Clinical Educator Programme

Reflective Portfolio Assignment

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Plagiarism Declaration

I declare that the following work is my own and that the work of others has been appropriately referenced.

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Introduction

I have just completed my Core Psychiatry Training, and this month have taken up a post as a Clinical Teaching Fellow. During my career I have aspired to end up in a medical education role. This has been strongly shaped by my own experiences as an undergraduate student and junior doctor. I have learned from notable teaching sessions and feedback that challenged my own insights and understanding. These ultimately influenced my choice of career. As a doctor, teacher and mentor, I want to optimise my learning experiences for students, and ensure they get the most out of any potential learning opportunity.

With that being said, I was not entirely sure *how* I could accomplish these aims as I started working within clinical practice. Prior to starting Clinical Educator Programme (CEP) I had no formal training in educational methods. As a junior doctor I felt challenged trying to provide teaching opportunities of value whilst working in a busy and time limited system. I was in awe at times of some of the learning opportunities I had been on the receiving end of, with little knowledge of *how* the teacher had achieved this. The CEP has provided a sound framework for me to begin this journey of understanding relatively early in my career, and a springboard for me to pursue further qualification in medical education. I felt spurred to enter the programme after attending the South-East Faculty of Clinical Educators (SEFCE) Symposium in 2012, with Professor Eric Mazur's keynote presentation on the 'flipped classroom' a particular highlight. Once enrolled, I attended workshops in Fife and Lothian before signing up to the Edinburgh Summer School in Clinical Education (ESSCE) in 2014. The insights and knowledge I have gained through the programme have been enormous. As I will show in this essay, my approach to teaching has drastically changed.

In my clinical role I am required to think critically about how a patient has presented at a particular time, with a particular set of difficulties: "why this person, why here, why now"? Writing this essay has presented an opportunity for me apply this lens to my own practice within clinical education, and how it has been shaped by my experiences within the CEP. Over the past several years my main role as a clinical educator has been to provide a mixture of small group and lecture-based teaching. I have also mentored students rotating through a particular placement, and in my role with Edinburgh University as a Clinical Tutor Associate (CTA). Therefore, in the first section I will review my education practice with respect to how I design and plan learning activities, and to how I assess and give feedback. In the second part I will define my own 'philosophy of clinical education' and describe how it has evolved during my time enrolled on the CEP.

Designing and planning learning opportunities

My first formal involvement with the CEP was my teaching observation (**Appendix 2)**. This also happened to be my first ever delivery of a lecture. This was to a group of fourth year medical students during their psychiatry rotation, on the subject of dementia. I was initially tentative about teaching a large group, further compounded by being observed by an experienced clinical educator. Thankfully, the advice from this session has been invaluable in both

boosting my confidence and influencing how I have tried to develop as an educator on the CEP; it has shaped how I approach engaging my audience within a teaching session itself.

On the whole, I received very positive and encouraging feedback during the observation, and from the students themselves (**Appendix 4a**). From my psychiatry training I have always considered setting up a room and the physical environment to be a key skill in facilitating a satisfactory consultation. I was pleased this early preparation prior to the lecture was positively commented upon. Given my choice of medical specialty I was glad that engaging with the audience was identified as a strong suit as well as my non-verbal communication skills. Hearing this has allowed me to more comfortably focus on other aspects of my development as a clinical educator, and given me the impetus to teach more! I was also pleased that the feedback regarding my slide content was generally positive – I had tried to provide a mixture of texts, pictures and diagrams to accommodate a range of learning styles. Following my feedback, I have thought more about planning my slides, specifically thinking about how they may look on a projector screen. I have subsequently changed my background designs and font colour having consulted the 'Slides Tips' document on the resources section of the SEFCE website (no author given for citation).

I had been studying for membership of the Royal College of Psychiatrists at this time, and purely by coincidence had been revising Maslow's hierarchy of needs (Maslow, 1943) at the same time as delivering this lecture. It has only been since engaging on the CEP that I have gained an appreciation of adapting Maslow's theory to a *learning* environment (Hutchinson, 2003). I was happy to see that, unintentionally, I had been trying to adhere to Maslow's principles in creating an environment conducive to learning and self-actualisation.

My observation also highlighted clear suggestions for improvement which I have taken forward. A key area of development emerged with regards to considering the 'safety' of the group within Maslow's model. Whilst I had worked hard at fostering a supportive and respectful atmosphere, the phrasing of some of my questions (e.g. "Does everyone feel comfortable with…?") was identified as an area for development. This may have created an environment where students were not comfortable speaking out for fear that they may be embarrassed or feel they should already know the answer. This is precisely the type of scenario I had wanted to avoid. Upon discussion with my observer, we reflected on these moments as an opportunity to actively engage the students in a learning process – either through brainstorming or small group teaching, rather than directly questioning. I had also tried to pause for questions every 15-20 minutes, or after a 'knowledge dense' slide, before then returning to the *same* material. My observer highlighted that 20 minutes is really the maximum amount of time that students could stay focused on one stimulus. I certainly agree with this from my own personal experience of being in lectures, and was interested to seek out evidence from literature. I found an excellent synopsis (Brown & Manogue, 2001) which highlighted studies showing performance on tests of recall of knowledge over a 40 minute lecture is vastly improved by varying the student activity at 15-20 minute intervals.

I recall this feedback and research as a pivotal stage in my development as an educator. The idea that changing the focus of a session with student-led self-discovery to reinforce learning was a powerful one. The benefits appeared two-fold: engaging the students further, and allowing myself time to pause, refocus and make my teaching as effective as possible. This has transformed my approach to planning such teaching delivery. One of the most valuable sessions in the ESSCE was the small group teaching workshop. Here we trialled techniques including brainstorming, buzz groups, line ups and snowballing. I have taken some of these small group teaching principles and learning points (**Appendix 1**) into my small *and* large group teaching.

Utilising these techniques has been transformative for myself and the persons I am teaching. This is reflected in the feedback from the teaching I delivered to Core Psychiatry Trainees on statistics. I used this session as a further teaching observation, observed this time by a psychiatry registrar as part of my mandatory training requirements. I was delighted at how engaged the trainees were during the buzz groups. As per my Teaching Card I aimed to time the buzz groups at 15 minute intervals to break up my own slide delivery. The lecture came at a timely manner for trainees about to sit their membership examinations, where statistics is heavily examined. The feedback from my own observation (**Appendix 4b**) and from the trainees (**Appendix 4c)** was very positive indeed. The trainees not only enjoyed the interactive components, but also felt they had achieved the curriculum-aligned learning objectives. To me, this teaching experience strongly validated my own development as an educator through the CEP. I have also taken my skills learned from the ESSCE into a series of small group workshops working with nursing staff on using of Early Warning Scores charts. The feedback from these workshops (**Appendix 4d**) has again highlighted the learner enjoyment from the interactive components of these workshops. I am immensely grateful to the CEP in equipping me with the tools to deliver these kind of sessions effectively.

