

'Teaching the teachers' in psychiatry

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Abstract The teaching of medical skills to medical students and to other doctors is a skill in itself. The traditional 'apprenticeship' system of learning within medicine is now known to be inefficient and flawed, in both the UK and in other countries where it has been scrutinised. This article sets out guiding principles to help doctors set up 'teaching the teachers' courses, which teach the skills of teaching. Psychiatrists at all grades, from senior house officer up to consultant, need some teaching skills, and the authors outline how to plan a course, determine the needs of potential learners and set its objectives and content. Guidance is given on some of the opportunities that are available to obtain formal qualifications in medical education.

The practice of clinical medicine and psychiatry has evolved rapidly in the past 20 years and the teaching of clinical skills has had to adapt to many changes. It used to be assumed that good clinicians and good researchers would automatically be good teachers, but these assumptions no longer hold true and doctors are increasingly being called on to train as teachers. In this article, we look at the background to these changes and highlight the different learning needs of psychiatrists throughout their training. We show how teaching courses can be set up by consultant psychiatrists to teach these skills to others and use examples from our own teaching in the West Midlands region to show how such courses might work in practice.

A history

There has been concern at the standard of clinical teaching in hospitals in the UK for some time (Hore, 1976). Teaching by humiliation and ritual sarcasm, and the demotivating effect this might be having on junior doctors and medical students, have been described (Metcalf & Matharu, 1995). Similar problems are found in other countries when medical teaching programmes are examined. The situation seems to be worse in large teaching hospitals. These

findings have resulted in calls in the medical education literature for a 'training the trainers' strategy.

In 1990, the requirement to teach was included in the contracts of hospital consultants. At the same time, several new initiatives were beginning in hospital medicine. The General Medical Council (1997) made recommendations regarding the pre-registration year in its publication entitled *The New Doctor*. For higher specialist training, the Chief Medical Officer set up a working group to make recommendations on the training of hospital specialists. The Standing Committee on Postgraduate Medical Education (SCOPME) commissioned a working party to examine 'ways in which the teaching of postgraduate educational methods to hospital doctors can be facilitated' (Standing Committee on Postgraduate Medical Education, 1992). This first report concluded that it was time to reassess the quality of teaching in hospitals and to create a better learning environment. The report made several recommendations and emphasised the importance of providing those who train junior doctors with opportunities to acquire the skills necessary to teach.

Following this publication, there was an upsurge in the level of professional debate about the need to improve clinical teaching. In a review of the current

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medical education, Coles (1993) concluded that a change in educational and teaching methods, rather than a rearrangement of course content, was needed. He drew attention to the teaching culture and advocated methods that reflected the aims and objectives of the curriculum, the principles of adult learning, more small group work and problem-based learning.

The second SCOPME report (Standing Committee on Postgraduate Medical Education, 1994) identified postgraduate deans as having a key role in managing postgraduate medical and dental education, including monitoring of standards of teaching and learning for all junior doctors and dentists.

Teaching for psychiatrists

Medical students

Although most medical students will not be directly involved with teaching others, there is an increasing expectation that they will present topics or cases, often in small group settings. *Tomorrow's Doctors* (General Medical Council, 2002) requires that medical students have teaching skills. Basic presentation skills and knowledge of computer presentation packages are also useful.

Senior house officers

Senior house officers (SHOs) will be involved primarily in teaching medical students and more junior trainees. As they increasingly work as part of a team, they will teach nurses and other paramedical disciplines. Some areas of training that SHOs might benefit from are identified in Box 1.

Specialist registrars

Specialist registrars (SpRs) in psychiatry are called upon and expected to teach a variety of learners, and teaching skills are a core competency required by the Royal College of Psychiatrists for SpR

training. They have an important role in providing advice and supervision to their team's SHO and will be involved in providing formal teaching sessions to SHOs. They are frequently required to teach medical students, both during clinical attachments and in lectures or tutorials. They come into contact with a range of clinical staff, both psychiatric and non-psychiatric, and with various non-clinical staff such as police officers, social workers and teachers.

Specialist registrars are well placed to offer teaching to a range of learners, as they have a high level of specialist knowledge and, owing to their supernumerary status, may have more time to use for teaching than have consultants.

