Malaysian Family Physician 2008; Volume 3, Number 2
ISSN: 1985-207X (print), 1985-2274 (electronic)

Online version: http://www.ejournal.afpm.org.my/

Medical Education

Notes for the Primary Care Teacher

TEACHING IN THE FAMILY PRACTICE CLINICS

SK Kwa *MBBS, FRACGP, FAFP, MSc Med Demog, DRM, DLSHTM, AM*
International Medical University, Seremban, Malaysia

AR Yong Rafidah *MBBS, FRACGP, FAFP, PGDip Rep Med, PGCert MedEd*
Cyberjaya University College of Medical Sciences, Malaysia

Address for correspondence: Associate Professor Dr Kwa Siew Kim, Clinical School, International Medical University, Jalan Rasah, 70300 Seremban, Negeri Sembilan, Malaysia. Email: siewkim_kwa@imu.edu.my

Kwa SK, Yong Rafidah AR. Teaching in the family practice clinics. Malaysian Family Physician. 2008;3(2):101-103

Introduction

Teaching in family practice clinics is especially powerful. The "one-to-one" teaching creates opportunities for active learning in authentic clinical settings while modelling desirable personal and professional attribute.[1] Learner's contact with ambulatory patients enhances development of accurate clinical reasoning and quick decision making. However, it is also fraught with challenges: time, space, case-mix and conflicting demands from patients and learners.[2] The close encounter with a particular learner can be especially daunting for both teacher and learner, as it exposes their strengths and weaknesses.[1] This paper highlights some of these challenges and provides practical tips on how to overcome them based on teaching-learning principles and the experiences of various teachers.

An Undergraduate Student in Your Practice

Preparation for teaching should begin before student's arrival. Some tips are listed as the following:

- the teacher must familiarise himself or herself with the course aims, objectives and what is expected of them.
- new teachers may find it helpful to plan teaching sessions beforehand e.g. what to cover with the student if a hypertensive or diabetic patient should walk in and to read around the subject first.
- clinic staff including doctors and paramedical staff should be primed and recruited to supplement and complement teaching.
- a handout for the students with details regarding the clinic would save up time for the first day and this is important especially for a busy clinic. Information may include clinic hours, the contact number, the clinic staff, rules on punctuality, dress code, access to patients, records and medications and other do's and don'ts in the clinic.

On the first day of the student's posting, brief the student and provide information regarding the practice. The next step is to identify and agree on learning objectives, taking into consideration the student's needs. Most universities provide a guidebook on the students' level of training and the objectives of the posting. This will form the basis for discussion and negotiation on an appropriate teaching-learning plan. A written plan makes it easier to monitor progress and provide timely and relevant feedback. Ground rules need to be communicated clearly to prevent future misunderstanding and ill-feeling.

Preparing the patients

Patients are indispensable for teaching but a consultation with a student in tow can impact on confidentiality and the doctor-patient relationship. Permission from patients should be obtained before the learning encounter. [2] They should have the flexibility to opt out without any fear of loss of care. . Personally explaining to patients or putting up a notice emphasizing the importance of their role in the education of future doctors would enhance cooperation from them.

Teaching in the family practice clinic is said to be haphazard, opportunistic and inconsistent especially in Malaysia as we cannot predict which cases will walk in. This can be mitigated by arranging for patients with good symptoms, signs as well as with other interesting primary care issues to follow-up during students' attachment.

Creating time and space

Space is a constraint in most public and private clinics. However, with a bit of creativity even the smallest corner can be sufficient for students' needs. An extra, little-used room or even the treatment room can be designated for students to see patients or have a quiet reading time.

Teaching in any clinical discipline is indeed a balance of having to cater to needs of learners as well as providing services to patients. Especially now that student-directed learning is very much emphasized, the role of the clinical teacher is best seen as a facilitator of learning. Any moment can be full of learning opportunities; it is a matter of recognizing and highlighting it to the learner.

If desired, time for more in-depth discussion or feedback can be set during lunch break or at the end of the day. In really busy clinics, even asking the students to write down their

Malaysian Family Physician 2008; Volume 3, Number 2
ISSN: 1985-207X (print), 1985-2274 (electronic)

Online version: http://www.ejournal.afpm.org.my/

observations, reflect upon what they have learnt and passing them to their course supervisors are the least teaching a family doctor can do.

What and how to teach

Most doctors have no formal training on teaching and are naturally apprehensive. But, the family doctor's forte lies in the unique art of consultation as well as the varied contents of the family medicine discipline. Table 1 summarizes important features of family medicine that serve as topics for discussion or "teaching materials" for learners.

Table 1. What can students learn in family medicine?