Another key area of feedback from my CEP observation was to consider the timing of my lecture and how I could ensure all of the content for a topic is delivered. My lecture ran 10 minutes over time – so late I wasn't able to distribute all of my feedback forms for it, and made some students late for their clinical commitments. While, on reflection, there is a lot of relevant subject material to cover within the topic of dementia (I was pleased to present all of it within 70 minutes!), it is clear from feedback I must consider *how* this content could be delivered, and if I could deliver it outwith the lecture. Could I give students information before the lecture to process and then discuss within the session? Or highlight key topics for them to read after? I had recalled some of the principles of a 'flipped classroom' from the SEFCE symposium the year before, where I heard Professor Eric Mazur's enigmatic keynote speech, before planning this teaching session; one can give students key content *before* the lecture allowing more time in the lecture itself to focus on understanding. In honesty, I lacked the confidence in my own teaching abilities to implement his methods before delivering my first large-group teaching session, even though I was aware that it would help me to deliver all of the necessary learning objectives. But this has changed since the positive feedback I have received following my observation. I also appreciate first-hand the necessity to consider this type of teaching

model, in the face of an ever-expanding undergraduate medical curriculum, and increasing pressures to deliver more content in less time. I have returned to Professor Mazur's presentation at the symposium (available online, Mazur 2012), and to further literature on the notion of the flipped classroom (Prober and Heath, 2012). I am aware that one needs to strike a fine balance in making sure students have information *prior* to a lecture beginning, but ensuring they are not overloaded with content given their multiple other commitments. In order to do this I have tried to adapt these principles into my own practice – for example in my teaching to Core Psychiatry Trainees on statistics I have directed them to a small amount of recommended reading *prior* to the lecture itself, focusing more in the session on working examples of statistics in practice, and then directing to further reading for the next part of the course to consolidate knowledge and build towards the next lecture. Professor Mazur's mantra of "not transfer but *assimilation* of information is key" has really resonated with how I plan my teaching around learning objectives.

Finally, I was very grateful for the constructive input on how I could structure my lecture in further detail. A consideration from my observation feedback was to clearly outline the learning objectives at the start of my presentation. This has led me to further research and experience through the CEP to consider how to structure my sessions more cohesively. Up to this point, my planning of large group teaching activities had loosely followed a 'beginning, middle, end' format, but did lack structure in areas such as identifying key learning points and differentiating essential knowledge from points of interest. Through the ESSCE I have developed this further, trialling out ways of planning my session 'beginning'. Using the 'MMUCKO' planning template has been immensely helping at the planning stage to try match what I am going to deliver in a teaching activity to what the student wants and needs to gets out of it.

Thanks to the ESSCE I have also formally incorporated the 'Must know, should know, could know' approach into the main body of my teaching set. This has helped me to rationalise the content I deliver to students, and also pair the content of my teaching to different approaches to learning (Marton and Säljö, 1976). I have to acknowledge that whilst I find psychiatry endlessly fascinating, there are those who may see their placement as a 'means to an end' in terms of completing medical school or their foundation training. Applying the above template to my teaching has allowed me to effectively 'rein in' my own enthusiasm whilst also delivering content matched to different learning approaches. For example, in my teaching session delivered to Foundation Year 2 doctors on use of the Mental Health Act (**Appendix 4e)**, I deliver key 'must know' knowledge on the criterion for Emergency Detention, with interactive case examples. They must know this in order to perform as safe junior doctors, and I have a one-slide summary of this information for more surface learners. For those interested, I highlight areas for reading regarding the history and evolution of the Scottish Mental Health Act, emphasising that this is interesting but not essential reading. This allows any peaked interests to be explored and develop understanding for deep learners. I wonder if this has been of the greatest benefit to the persons I teach. I am aware that when delivering a lecture that I am delivering one set of content to a heterogeneous group of learners, with differing backgrounds and learning styles. I feel adapting the

above approach, together with the other inputs described previously, has really helped me to comprehensively address the needs of the learners I am teaching.

Assessing and giving feedback to students / colleagues

Alongside signing up to the ESSCE I made an effort to attend one of the CEP 'Giving Effective Feedback' sessions several months before. This was to target an acute need I had become aware of – trying to give medical students meaningful learning experiences whilst working on the busy 'shop floor' of the wards. I needed to teach quickly, but at the same time make it high quality, and allow time for constructive 'here and now' feedback. I was not achieving this. I was to learn in the workshop about Sanford's Challenge / Support Grid (Sanford, 1966). Prior to attending the CEP workshop related to feedback, I found it difficult to differentiate feedback that was quick from feedback that was unchallenging or unsupportive. So, instead, I would tend to give it at the end of a clinical day – usually sometime after the learning event and making myself (and any students) late home. I feared that any feedback I was giving 'on the fly' was neither making students self-reflect on their practice, nor act on the feedback to make an appropriate action plan.

Feedback tools I have learned from the CEP have transformed my approach to giving feedback in a timely manner. A number of feedback models were appraised in the Giving Effective Feedback workshop, and out of curiosity I have trialled several of them in the subsequent months (e.g. traffics lights, feedback 'sandwich'). The model I have found most useful however, is adopting Pendleton's rules (Pendleton et al, 1984). I am aware that previously, when time pressured, I would tend to offer my own impression of positives that had come from the learning event *before* asking the student for his view. I had thought this would be helpful in growing their confidence – as I found students often tend to immediately describe what they feel *did not* go well. Whilst this may be true, the CEP feedback module has challenged the effectiveness of my previous practice. By immediately offering my own impressions, I was effectively preventing the student from applying their own reflective observation powers. When considering Kolb's experiential learning cycle (Kolb, 1984), denying the student an opportunity to reflect on their practice may diminish their chances of further conceptualisation or experimentation. This was a key factor for change which I had put on my Learning Card from this workshop (**Appendix 1**).

Putting Pendleton's rules into practice has allowed me to offer my own thoughts on positive behaviours and factors for improvement, but first giving the student an opportunity to reflect on their own practice. I especially like the collaborative feel of Pendleton's model. It feels as if the student – with my direction – ultimately takes responsibility for their own learning needs, and creates a plan with me to address these. It can also be given in a matter of minutes– and so has 'real-world' validity in my clinical environment. One of the most effective applications of this feedback model was during a Mock OSCE I organised for my CTA tutees two months after I attended the Giving Effective Feedback workshop (**Appendix 4f**). Together with another CTA we generated eight scenarios for seven rotating students, with 5 minute pauses between stations for feedback. Having a structured model to fall back on to

provide 'here and now' feedback was invaluable. I was able to run the stations on time, whilst also feeling the students had opportunity to reflect on their learning and identify clear plans to further improve their performance.

