</p>
Consent and confidentiality	<p>Warn everyone you have a student with you, it saves time if the patient is expecting a student. A waiting room poster may be a very good idea.</p>
All your responsibility	<p>Involve all the primary care team. It's important that the student has a good grasp of who they are and they will be expert in other fields</p> <p>.</p> <p>Share the learning with your other partners, a GP registrar also usually makes a good teacher as he/she is usually nearer their own age.</p>

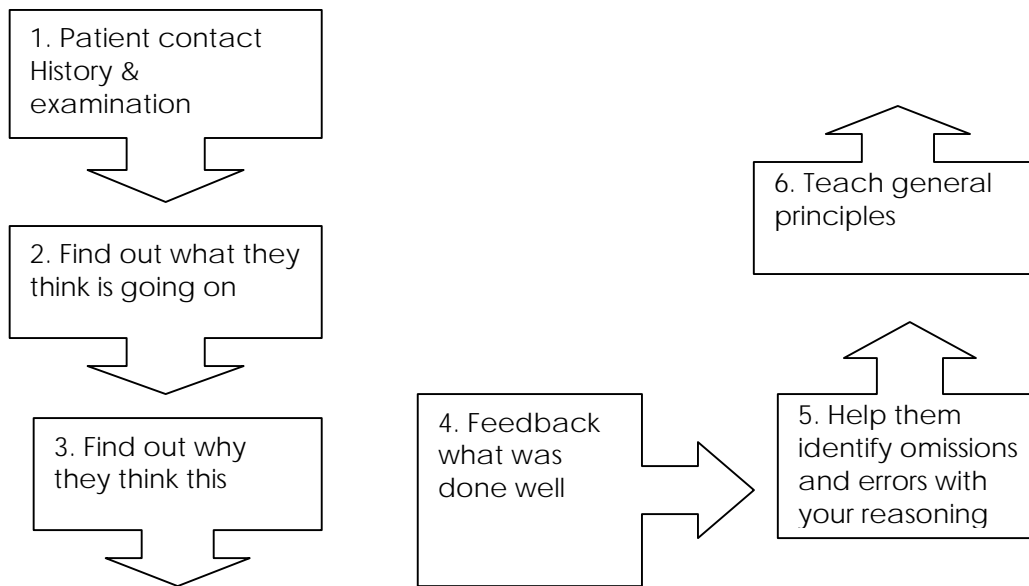
In this setting you will be studied in detail by your student. You will have a powerful effect as a role model.



**Action point:** It is here that students pick up ideas about doctors attitudes to patients. Think back to a recent surgery and list the positive features you would have demonstrated



**Key tip:** “The one minute preceptor” model



**Educational opportunity:** Try doing audiotape analysis of your consultations, like Byrne and Long did. Are you patient centred in your consultations, are you student centred in your teaching?



Further reading

1. Spencer J. ABC of learning and teaching medicine. Learning and teaching in the clinical environment. BMJ 2003; 326:591-594
2. Carter F. Berlin A. The clinical consultation as a learning opportunity, a practical education module for clinical teachers. [www.clinicalteaching.nhs.uk](http://www.clinicalteaching.nhs.uk)

## 8. Small Group Teaching

### Definition of a small group



**Think point:** Can you define a small group. What advantages can it offer to learning?

Many people concentrate purely on a numerical divide between small and large groups and this obviously does have importance. However it's the amount of student interaction that is key to being a small group, you can still lecture to two people!

### Why teach in small groups

Because general practice placements are organised that way because GP surgery's do not usually have space for more than six students!!!

But there is more to it than that.