The SpR years provide a good opportunity to receive training in educational skills and we believe that such training should be integral to their education. Supervision of teaching is also important, enabling SpRs to discuss the progress of their teaching and any difficulties encountered. Finally, SpRs should be made aware of opportunities for pursuing formal qualifications in medical education and assisted in accessing such courses.

Consultants

Most consultant psychiatrists are involved in teaching and training. There has been a large increase in medical student numbers over the past two decades and much of their teaching takes place outside the traditional teaching hospitals. Consequently, a greater proportion of consultants are involved in the teaching of undergraduates. Most consultant psychiatrists have an SHO attached to them and some may also have an SpR. Although college tutors have an organisational role in medical training, it is 'jobbing' consultant psychiatrists who do the bulk of the work in teaching and training.

Gibson & Campbell (2000) studied the situation of hospital consultants in Northern Ireland and identified their learning needs to be in basic teaching skills and skills in assessment and appraisal. They suggested that 'teaching the teachers' courses should be set up, run in small groups, and regularly monitored and evaluated.

With new requirements from the Royal College and the Postgraduate Dean about regular appraisal and educational supervision, skills in these areas are essential. Keeping up to date with changes to the College's examinations is important, especially when trainees need to learn about critical appraisal, extended matching items and objective structured clinical examination as new parts of the MRCPsych examinations. Although literature exists concerning the interface of psychiatry and education, until now there has been little with specific regard to teaching psychiatrists teaching and learning skills.

Box 1 Suggested teaching skills for SHOs

- Appraisal skills
- Small group learning
- Setting up groups to encourage self-directed learning
- Presentation at the postgraduate teaching programme
- Journal clubs, critical appraisal skills
- Audit presentation
- Interview skills

Designing and running a teaching the teachers programme

Why run courses locally?

University courses leading to formal qualifications in medical education will not be suitable for, and will not appeal to, everyone. They may contain more detail than the average doctor believes he or she needs and time constraints might make it difficult for clinicians to undertake such courses.

Locally run courses on teaching skills have a number of potential advantages. They can be pitched at an appropriate level for the learners and the course curriculum can be selected to be of relevance to the particular learner group. Attendance at local courses is easier and less time-consuming, and learners might be more motivated to attend if their peers and colleagues are also doing so.

Courses can be based on programme or rotational areas. This will have the additional benefits of generating local peer group interest in, and contemporary knowledge about, education in the consultant population. For example, we have designed, set up and run courses for a number of years in the West Midlands. These have been designed for all psychiatrist consultants in the All Birmingham Rotational Training Scheme and, more recently, for the psychiatric SpRs in the region.

Evaluation of courses run by Deaneries in the UK has indicated high levels of participant satisfaction and demonstrated that participants incorporate a significant amount of the course material into their teaching practice (Rayner *et al*, 1997). Here, we outline how to construct such a course (see also Box 2). The exact structure and content should be tailored to the potential target group and take into account local factors.

Designing an educational course

Identifying learning needs

What do your learners need to learn? One useful way to divide up learning needs is into real needs and perceived needs. Real needs are objective deficits in knowledge or skills, such as those identified by national policy, local guidelines or research. Perceived needs are those defined by the learners themselves. Real needs provide a solid foundation for the formulation of educational objectives; perceived needs can be used to refine the initial objectives and to gain insight into the learners' motivation.

There are various ways of conducting a needs analysis: by interview; questionnaire; job analysis; and study of records and reports. Not all of these

Box 2 The stages of educational course design

- 1 Identify learning needs
- 2 Set learning aims and objectives
- 3 Determine the course content
- 4 Sequence and structure the content
- 5 Determine teaching strategies and resources
- 6 Design an appropriate assessment and evaluation

methods will be practicable for those wishing to set up a local course. Real learning needs can usefully be established by consultation with local experts in the field of medical education and by reference to relevant literature. Perceived learning needs can be identified using a questionnaire survey or with small focus groups of the potential learners. The literature tends to focus on formal ways of assessing needs, although more informal methods can be just as valid.