One of the greatest benefits I have had from the CEP has been applying the feedback principles from this workshop into my impromptu teaching scenarios. When time permits I tend to follow the framework provided by Pendleton et al. (1984). However, there are often times when I will only have a matter of minutes to deliver a teaching observation and feedback session. As such, I was delighted to cover the one-minute preceptor model within the ESSCE (Neher et al, 1992), and complete a learning card on this after this workshop (**Appendix 1**). In practice I have found that it takes around three minutes to deliver. But this has allowed me to deliver effective teaching within a busy working environment. Within this time I am able to commit a student to a process/diagnosis, explore their rationale and alternatives and teach around any gaps. Thanks to the teaching on effective feedback, I feel much more confident reinforcing positive behaviours and identifying areas for improvement.

One tool I have tried to develop through the CEP is using a student group's own feedback as a measure of their confidence following a teaching session. This has felt especially relevant in psychiatry, an area I have often found students to be initially lacking confidence in. During the ESSCE large group teaching workshop, part of the session was devoted to the attendees giving a series of short presentations. A wide range of technologies were used. I was impressed with the interactive nature of 'Poll Everywhere' – an online audience response system which allows one to create online polls which 'live update', and preserve the anonymity of the voter. I have since adopted this in large group teaching formats with strong results. An example of this is where I used this in my preparation session for the Psychiatry VIVA. I checked students were happy to participate in the poll at the cost of one standard network message before starting. At the start of my teaching session I asked them to participate in a poll asking if they feel confident about passing the Psychiatry Viva (**Figure 1**):

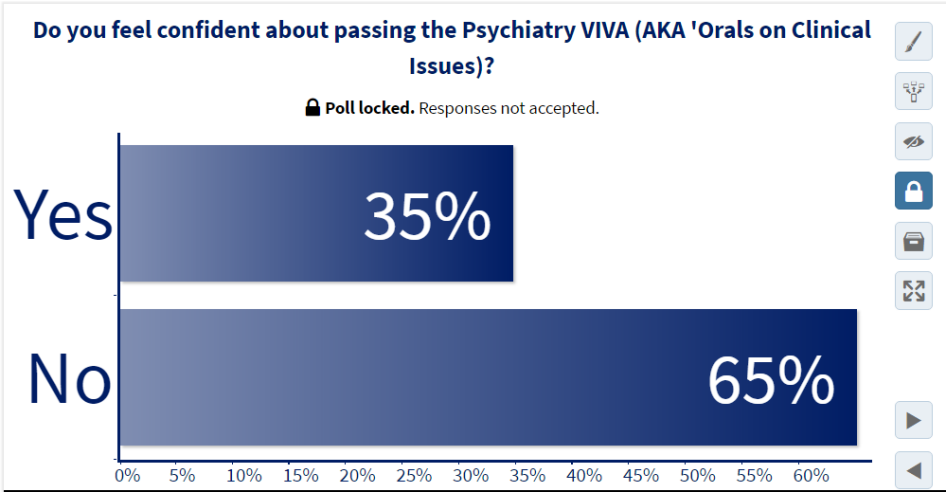

Figure 1. Poll Everywhere pre-teaching survey results

Together with colleagues I then delivered content (planning using the Set, Body, Closure structure), with students completing interactive vignette samples in small groups. I then used a further Poll Everywhere survey, asking the students if they now feel more confident about achieving a pass in the exam. This had overwhelmingly positive results (**Figure 2**).

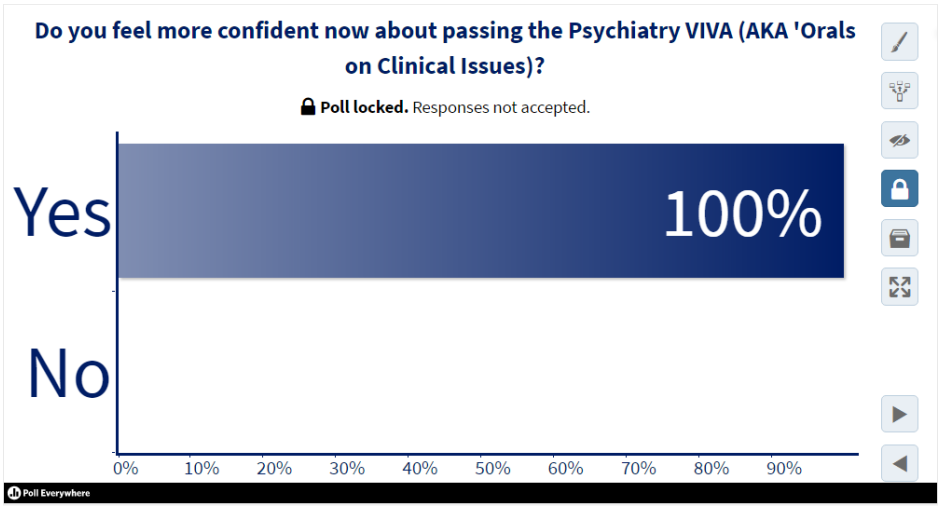

Figure 2. Poll Everywhere post-teaching survey results

I have found seeing this positive feedback has tended to relax the students. The overall feedback for this session was very positive (**Appendix 4g**). This allows the students to see their improved confidence, which can help foster a positive group attitude. Those students I have spoken to since their exam have told me their own feedback displayed this way allowed them to focus more on the core content of the exam as opposed to worrying about whether or not they would pass it. I am pleased that through this use of technology from the ESSCE I have been able to advance student learning beyond passing a particular exam, and towards a deeper understanding of the subject matter.

My philosophy of clinical education

Respect for individual learners and diverse learning communities

In terms of respect for individuals and diverse groups, there are striking similarities between how I approach this within education and how I approach this from a clinical perspective. Understanding the perspectives of others lies at the heart of psychiatric practice. A person's beliefs, their ethnic background, their socio-economic background and their personal experiences all influence the "why this person, why here, why now" that I discussed in my introduction. This is especially pertinent in nursing and medicine, where the student composition has become increasingly diverse with respect to these factors. I believe this attitude of being respectfully curious about others has equal parlance in clinical education. My development on the CEP has coincided with my development as a psychiatrist. I have enjoyed adopting these principles symbiotically between my role in education and psychiatry. For

example, my increasing experience as a psychiatry trainee has helped me to greater understand the influences of one's personal/social history on how one may act in a particular situation. This has been helpful when mentoring tutees in my role as a Clinical Tutor Associate, and adapting my teaching to best match the needs of the learner. Conversely, the principles learned on the CEP about how to best distribute information and feedback has helped me to deliver information in challenging consultations in a structured manner. I hope to continue this positive feedback loop throughout my postgraduate training and beyond.