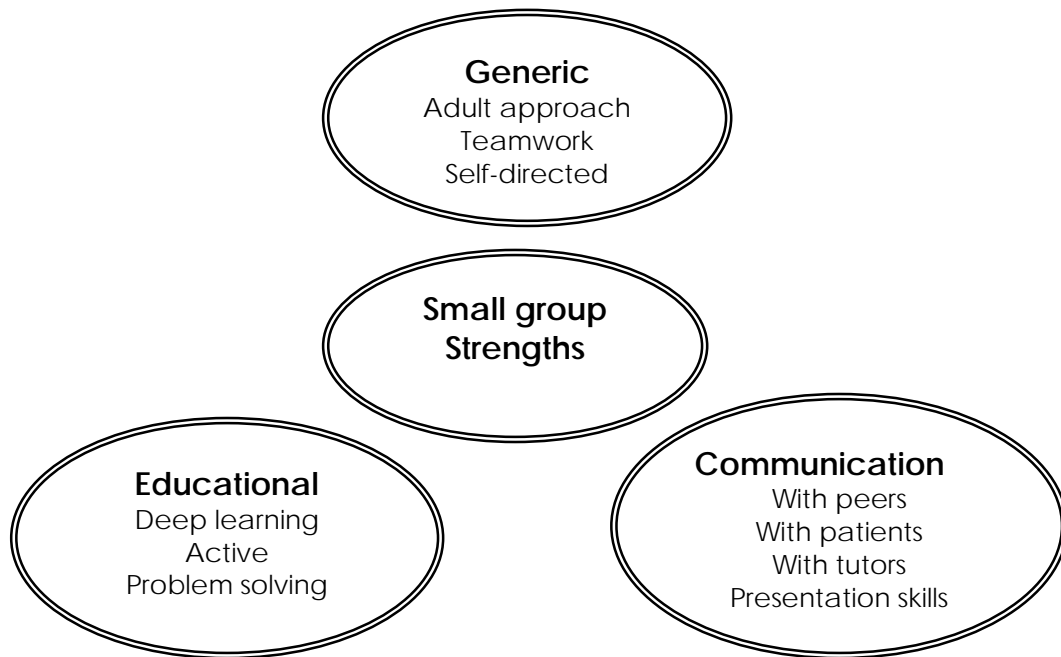
Teaching is in **protected time** and should combine:

- Focused history taking, with discussion and feedback
- Observed history taking and examination
- Brief topic based tutorials and case/topic presentations.
- Variety of settings (surgery, patient's home or residential care)

Teaching can take place in the surgery, in the patient's home or in a residential setting.

Small groups offer rich educational opportunities and are a mainstay of clinical teaching.

So what are the features of small groups that can make the learning opportunities so good?



**Student-centred:** meaning that learning is based on what the student needs to know rather than what the teacher wants to teach. It means finding out students learning needs and tailoring the course appropriately. This is especially relevant towards the end of year when student's abilities are much greater.

**Promoting deeper understanding:** by working in small groups and focusing around patient problems you are able to ensure that learning is not superficial. Use questions to clarify and ask students to discriminate and justify their responses. Make the learning as active as possible and focus it around real patient contacts.

**Team working:** as doctors we work in multi-professional teams, beginning working in this way is a very important aspect of this type of teaching. Start to use your students, get them to develop their own feedback skills and peer assessment. Taking control over their own learning is a vital aspect if we want to promote life long learners.

Two other important areas as you work in teams (remember to include your patients in this definition) is assessment of professional attitudes and getting active participation from the quieter members of the group,

Attitudinal assessment is a major strength of small group work; often the GP tutor will be the one person that will have observed it first hand



## The developmental stages of a small group

We have mentioned some of the educational benefits of a small group. However problems may arise and it may be helpful to realise that the group has to evolve and go through five stages before it can “work”

**Forming:** The meeting and getting to know each other

**Norming:** Working out how the group is going to run

**Storming:** Leadership of group established and merits of individual participants. This can be the time when your skills of facilitation are required most.

**Performing:** The group starts to work effectively and a sense of belonging is developed

**Mourning:** Upset at the dissolution of the group.

It is one of the arts of a good small group tutor to diagnose and treat developmental delay!