Setting learning aims and objectives

What do you want the learners to know and be able to do at the end of your course? 'Learning aims' are broad-ranging, covering several topics and often more than one domain of learning, and they tend to be written from the point of view of the teacher. They refer to the longer term and are difficult to observe directly (Reece & Walker, 1997). 'Learning objectives' are specific statements of the patterns of behaviour that the learners will achieve and are written from the point of view of the learner. Bloom and his colleagues divided learning objectives into three categories or domains (Bloom's taxonomy): cognitive (knowledge and intellectual skills), psychomotor (physical skills) and affective (attitudes and feelings) (Bloom *et al*, 1956).

Setting objectives for each course has benefits for those running the course, in that the course design and curriculum follow on naturally from the objectives. For learners, it means they start by knowing what they are going to get out of the course. A variety of acronyms are of use when constructing objectives; the one that we use is SMART, defined in Box 3.

Box 3 Characteristics of SMART objectives

- Specific, are clearly spelled out and detailed
- Measurable, can be tested
- Achievable, in terms of time and resources
- Relevant, appropriate
- Timed – there is a defined time period in which to achieve them

The course content

In setting the curriculum for a local 'teaching the teachers' course, it may not be necessary to start from first principles. Wall & McAleer (2000) identified 15 key curriculum items for teaching doctors how to teach. These were derived by interviews with experts, literature review, analysis of the content of relevant courses, and questionnaire survey of large numbers of consultants and junior doctors (although not including doctors working in psychiatry). Box 4 lists the 10 most frequently identified items in the order that they were chosen.

These items are meant as a starting point. For psychiatrists, supervision and the teaching of interview skills might be particularly important topics. A number of newly developed teaching methods might usefully be taught, such as: small group teaching and problem-based learning (Wood, 2003); self-directed learning (Candy, 1991); computer-based learning and the use of video in teaching (Vassilas & Ho, 2000). Further examples of the content of courses are given elsewhere in this article.

Delivering the teaching

This section outlines some of the teaching methods that can be used to deliver a teaching the teachers course. In addition the teaching of these teaching methods may form part of the content of such courses. The teaching strategies chosen for use in a course will depend on the learning objectives, environmental and resource constraints, and learner-related factors. For example, different teaching methods may be indicated for teaching theoretical and practical topics. The numbers of learners and tutors and the available space, time and finances will all influence selection of teaching methods. The learners' needs, prior knowledge and motivation should also be taken into consideration.

In the 1920s, Lindeman proposed that the teaching models developed for children were not

Box 4 Key curriculum items for teaching doctors how to teach

- Giving feedback constructively
- Keeping up to date as a teacher
- Building a good educational climate
- Assessing the trainee
- Assessing the trainee's learning needs
- Knowing the attributes of good and bad teaching
- Practical teaching skills
- Setting learning aims and objectives
- Evaluating the teaching that we do
- Knowing and using various teaching methods

Box 5 Brookfield's principles of adult learning

- 1 Participation is voluntary
- 2 There should be mutual respect between teachers and learners
- 3 Collaboration between learners and teachers, and between learners, is important
- 4 There should be a continuous cycle of investigation, exploration, action, reflection and further action
- 5 Critical reflection should encourage the learner to gather evidence, ask questions and develop a critically aware mind
- 6 There is a need for nurturing self-directed learning

appropriate for adults (Lindeman, 1926). Subsequent research has substantiated these ideas. Brookfield (1986) describes six principles of adult learning that ought to be borne in mind (see Box 5).

It is generally considered that active participation by the learner leads to more effective learning (Coles, 1993). By using teaching and learning methods based on educational theories and the principles derived from them, medical teaching will become more effective (Wall, 1999).

The lecture has received considerable criticism as a method of teaching, and undoubtedly it does have several disadvantages. These include passivity and lack of interaction on the part of the learners, the single pace of teaching, which might not suit all the learners, and reluctance of learners to ask questions in front of a large audience. It is not a good way to teach skills or change attitudes. However, the lecture still has value as a method of teaching. It is an efficient means of transferring knowledge and concepts to large groups, and it can be used to stimulate interest, explain concepts, provide core knowledge and direct student learning (Cantillon, 2003). The traditional lecture can be adapted to make it a more effective mode of teaching, for example by shortening the duration to 10 or 15 minutes (the 'microlecture'), using interactive techniques such as 'buzz groups' (see below) and linking the content to the learners' knowledge and experience.