Promoting participation in higher education, acknowledging diversity and promoting equality of opportunity

I firmly believe that access to a higher education is a right for all, regardless of their background and circumstances. I am acutely aware of this myself having only been able to attend Edinburgh University thanks to an Access Bursary. Through such experiences I am conscious that barriers to further learning can unintentionally arise in medical education. These include, but are not limited to, students not being able to access textbooks due to financial means or limited library copies, or recommended online materials such as online access to BMJ modules only being available if one has a paid subscription. I have revisited this myself following my involvement with the CEP. My first large group lecture coincided with my teaching observation, and in my reflections following the observation (**Appendix 2**) I have considered how to best develop interests or recommended reading in a subject with no financial burden. I have subsequently recommended a number of free to access materials depending on the subject, the interest of the learner and their learning style. These have included podcasts, Massive Online Open Courses, and online videos such as Khan Academy and YouTube.

The tutees I have mentored as a CTA have had a diverse background and a huge range of personal responsibilities and socioeconomic circumstances. It has been a pleasure to work collaboratively with them to further their individual learning, and guide them at the early stages in their medical career.

Evidence-informed approaches

Again, there are strong similarities here between my approach to my clinical work and my approach to clinical education. I would not treat a patient without an understanding of literature behind an approach. I tend to seek out key studies and review articles in support of a particular intervention. It feels intuitive that I should do the same when thinking of my own teaching practice. As mentioned in my introduction, I was looking for the CEP to give me an understanding of *how* and *why* learning experiences can be positive. I am indebted to the guidance that it has given me in seeking this out. For example, my teaching observation highlighted a learner's difficulty in general with focusing on one stimulus for more than 20 minutes. I enjoyed the subsequent literature search that followed, where I found the original source materials and review articles in support of this evidence. I firmly believe in a role for innovating styles of teaching delivery, but only continuing that method if it can be demonstrated to be of benefit. An awareness of the pros and cons of the respective means of teaching is essential and have found review articles such

as Sharma (2016) most helpful in informing my practice. Remembering these and adapting one's teaching style depending on the needs of the learner, the group, and resources available, is a must.

A commitment to CPD and continuing evaluation of my practice

I believe that continuously identifying and developing areas of one's practice lies at the heart of medicine and education. I am very grateful for the opportunities I have had to develop my interests as well as areas for improvement through my specialty training and in education. I believe that good quality and frequent reflective practice underpins one's own continuous development. The formal training I have had on reflection during my psychiatry training has helped me to identify challenging but achievable personal goals.

My CPD is helped by the fact that I really enjoy my job, and keeping up-to-date with best practice is enjoyable as well as a professional responsibility. Recent personal highlights have included completion of membership exams to the Royal College of Psychiatrists and presentation of work at national conferences. Undertaking the CEP has allowed me to meet my own goals in delivering higher quality medical education, but also to become aware of where I need to develop further. This was strongly influenced by my teaching observation. I have planned a lot of my development on the CEP around the goals identified from that feedback session. I am delighted that I feel more confident now in large group teaching, giving pertinent feedback and utilising small group teaching methods. I will continue to evaluate my teaching practice regularly, and to identify further areas of development and innovation. I have felt encouraged through my development on the CEP to enrol in further higher education, and have registered for Edinburgh University's Postgraduate Certificate in Academic Practice. I have also successfully applied to become a Clinical Teaching Fellow in NHS Lothian. I aim to spur myself on to develop further as an educator, and continue to reflect on my own practice to ensure I am providing the best care and teaching.

Practical constraints / affordances of my workplace on teaching and learning

We are presently faced with an interesting juxtaposition – NHS finances are becoming increasingly scrutinised at a time where it ironically costs more to access university courses such as medicine. I have noticed this increasing demand on clinical services myself during my 5 years working in NHS Lothian as a doctor. With increased strain on resources comes increased demands on time management; one of the key skills I was looking for from the CEP was a way to deliver good quality teaching and feedback in a time-focused manner. I was delighted to have attended the workshops focused on impromptu teaching and on giving effective feedback. I believe we share a collective responsibility for expanding the medical knowledge of our staff and students, and this shouldn't be constrained by the environment we work in. Rather, we need to adapt our own styles to fit the environment. It is worth remembering that teaching and feedback is a two-way process, and I have been grateful to students on many occasions for influencing my own reflection within clinics and ward rounds. In my new post as a teaching fellow I

have a reversal of my teaching to clinical commitments; I am fortunate to be able to take my lessons forward from the CEP to a post with much less clinical demand.

One of my other difficulties as a trainee has rotating frequently between new roles. Due to the nature of 4-6 monthly rotations I have often had to take feedback from particular learning opportunities into my next posts. For example, I have not been able to give the same dementia lecture again since my teaching observation. However, I firmly believe that the skillset I have acquired from the CEP is transferable. This is evidenced by my positive feedback from my subsequent large group teaching sessions.

Conclusion

I believe the CEP is a truly excellent teaching programme. It has helped me immensely to address my immediate teaching needs as a junior doctor. It has also allowed me to provide high quality teaching and feedback students can reflect and act on, regardless of the busyness of the clinical environment. My capacity to reflect on my own teaching style has been enhanced, and I have found my teaching to be much more adaptable depending on the need of the learner. I look forward to opportunities to teach within different environments. I can thank the CEP to a large extent for influencing my career and personal development. I eagerly await the challenges that lie ahead in my teaching fellowship, and throughout my Postgraduate Certificate in Academic Practice.

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Appendix 1. **Reflective Learning Cards**

1.a. Small Group Teaching Learning Card

Clinical Educator Programme

Small Group Teaching Workshop Learning Outcomes

By the end of this workshop, participants will be able to:

- **Recognise advantages and disadvantages of small group teaching and identify how to maximise learning**

How am I going to implement this into my own practice?
What exactly will I do?

In planning stage of teaching design, think about what small group teaching method would best fit the content I am delivering.
Then, incorporate this into the teaching content so students can engage in more active learning / break up of my delivery every 15-20 minutes or so.
Take what I have learned from the small group teaching workshop and try incorporate this into my larger group teaching - using the same principles to get the learners more engaged.

When will I start?
Now

When will I review my progress?
After each teaching sessions where I have used any of these techniques learnt

- **Select and use appropriate teaching techniques, resources and aids**

How am I going to implement this into my own practice?
What exactly will I do?

At the planning stage of designing small and large group teaching sessions, incorporate pauses for opportunities to brainstorm / snowball / buzz group etc into the body of the session plan. Aim to break these / incorporate them into session every 15-20 minutes. Vary the small group teaching technique depending on the complexity of the content delivered.
Also plan to make sure I have a few 'back up' techniques / tasks which I can quickly put into practice if I / students are losing focus.