## The role of the tutor

You are encouraged to move away from the chalk and talk methods that you may be familiar with from your days of being taught. Try to facilitate sessions rather than “lead from the front”, encourage your students to identify and vocalize their learning needs, just as you should yours when they raise a question to which you are uncertain of the correct answer. It is important to show students it’s OK not to know all the answers!

It is your role to prepare the session, as we mentioned before this is what your students rate top of the hit parade.

It is also your role to foster the climate for learning, valuing the individual.

During the session try to ensure the following eight attributes of an effective small group occur.

- All participate
- Problem solving and clinical reasoning is prevalent
- There is vocalization
- Learners interact
- Stay focused on task

- Recapping on progress
- Staying on time
- Feedback

## The role of the student

The student's role is to take an active part, work within the team and contribute.

## Methods for small group teaching

There are many techniques and tips for getting a small group interacting. We will only cover a few of the most practical ones here but if you're interested read McLeod P J and Harden R M (1985) Clinical teaching strategies for physicians. *Medical Teacher* 72: 173-89

### Physical groupings

You will have groups of 4 – 6 students at a time. For some aspects of small group work this will be fine, however in certain instances you may want to work in sub units. A few examples are listed below

- Patient interviews – usually best done in smaller numbers or give each participant a task. Some students become inactive without guidance, so for example ask a member to comment on communication skills, another on questioning skills etc.

Quiet groups – Your group may have only just formed and not be functioning optimally. Perhaps rather than brainstorm get them to talk in pairs and then feedback to the group. This feels less threatening.

### Teaching Methods

- Clinical teaching – this is the mainstay of clinical instruction. You can do it by “themeing” your sessions around clinical scenarios and inviting in appropriate patients. It is excellent for teaching clinical skills, by demonstration and practice, but all domains relevant to clinical competence can be taught and assessed in this way.  
For an example see the lesson plan for the Neurology session focusing on common neurological conditions, page 22

- Problem based learning – Instead of delivering information set a clinical conundrum. Let the group discuss the problem and come up with solutions. In the medical school they are often expected to go off and research the topic but in the community this is not appropriate. However you can easily highlight to them areas for further self directed learning
- Brainstorming – Fun and quick but remember to value all contributions. Some ideas will need to be explored further and it's useful to keep a visible record on a flipchart. An example may be “What factors cause falls in the elderly and why”
- Games – Games are a useful adjunct to a teaching session and are very handy in case a patient is unable to attend. There are many and you can devise your own. We use a set of cards each with a medical diagnosis and ask students to rank them in likelihood order on hearing an evolving patient story. A fun way of testing clinical reasoning.



#### Further reading

1. Jaques D. ABC of learning and teaching in medicine. Teaching Small groups. BMJ 2003;326:492-4
2. Dent J. Harden R. 2001. A practical guide for medical teachers. Churchill Livingstone Chapter 7, pp 74-81

## 9. Planning a teaching session and writing a lesson plan

When asked, it's planning of teaching sessions that students rate most highly.

In "Behaviour of effective teachers" (Irby 1978) organisation and clarity of presentation was ranked number one skill for effective teaching.

1. Organisation and clarity of presentation
2. Enthusiasm and stimulation
3. Teachers knowledge
4. Group teaching skills
5. Clinical supervision
6. Clinical competence
7. Modelling of professional characteristics

Even above knowledge and enthusiasm!



**THINK POINT:** You may find that surprising. So how are you going to plan a session? Do you have a structure?

A very easy structure to follow is

- Beginning
- Middle
- End

Or you may have hear this expression used

- Tell them what you're going to tell them
- Tell them
- Tell them what you've told them

Into each of those 3 subdivisions you will need to consider some other factors.