Small group teaching encourages active participation of the learners and collaboration between learners and teachers, motivating learners to explore and develop ideas independently. It is good at developing intellectual skills such as reasoning and problem-solving, but it can be time-consuming as issues may be discussed in great depth. Problem-based learning, which relies on small group work, has become a core teaching method in many UK medical schools (Wood, 2003). Organising small groups to work effectively takes planning and effort.

Tutors must ensure that the group has clearly defined tasks and that group members adhere to carrying out these tasks (Walton, 1997). The other area that tutors must pay attention to is ensuring that the group 'climate' is supportive and open. This means that group tutors must actively maintain the group, for instance by stepping in if students are too talkative or rude (Newble & Cannon, 2001).

A variety of techniques can make small group and large group teaching more interesting and interactive. One of these is the buzz group, where learners are split into small sub-groups of two or three, given a specific task and a short time to discuss it, come to a conclusion and present to the wider group. Another is role-playing, particularly using actors or making use of prepared video recordings. Whenever skills are practised, for example in role-plays or when teaching other learners a practical skill (the latter being a useful teaching exercise), structured feedback is important and usually follows Pendleton's rules (Pendleton *et al*, 1984), which involve the learner and the group in a discussion of what each side thinks that the learner has done well and what might have been done differently. Further help is available in the standard texts (Chambers & Wall, 2000; Newble & Cannon, 2001).

The courses we have run vary in their content, but include a mixture of microlectures, small group work with tasks, plenary feedback sessions, practical teaching exercises and role-plays.

Assessment and evaluation

Assessment is the process of measuring learners' achievements, generally after they have completed all or part of a learning programme. Evaluation is the process of measuring the teaching that we do. Assessment can be formative or summative. Formative assessment provides information to both learner and teacher about the learner's progress, the effectiveness of teaching and the need for further learning. It is carried out during a programme of learning to benefit the learners, not to pass or fail them. Summative assessment determines the success or failure of the learner on completing a period of learning or training. Assessment methods should be valid, reliable, useful, practicable, fair, acceptable and appropriate (Chambers & Wall, 2000). Examples of assessment methods are examinations, logbooks, written assignments and interview by internal or external assessors. For a local course in teaching skills, formative assessment would generally be most appropriate.

Evaluation of courses may occur at different levels and the Kirkpatrick hierarchy (Box 6) supplies a framework for evaluating an educational event (Kirkpatrick, 1967).

Box 6 The Kirkpatrick hierarchy for evaluating an educational event

- 1 Impact – the impact of education on the delivery of health care
- 2 Performance – have there been changes in the candidates' performance?
- 3 Learning – what new knowledge or skills did the candidates gain?
- 4 Reaction – did candidates feel they learnt anything from it?
- 5 Participation – did the candidates participate in an educational event?

One common method of gauging trainees' reactions to a programme is simply to use an evaluation form at the end of each course. This feedback is about what the learners thought of the teaching, venue and so forth. However, this is of limited value. It is crucial to enquire at levels higher up the hierarchy, for example performance and impact. One might look at the effect the programme is having on a consultant's performance in psychiatric training by eliciting the views of the trainees on their education and training. This is in part achieved through inspectorate visits by the College approval body (for higher education or basic training) and through postgraduate deanery contract monitoring schemes.

Running a course for specialist registrars

In the West Midlands, we have recently set up a 'teaching the teachers' course for psychiatry SpRs. Informal discussion revealed that SpRs were involved in a large amount of teaching, but that they often felt ill-equipped to teach in terms of knowledge of educational methods. They also had difficulty in gaining advice and supervision on their teaching. Few local courses on teaching skills for doctors were available other than to employees of Birmingham University, and no course catered specifically for psychiatrists. The results of a questionnaire survey of all psychiatry SpRs in the West Midlands reinforced these points and suggested that the SpRs were keen to attend further training.

The stages involved in setting up, running and evaluating a local 'teaching the teachers' course for psychiatrists followed those outlined above. The aims of the first year were that participants should:

- achieve knowledge and understanding of how adults learn;
- relate this understanding to the practical educational needs of health professionals;
- develop their professional skills in applying educational knowledge to practice.