When will I start?
Now: For next teaching session

When will I review my progress?
After each session where I use the techniques

1.b. Impromptu Clinical Teaching Learning Card

Clinical Educator Programme

Impromptu Clinical Teaching Workshop Learning Outcomes

By the end of this workshop, participants will be able to:

- **Recognise the value of patients as the ultimate learning opportunity, and the workplace as an excellent educational environment**

How am I going to implement this into my own practice?

What exactly will I do?

Awareness of my own time limitations in clinic, and using that as an opportunity to give time-limited and focused Teaching. Not to let my own business limit this, and to use this to my advantage to focus on specific learning opportunities between student and patient.

When will I start?	When will I review my progress?
From next student placement where I have students allocated to me.	

- **Incorporate opportunities for feedback and reflection into impromptu clinical teaching**

How am I going to implement this into my own practice?

What exactly will I do?

Adapting Principles from both Pendleton's Principles of feedback, and the one Minute Preceptor Model, and using these in my teaching sessions on the ward. e.g. when asking a student to perform a certain task, to use Pendleton's rules to ask student what they feel had gone well and how they could improve, asking student to reflect on diagnosis

When will I start?	When will I review my progress? I suggest I implement
From next student placement.	After every student placement.

- **Ensure that 'generalisable' key points are highlighted during impromptu clinical teaching**

How am I going to implement this into my own practice?

What exactly will I do?

Adapt the 5 stages of the ONE MINUTE PERCEPTOR into my teaching when time is limited on impromptu basis. For this, after I have probed reasoning/understanding, to use this tool to teach ~~the~~ relevant points/principles in relation to the learning opportunity.

When will I start?	When will I review my progress?
From next student placement	Reflect on own feedback after each learning episode.

- **Apply structure, and specific teaching 'tools' where appropriate (eg the One Minute Preceptor), to impromptu clinical teaching**

How am I going to implement this into my own practice?

What exactly will I do?

Reassess my knowledge/understanding of the One Minute Preceptor model, and Pendleton's Feedback Principles, prior to ~~new~~ arrival of new medical students rotating. I will then apply these tools when looking to teach a specific point/appraise a student's performance.

When will I start?	When will I review my progress?
Now	After using the models in practice.

1.c. Giving Effective Feedback Learning Card

Clinical Educator Programme

Giving Effective Feedback workshop Learning Outcomes

By the end of this workshop, participants will be able to:

- **Identify and maximise opportunities for assessment and feedback**

How am I going to implement this into my own practice?
What exactly will I do?

Reflect on my own teaching sessions with students who I can observe them in practice, and making sure I allocate adequate time at the end of the session to give adequate feedback. Make sure I give feedback focused on behaviour, in the right environment (calm), that focuses on reinforcing positive behaviours, and constructively identifying areas for change.

When will I start? Now

When will I review my progress? At end of placement and by asking students.

- **Define the principles of giving and receiving effective feedback**

How am I going to implement this into my own practice?
What exactly will I do?

~~Having~~ had positive experiences of using Pendleton's Feedback Model in my practice, I aim to continue applying these principles when giving feedback to students following a learning opportunity.

When will I start? Now

When will I review my progress? During student placements.

- **Provide feedback on performance that students can act on**

How am I going to implement this into my own practice?
What exactly will I do?

continue to try and provide feedback that gives specific examples of positive and negative factors. Continue to ask students for their impression first. Working together with the student to create a joint plan.

When will I start? Now (ongoing).

When will I review my progress? Asking students at end of placements.

- **Help students to set and work towards clear objectives**

How am I going to implement this into my own practice?
What exactly will I do?

continue to work collaboratively with students to identify good behaviours and give constructive, concrete examples of behaviours/points to try and improve; working to make the student formulate a plan (with my support)

When will I start? Now (ongoing)

When will I review my progress? Asking students at end of placement.

Appendix 2. **Teaching observation and feedback**

Trainee observed: (deleted)

Observed and feedback given by:
Lisa MacInnes
Fellow in Medical Education
(Tutor of the Clinical Educator Programme)

Centre for Medical Education (CME)
College of Medicine & Veterinary Medicine
The University of Edinburgh
Room GU304
Chancellor's Building
49 Little France Crescent
Edinburgh
EH16 4SB

Details of teaching:
(To be completed by consultant/trainee observed)

Date	(deleted)
Location	REH
Type of teaching (e.g. tutorial)	Lecture
Audience (e.g.3rd year medical students)	Year 4 students
Length of session	1 hr 10 mins

ASPECT	COMMENTS
VOICE (Clarity, diction, interest) UKPSF A2, V1	Varied tone appropriately. Very clear and engaging. Really easy to listen to, a really encouraging, confident, calm and positive tone.
PACE (Too fast, too slow, timing etc.) UKPSF A2, V1	A really nice pace, you deliver information and questions / tasks a clear pace which allows your students to take on board AND think about all of the information you present. Slightly too much content for the hour lecture.
NON-VERBAL COMMUNICATION (Eye contact, reinforcement of verbal signals, positioning etc.) UKPSF A2, V1	Excellent eye contact, appropriate supportive and encouraging language used to reinforce various points. Excellent positioning so the students could see you, good room set up. You come across as enthused by your topic which makes you really easy to listen to.
ORGANISATION AND PREPARATION (Clear overview, focus on key ideas, logical sequence, recapping and signposting etc.) UKPSF A1, V2, A4, K1, K2, (V4)	Clear logical flow to your presentation. Excellent start putting Dementia in context. Clear sections within your session, regularly asking for questions.
USE OF VISUAL AIDS (Organisation, clarity etc.) UKPSF K2, K4, (V3)	Really lovely slides - a good mix of text and images which addresses a variety of students learning styles and changes the stimulus of the session. Take care with coloured writing (the yellow was difficult to read) and over busy slides.
ATTITUDE (Creates effective learning environment) UKPSF A4, V1, V2	Highly encouraging. The session was very informal yet structured and controlled and your warm encouraging attitude encouraged your students to learn and question.
INTERACTION (Appropriate, well-planned, engaging) UKPSF A1, A2, V2, (V3)	Students engaged throughout. You helped to make the group feel at ease when asking and answering your questions and allowed them to think out loud.
STRUCTURE (Specific-general, set – body – closure) UKPSF A1, A2, K2, V3	Excellent beginning, establishing who people were and the utility of the session for all. You could consider putting some learning objectives together on an initial slide. You allowed plenty of opportunity for questions to be asked at any point throughout the session. The students understood the structure of the session and what was expected of them. Good closure – excellent summary of key points.