Robert Gagné was responsible for "nine events of instructional design". These are nine important aspects to incorporate into your lesson plan to make your teaching effective, they are:

- Gain attention
- Informing the learner of objectives
- Stimulating recall of prior learning

- Presenting the stimulus material
- Providing learner guidance
- Eliciting the performance
- Providing feedback
- Assessing performance
- Enhancing retention and transfer

We will now place these events into our structure

### **Beginning**

- **Motivate** – your students to learn, highlight the importance, relevance. Coming up in exams is always a good one if you're stuck
- **Mood** – get this right, a non-threatening environment where it's OK not to know the answers. Remember coffee and a chocolate biscuit say more than words.
- **Objectives** - Tell them what they will be able to do at the end of the session that they couldn't do before
- **Content** – Tell them how they will be achieving objectives
- **Stimulate previous knowledge** - "The most important single factor influencing learning is what the learner already knows." (Ausubel, 1968). Find out what they know by asking questions, or setting a patient problem for discussion.

### **Middle**

- **Vary the stimuli** – Our attention span is about 15 minutes. By varying the learning stimuli you can keep attention maximised. Mix information delivery with brainstorming with practical sessions and presentations.
- **Less is more** – Self-explanatory but an easy trap to fall into unless you remind yourself!
- **Check learning** – just because you've taught it, it doesn't mean that's what has been learnt. Check

## End

- **Summarise** – Tell them what you’ve told them
- **Sense of achievement** – do a little quiz, ask a question about patient care or get them to reflection on what they’ve learnt.

### Sample lesson plan for an introductory session on Neurology

It’s often easier to illustrate a point with some examples and this guide will contain two sample lesson plans illustrating Gagné’s Nine events for instruction.

Just before that a little bit on aims and objectives

#### **Aims & objectives:**


In summary, an aim is the broad-brush intention of the teaching programme.

An objective is a more detailed statement of exactly what you intend the student to know at the end of that period of time. This may seem a bit basic, but makes an important point. Students learn best if they know what they are setting out to do and how they are going to get there.

Below is sample lesson plan. The topic is how to take a history and examine a patient with a neurological condition.

<b>Part of session</b>	<b>Content</b>	<b>Time</b>	<b>Resources</b>
<b>Beginning</b> Motivate	Neurological problems are very common in later life. Making an assessment is vital and not formally taught anywhere else in year 3. Neurological problems still however come up in examinations. You will also need this skill for next weeks session on falls	5mins	
Mood	Ensure physical requirements satisfied i.e. tea etc. OK not to know answers climate		
Objectives	By the end of this session you will be able to	5mins	OHP Objectives
Objectives cont.	<ul style="list-style-type: none"> <li>• Take a neurological history</li> <li>• Perform a neurological examination</li> <li>• Describe the impact of a neurological disease in terms of physical, psychological and social impact</li> </ul>		

Content	Small group work re prior knowledge/History taking. Patient interview in pairs Observed examination /demonstration depending on competence Presentation of clinical cases by the pairs and plenary session.		
Prior knowledge	Reflection of patients with neurological conditions on ward/own experiences. Think about the steps in performing a neurological examination	5mins	Flipchart
<b>Middle</b>	History section – common neurological conditions (prevalence and perspective). Think about hospital versus community balance. Patterns of common diseases and why – link symptoms to pathological process	30mins	Flipchart
	Patient interview and examination	60mins	Room space. Equipment Patient
	Examination practice	30mins	On each other or patient
	Plenary – case presentations and feedback	30mins (15mins each pair)	
<b>End</b>	Sense of achievement – performed an authentic examination  Summarise key points  Revisit objectives – have they been achieved?	5mins	OHP

 Congratulations.

You have now reached the end of this “taster” guide to teaching and learning. We hope that you have enjoyed taking part in the various sections on principles, teaching history taking and skill acquisition. We hope that you will be able to teach students the more generic skill of feedback both in the consultation and small group setting.

Your feedback on this guide would be much valued, we would be grateful if you could complete the evaluation sheet.

Good luck and enjoy the teaching.