Box 7 Curriculum items rated in order of importance by West Midlands psychiatry SpRs

- 1 Setting learning aims and objectives
- 2 Knowing the attributes of good and bad teaching
- 3 Knowing and using various methods of teaching
- 4 Giving feedback
- 5 Evaluating our teaching
- 6 Keeping up to date as a teacher
- 7 Assessing learning needs

The format of the course is that of annual workshop days, with trainees attending quarterly tutorial sessions where they are encouraged to discuss problems that have arisen from teaching and also debate educational issues.

The curriculum for the West Midlands course was derived by consultation with local experts in medical education and from the results of the questionnaire survey. The SpRs were asked to rate the importance of the 15 curriculum items derived by Wall & McAleer (2000) and the top seven are listed in Box 7.

Formative assessment on the West Midlands course was carried out through discussion between the learners and their group tutors and by written questionnaires asking learners to rate their knowledge and skills in teaching. Trainees have had the opportunity to practice their own feedback skills with role-playing actors, be observed and themselves receive structured feedback.

The course was evaluated at various stages by participant-completed questionnaire. The same instrument was completed at the same time points by a control group of SpRs who had not participated in the course.

Running a course for consultants

For the past few years we have been running 'teaching the teachers' events (with two courses per year) for consultant trainers in the all-Birmingham rotation. We think that this has had several benefits.

Getting colleagues together from different units has been a worthwhile exercise and they have commented that it has helped to foster working and learning together as teachers. It has enabled discussion among consultant trainers' colleagues, sharing experiences and the difficult situations that we come across. The courses have helped consultant trainers to keep up to date as teachers. With new parts of the MRCPsych examinations now in place, some consultant teachers have felt vulnerable and felt the need for new knowledge and

skills. In addition, there are requirements from the Postgraduate Dean and the College for induction, regular appraisal and the giving of constructive feedback. We have been able to inform consultant trainers about these requirements and give opportunities to practise the skills on the courses, with observers providing feedback.

The curriculum for a first course should be derived using several methods. These include a focus group of consultant trainers, reflections on current practice and experience in running existing generic 'teaching the teachers' courses and review of the research literature on the curriculum for such courses (Box 8) (Wall & McAleer, 2000).

The delivery of the course should use a mixture of short keynote talks, group work, plenary sessions, role-play in case scenarios and time for interaction. Each participant should be given a handout pack at the start of the day, with details of the material in all the keynote talks. An important part of the first course is the final session, asking for plans for the future and suggestions for further courses. The course must be evaluated with a simple evaluation sheet, gaining feedback on process and content.

We found that consultant trainers were keen to improve their appraisal skills. They also asked for training on the new MRCPsych examinations, and particularly on evidence-based medicine and the new critical appraisal paper.

Box 8 Suggested key topics for a course for consultant trainers

First course

- Educational terms explained
- Setting objectives, teaching, assessment and appraisal in your post
- Supervision and its uses
- Giving feedback constructively
- Practical teaching exercises
- Plans for the future

Second course

- Appraisal – what it is and how to do it
- Using appraisal to deal with problems
- The difficult trainee – what to do
- The MRCPsych examinations
- The observed structured clinical examination (OSCE)
- The critical appraisal paper
- Coaching for the MRCPsych examinations
- Supervision and its uses (yes, a repeat, but experience suggests that this is worthy of repetition: supervision remains the cornerstone of the trainer–trainee relationship)

Aim for a pleasant, relaxed environment. The numbers should be kept small and groups should have no more than six members each. Facilitation must be supportive and constructive. Courses will be approved for continuing medical education points – a register must be kept and a certificate of attendance given at the end of each course.

In the West Midlands, a validated and reliable evaluation tool has been developed (Wall *et al*, 2000). This is sent to all 1500 SHOs in all specialities, every 6 months. There has been a statistically significant improvement in scores in 8 out of 10 of the criteria over the past five evaluation runs. Results in psychiatry show evaluations well above the mean for all specialities. This is especially noticeable in such topics as clinical experience, supervision, formal teaching, and feedback on an individual's work. It was good to see that areas concentrated on in the courses had such high evaluations by the SHOs. Importantly, we have also been able to feed these results back to local consultants.