WHAT WENT WELL

HOW MIGHT ASPECTS OF THIS SESSION IMPACT ON YOUR CLINICAL PRACTICE?

Evidencing Professional Value 1: Respect individual learners and diverse learning communities

This focuses on the way teaching and supporting learning incorporate activities, actions and approaches which respect individual learners. It depicts the ways we communicate and interact with individuals and different communities in the context of teaching and supporting learning. The term 'diverse learning communities' might include campus based groups of students, electronic communicates, work based communities, or be defined on the basis of ethnicity, faith, social class, age etc. The practitioner needs to be able to demonstrate that they value and can work effectively with and within these diverse communities.

The main group I tend to teach in my role are undergraduate medical students. Through my clinical work, and role as a Clinical Tutor Associate, I am often amazed at how heterogeneous a group the undergraduate medical cohort are. There are diverse ethnic backgrounds; mature students; undergraduates who are straight from school; and a huge range of personal responsibilities and socioeconomic circumstances. These make for fascinating individual teaching sessions as I can work collaboratively with a learner to help identify their learning needs and support them. This is slightly more challenging when in large (and to a lesser extent small) group teaching sessions. Here the students may have a range of diverse learning needs, yet every person will receive the same teaching delivery by me (i.e. it is much harder to adapt to each individual learner). I really welcomed the feedback here as to how to change the stimulus of a teaching session, and will work to develop this through the CEP programme to help improve my teaching within such a heterogeneous group.

"Diversity" also extends to what the learners want to achieve from my session – if the 'community' are undergraduate students, their focus is often towards a combination of "how do I use this learning to be a safe junior doctor" and "how can I use this learning to help with my pending exams / learning objectives". Junior doctors who I have taught are perhaps more focused on how my teaching is directly relevant to them. My feedback suggested having a set of learning objectives for students to meet. When planning teaching sessions in the future I will reflect on the grade/stage of the learner themselves to try and construct more aligned objectives.

Taking this forward clinically, psychiatric practice itself focuses on interactions with persons with a wide range of cognitive capabilities and learning styles. In my clinical practice I will try and adapt the materials I signpost persons to depending on their own learning needs (e.g. written information vs online material vs podcasts and App-based information). I will also consider the feedback from this lecture to think about how I myself best present information (e.g. when giving information and advice to a patient).

Evidencing Professional Value 2: Promote participation in higher education and equality of opportunity for learners

The focus here is on providing evidence of how a commitment to participation in Higher Education and equality of opportunity for learners underpins practice related to teaching and supporting learning. There is potential to cover a broad spectrum of activities, approaches and behaviours linked to all the Areas of Activity and Core Knowledge. Evidence should ideally indicate wide and pervasive approaches to ensuring equality of opportunity.

In terms of promoting participation in higher education, I am not sure how this teaching session alone will change my approach to promoting participating in higher education. This is influenced by the fact that my audience for this teaching session were fourth year medical students – already engaged in a tertiary degree programme. This question itself has made me think about how I could promote further study in such a student group – I have signposted students to further learning materials, but I will also consider signposting students to relevant other areas of study in future to further develop their learning – e.g. some university offer Massive Open Online Courses (MOOC) in dementia theory and prevention. This observation has helped me to think about how my learning material – in this case lecture slides – are actually perceived by an audience. I welcomed the input that my slides were diverse and covered a lot of different learners needs. I welcomed Lisa's feedback as to how to change the stimulus of a learning activity to keep diverse groups engaged. This is a key area for me to develop going forward – to learn more about ways to keep students engaged, and with this have a wide repertoire of learning techniques in my teaching session. In my clinical practice I will make sure patients have access to

Appendix 3. Teaching log over course of CEP

Supporting learning

- 2013 – 2014, 2016 – Present: Employed as Clinical Tutor Associate through University of Edinburgh, providing mentoring and support for a group of 6 medical students entering their clinical year. Through this, providing ad-hoc teaching on topics as requested by the students, and longer-term mentoring/career guidance.
- August 2016 – Present – Employed by NHS Lothian as Clinical Teaching Fellow, with view to implementing positive changes to undergraduate and postgraduate psychiatry curriculum.

Ad hoc teaching

- 2013 – 2016. Informal tutorials and feedback on interview skills with fourth year medical students (now 'New Year 5') on psychiatry attachments
- Bedside teaching and clinical examination skills teaching given through my role as Clinical Tutor Associate

Small Group Teaching

- May 2014 – Mock OSCE for 8 year 3 medical students (mixture of my own tutees and tutees from another supervisor, joint session with another facilitator who is on the CEP programme)
- January 2014 – November 2014 – Series of 9 interactive workshops with nursing staff in Old Age Psychiatry Wards at Royal Edinburgh Hospital, looking at use of Early Warning Scores Charts and recognition / management of medically unwell patient.
- June 2016 - Use of the Mental Health Act. Delivered to FY2 doctors with attachments in Psychiatry at the Royal Edinburgh Hospital. (Ongoing delivery as part of FY2 teaching programme at Royal Edinburgh Hospital).

Large Group and regular teaching commitments

- November 2013. Dementia lecture. Delivered to fourth year (now 'New Year 5') medical students on Psychiatry rotation.
- September 2014 – Ongoing. Preparation for the undergraduate psychiatry Viva. Large group teaching (with small group subcomponent) delivered to fourth year (now 'New Year 5') medical students.
- October 2015. Statistics – Understanding Numerical Data (next due to give September 2016)
- April 2016 – Ongoing: Benzodiazepines: Prescribing Guidance and Advice. Talk to all new Junior Doctors at Royal Edinburgh Hospital Induction

Appendix 4. Feedback on teaching

4a. Undergraduate Year 4 Medicine: Dementia Teaching

Undergraduate Medicine MBChB, 2013 – 2014 Academic Year, Initially Delivered on 29th November 2013 (and repeated in subsequent years). Feedback is from initial lecture.

Format: Lecture – large group teaching

Attendance: 20 approx (though feedback only filled in by 6)

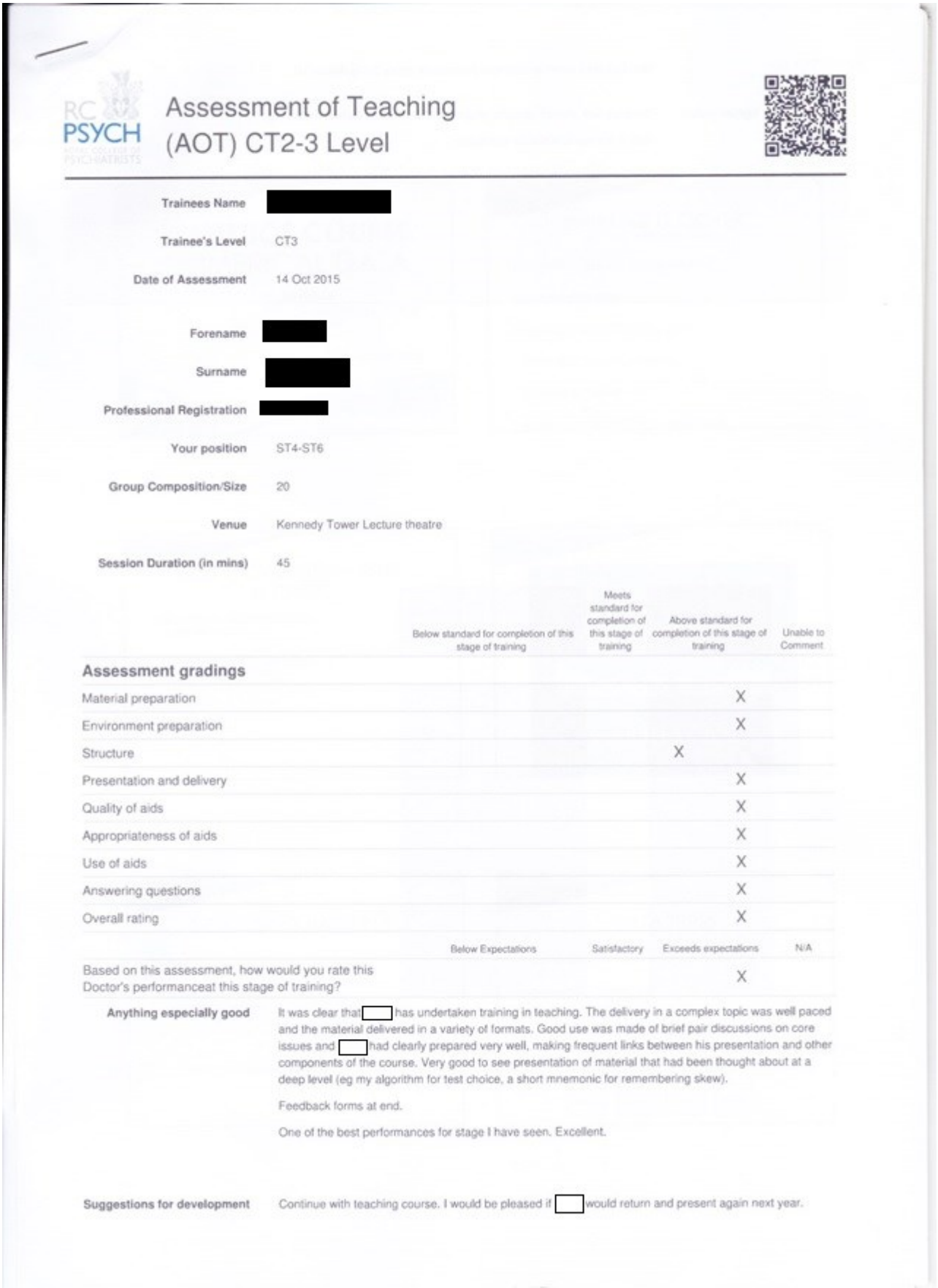
Did you find this lecture useful?	*Very 6/6*	*Quite 0/6*	*No 0/6*
How was the presentation?*	*Good 5/6*	*Quite 0/6*	*No 0/6*

* - one student created an extra section entitled '*excellent*' and circled this!

Comments:

- Clear, concise
- Very well thought out and logical presentation
- Really helpful!
- Good coverage of basics + neuro

4b. **MRCPsych course:** Statistics Course – Numerical Data: Assessment of my Teaching & Feedback



RC PSYCH

Assessment of Teaching (AOT) CT2-3 Level

Trainees Name [redacted]

Trainee's Level CT3

Date of Assessment 14 Oct 2015

Forename [redacted]

Surname [redacted]

Professional Registration [redacted]

Your position ST4-ST6

Group Composition/Size 20

Venue Kennedy Tower Lecture theatre

Session Duration (in mins) 45

Assessment gradings	Below standard for completion of this stage of training	Meets standard for completion of this stage of training	Above standard for completion of this stage of training	Unable to Comment
Material preparation			X	
Environment preparation			X	
Structure			X	
Presentation and delivery			X	
Quality of aids			X	
Appropriateness of aids			X	
Use of aids			X	
Answering questions			X	
Overall rating			X	

	Below Expectations	Satisfactory	Exceeds expectations	N/A
Based on this assessment, how would you rate this Doctor's performanceat this stage of training?			X	

Anything especially good

It was clear that [redacted] has undertaken training in teaching. The delivery in a complex topic was well paced and the material delivered in a variety of formats. Good use was made of brief pair discussions on core issues and [redacted] had clearly prepared very well, making frequent links between his presentation and other components of the course. Very good to see presentation of material that had been thought about at a deep level (eg my algorithm for test choice, a short mnemonic for remembering skew).

Feedback forms at end.

One of the best performances for stage I have seen. Excellent.

Suggestions for development

Continue with teaching course. I would be pleased if [redacted] would return and present again next year.

4c. MRCPsych course: Statistics Course – Numerical Data

Format: Lecture to Core Psychiatry 1 & 2 Trainees. Delivered on 14th October 2015

Attendance: 11

Were the objectives of the session clearly defined?
Strongly disagree (0/11) Disagree (0/11) Neutral (0/11) *Agree (2/11)* *Strongly Agree (9/11)*

Was the content relevant you?
Strongly disagree (0/11) Disagree (0/11) Neutral (0/11) *Agree (1/11)* *Strongly Agree (10/11)*

Was the teaching session pitched at an appropriate level?
Strongly disagree (0/11) Disagree (0/11) Neutral (0/11) *Agree (2/11)* *Strongly Agree (9/11)*

Did you enjoy the interactive components of the teaching?
Strongly disagree (0/11) Disagree (0/11) Neutral (0/11) *Agree (3/11)* *Strongly Agree (8/11)*

Did you feel you could ask questions?
Strongly disagree (0/11) Disagree (0/11) Neutral (0/11) *Agree (2/11)* *Strongly Agree (9/11)*

Did you achieve the learning objectives?
Strongly disagree (0/11) Disagree (0/11) Neutral (1/11) *Agree (1/11)* *Strongly Agree (9/11)*

Two Things You Have Learnt from This Session

Where to look for further information. The extent of what I didn't know & need to read about!

"The mean chases the tail" – love that way of remembering direction of skew

Categorical data. Numerical data

Definition and understanding of variance

Recap of averages and different types of data

Normal distribution. Variance.

Basic principles for descriptive statistics. Indication of level of knowledge required for examinations.

Standard deviation equations. Skew.