We recommend that other schemes in psychiatry training look at the possibility of annual (or perhaps more frequent) workshops for consultant trainers. The content of such workshops should address key educational themes and include the consultant trainers' perceived educational needs. The format should be interactive, supportive and enjoyable. Finally, the workshops should foster the generation of enthusiasm, new knowledge and skills among the consultant trainers.

What other formal training is available?

University courses

For some years before the SCOPME reports, the universities of Dundee and Wales (in Cardiff) ran courses leading to qualifications in medical education. An increasing number of universities now offer formal qualifications in medical education that are available either full-time or part-time.

Several universities run distance-learning courses: the University of Dundee offers an MSc in Medical Education; the Open University has a Masters degree in Education; and the University of Cardiff offers a Postgraduate Certificate in Medical Education by distance learning.

A qualification needing fewer hours of study will meet the needs of most clinicians who wish simply to have a special interest in teaching, and nowadays many universities offer qualifications on the basis of credits. This system is ideal for busy clinicians. Someone who just wishes to attend a course lasting a few days, do some reading and prepare a dissertation would be able to obtain a Postgraduate Award.

The credits from this could contribute at a later stage to a Certificate, which in turn could lead to a Diploma. Masters degrees are also available (Burton, 2000), and it is possible to study for a doctorate in Medicine (MD), Education (EdD) or Philosophy (PhD).

The Royal College of Psychiatrists together with the University of Wales in Cardiff has set up a Post-graduate Certificate in Medical Education aimed at SpRs in psychiatry that is primarily a distance-learning course.

The Institute of Learning and Teaching

One of the primary driving forces behind the current changes in UK higher education is the Dearing Report. One of its key recommendations was the setting up of the Institute of Learning and Teaching:

'The functions of the Institute would be to accredit programmes of training for higher education teachers; to commission research and development in learning and teaching practices; and to stimulate innovation' (National Committee of Inquiry into Higher Education, 1997).

All those who teach in higher education are encouraged to join. Full details about the Institute, including the accreditation process, can be found on <http://www.ilt.ac.uk>.

Conclusions

Despite the mushrooming of 'teaching the teachers' courses, there is still some way to go (Quine, 2002). Within university departments in the UK, promotion and prestige are largely dependent on research output rather than teaching. This bias has been reinforced by the Research Assessment Exercises. However, the idea that some doctors will specialise in education and training (the so called 'physician-educator') in the same way that some doctors already specialise in research has now become established, as has the recognition that in order to carry out these duties further training is necessary.

Change in medical education, like the changes in the organisation of the NHS, will be a continuing process, and we hope that this article will equip psychiatrists to better deal with this change.

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* denotes an item of particular interest.

Multiple choice questions

1 The Kirkpatrick hierarchy:

- a consists of 12 levels
- b is used to evaluate the impact of educational events

- c is an acronym to help write learning objectives
- d has 'learning' at the highest level
- e has 'participation' at the lowest level.

2 Doctors think that the following should be included in 'teaching the teachers' courses:

- a being able to run a small group
- b teaching by humiliation
- c masters degree in Education
- d setting learning aims and objectives
- e learning Bloom's taxonomy.

3 When designing an educational course:

- a the first stage is identifying learning needs
- b perceived needs are those objective deficits in knowledge or skills
- c learning objectives are usually classified into 10 domains
- d setting learning aims and objectives is the last stage
- e 15 key curriculum items have already been identified for teaching doctors how to teach.

4 The lecture in medical teaching:

- a has no value nowadays
- b is economical of resources
- c can be made more effective by shortening its duration
- d has been criticised for encouraging passivity on the part of learners
- e allows for learners to be taught at different paces.

5 The teaching of junior doctors:

- a has been characterised by humiliation and sarcasm
- b is free of problems in all countries bar the UK
- c in teaching hospitals is particularly problem-free
- d is addressed in two SCOPME reports
- e has now reached the point where there are unlikely to be any changes.

MCQ answers

1	2	3	4	5
a F	a T	a T	a F	a T
b T	b F	b F	b T	b F
c F	c F	c F	c T	c F
d F	d T	d F	d T	d T
e T	e F	e T	e F	e F