Variance simplified. "Mean lies to the extreme!"

One Thing That is Still Unclear

Standard error of the mean – I'm not sure I've exactly followed what that means

Negative skew data

Point estimates

Point estimates

What statistical tests will be covered in future teaching sessions.

Any other Comments?

Dr (named deleted) was incredibly knowledgeable on the topic & was comfortable answering questions. Very well paced presentation, engaging & highly relevant to our stage of training.

Very good presentation style. Clear and enthusiastic. I particularly liked the way Chris added in tips for how he remembered things for the exam.

More sessions on the topic

Very clear & engaging. Targeted at right level.

Well presented. Good use of examples to clarify message.

Thanks ☺

4d. Jardine Clinic, Royal Edinburgh Hospital: Nursing Staff Workshop on Early Warning Scores Charts

Series of 7 x workshops, delivered throughout 2014 - 2015, with fellow facilitator also on the CEP Programme.
(For sake of brevity (there are 77 responses), feedback taken from first workshop delivered on own on 28th May 2014

Format: Small group teaching sessions

Attendance: 12

	Strongly disagree	Slightly disagree	Neutral	Slightly agree	Strongly agree
I found the session useful			1/12	2/12	9/12
The presentation style was clear			1/12	2/12	9/12
The session was too easy*	3/11	2/11	5/11	1/11	
The session was too hard*	8/11	2/11		1/11	
I would recommend this workshop to my colleagues*				2/11	9/11

* - 1 x participant did not fill in this section of the form, hence scored out of 11

Comments:

- Great session highlights areas of SWWS charts usually looked over i.e. urinary output/pain. And makes you think of other issues that may affect scores i.e. dementia and new drugs being introduced
- Good workshop, easy to follow and highlighted the importance behind the use of SEWS charts
- I would like the idea of Powerpoint, however the discussion in group is really useful. In my opinion, Powerpoint would give the image of how SEWS chart would work and the presentation might be easier to follow
- I enjoyed the interactive nature of the workshop
- A little too easy due to my background at Liberton Hospital. Nonetheless, a good refresher.

4e. Foundation Year 2: Teaching on the Mental Health Act

Foundation Year 2 Teaching, 2015 – 2016 Academic Year, Initially Delivered on 20th June 2016

Format: Small group teaching sessions

Attendance: 7

I have found this tutorial useful:

Strongly disagree (0/7) Disagree (0/7) Unsure (0/7) *Agree (2/7)* *Strongly Agree (5/7)*

This tutorial has improved my understanding of duties and responsibilities for using the Mental Health Act / Granting an Emergency Detention Certificate:

Strongly disagree (0/7) Disagree (0/7) Unsure (0/7) *Agree (1/7)* *Strongly Agree (6/7)*

This tutorial has come at a timely manner in my rotation:

Strongly disagree (1/7) Disagree (4/7) Unsure (2/7) Agree (0/7) Strongly Agree (0/7)

What will you take away from this session?

- Appropriate use & indications for detention
- Practical points RE: filling in forms
- Key principles of Mental Health Act
- Avoiding use of comment “detainable if wishes to leave”
- List of things that DO NOT constitute a mental illness
- Where to find EDC online
- Rationale behind MHA
- Principles of detention
- Who to inform

Please suggest 1 thing which could be done to improve this session

- Give earlier in presentation – helpful though too late!
- Slightly late in rotation
- Include examples / scenarios in community, as some of us work more in outpatients than in inpatients
- Maybe some more case studies / examples
- Have earlier in psychiatry placement
- Q&A style session to test understanding at the end?

Any final comments:

- Good fluid presentation. Approachable and relaxed atmosphere. Clear points
- Very engaging and helpful
- Nice chill atmosphere, tips found very helpful
- Very helpful

4f. Clinical Tutor Associate Teaching: Mock OSCE

Clinical Tutor Associate Role, 2013 – 2014 Academic Year, Delivered on 4th May 2014, with fellow facilitator also on the CEP Programme

Format: OSCE

Attendance: 7

	Strongly disagree	Slightly disagree	Neutral	Slightly agree	Strongly agree
Overall, I found the session useful					7/7
The introductory talk prior to the workshops was useful					7/7
Having a 4th year student who had recently gone through the process presenting was useful				1/7	6/7
The history taking workshop was useful					7/7
The examination workshop was useful					7/7
I would recommend a similar workshop to a colleague					7/7
The session improved my confidence regarding the OSCE				1/7	6/7

Any comments as to how we could improve this for future years?

- Ensure all students read through the case studies previous to sessions so can be convincing patients!!
- Thank you!

4g. Undergraduate Year 4 Medicine: A Guide to the Psychiatry "Orals on Clinical Issues"

Undergraduate Medicine MBChB, 2014 – 2015 Academic Year, Initially Delivered on 5th May 2015. Feedback is from initial lecture.

Format: Mixture of large group teaching for content delivery, with smaller group teaching for case discussions

Attendance: 23

Poll Everywhere Results

Pre-tutorial survey – "*Do you feel confident about passing the Psychiatry VIVA (AKA 'Orals on Clinical Issues')?"*

Yes – 15/23 (65%) *No – 8/23 (35%)*

Post-tutorial survey – *"Do you feel more confident now about passing the Psychiatry VIVA (AKA 'Orals on Clinical Issues')?"*

Yes – 18/18 *No – 0/23* *(5 x non-responses)*

Please give up to 3 things you will take away from this session:

- Format of how to approach cases
- Useful recap of MHA
- Highlighted areas I need to cover!
- Use a simple structure to work through vignettes
- Don't stress too much about the tiny details
- Good overview of how to deal with it
- Structure of approaching the Viva
- Important differentials
- Assessing cognition quickly
- How to approach viva scenarios systematically
- Common topics to know
- Not to say anything dangerous
- Logical approach to answering vignettes
- Important topics to know about
- Key areas to discuss – e.g. risk, aspects of management
- Important to use a framework
- How important risk assessment is
- Common case scenarios
- List of things to familiarise
- Better idea of format and how to answer
- Increase in knowledge
- Structure of my answers
- What is expected of me
- The main things to cover in revision
- Framework for taking on viva
- Be logical and have common sense

- They are here to make you pass, hopefully…
- A systematic approach to any scenario
- Safety paramount

Anything we could improve for next time?

- Not really, good mixed format and efficient use of time
- Handout?
- More cases
- handout
- Example cases to take home?
- No, it was great!
- Nothing – it was great thank you!
- Model cases and answers?
- Shorter intro

Any final comments?

- V.good – thanks
- Really helpful
- Thanks was really good
- Thank you
- Very useful tutorial – enjoyed the case scenarios
- Cheers, really useful!
- Excellent
- V.Good thank you very much