1. Acute symptoms (and diseases)
2. Chronic diseases
3. Preventive care – including care of well children, expecting mothers and rehabilitation (tertiary prevention)
4. Doctor-patient communication and counselling
5. Patient management and special aspects of care in ambulatory patients
6. Appropriate cost-effective choice and correct interpretation of laboratory investigations, X-rays and ultrasound
7. Practice management

There are various ways to conduct teaching-learning activities in the family clinic. For the younger medical students, they can sit-in with the family doctor during consultations. Much learning can occur by active observation, which include being privy to his thought process in clinical reasoning and decision-making. The doctor can also be a role-model in the art of doctor-patient relationship and communication. Make this learning experience explicit by asking the student to specifically observe various aspects of communication. Usage of communication skills observation checklist aids this aspect of learning.[3]

For more senior students, they can be encouraged to do the initial consultation. The doctor can join in when the student is ready to present the history. This will prevent backlog as the doctor can continue to see patients in another room. Both can then examine and conclude the consultation together, with the doctor asking probing questions to stimulate active learning.

When time and space are available, one-to-one precepting[1] can be practised with the student clerking and the doctor-teacher sitting and observing unobtrusively out of the patient's line of vision. At the end of the consultation, feedback is given to the trainee with constructive suggestions for improvement of his relationship and communication with patients and their families.

Other useful tips to keep students occupied in the family clinic are as the following:

- Ask them to assist with physical examination and procedures, such as blood pressure or glucometer measurements. These create a sense of belonging and usefulness.
- Encourage students to continuously reflect on the observations. The adult learner learns best when it is relevant and can solve an immediate clinical problem.[5] Hence students should use their experiential learning for reflective "in practice" and "on practice" management of real life problems.[6]
- Quiet reading time may be encouraged, especially on topics or issues that they have just observed
- Try to conclude each day with a discussion of the day's experiences. This will encourage active learning.
- Allow a certain extent of independence and ask whether they want to see or do something else. It would also be prudent to take stock of how successfully the posting objectives have been met midway through the clinic attachment.

The teacher-student relationship

An educational environment which is mentally conducive is essential. Teaching pitched too high or low leads to undue anxiety or boredom but if in doubt, assume a lower level. The era of teaching through terrorizing and humiliation especially in front of patients and other staff is now archaic. Students should feel free to voice out.[4]

Feedback on performance should respect and not attack the learner. They must incorporate useful information for improvement. The teacher must also obtain feedback to evaluate his own performance. This two-way flow benefits both learner and teacher and fosters their relationship.

Postgraduate teaching

The principles for teaching postgraduates are the same as for undergraduates. However methodologies of teaching may differ slightly because postgraduates have already developed basic skills. The main role of the teacher is facilitating attainment of the higher skills of communication and consultation expected of a trained family physician. Time constraints forces the use of innovations in teaching approaches like the "One-minute Preceptor", "Aunt Minnie" and SNAPPS Models which deliver short but intensive teaching episodes appropriate for postgraduate trainees. Further information on these teaching methodologies are elaborated by Irby and Wilkerson.[7]

What benefits do doctors obtain from teaching?

Although there is no commensurate financial compensation, teaching the next generation of doctors provides the powerful satisfaction of passing on the baton. It also forces the doctor to keep updated and practise evidence-based medicine.

Malaysian Family Physician 2008; Volume 3, Number 2
ISSN: 1985-207X (print), 1985-2274 (electronic)

Online version: http://www.ejournal.afpm.org.my/

Teaching-learning activity is a win-win situation with the doctor learning something new from his learners.

In conclusion, clinical teaching though fraught with barriers is a powerful tool in the training of future doctors and family physicians. Some challenges can be overcome with planning and applying the principles of education. Teaching-learning is essentially similar for both undergraduate and postgraduate learning but methodologies differ as the latter has already some experience and competency.

References

1. Gordon J. ABC of learning and teaching in medicine. One to one teaching and feedback. *BMJ.* 2003;326:543-5
2. Howe A, Anderson J. Learning in Practice: Involving Patients in Medical Education. *BMJ.* 2003; 327:326-328
3. Yong Rafidah AR. Teaching doctor-patient communication in family medicine. *Malaysian Family Physician.* 2007;2(3):120-2
4. Hutchinson L. ABC of learning and teaching in medicine. Educational Environment. *BMJ.* 2003;326:810-2
5. Kwa SK. How do adults learn? *Malaysian Family Physician.* 2007:2(1):25-6
6. Kaufman DM. ABC of learning and teaching in medicine. Applying educational theory into practice. *BMJ.* 2003;326:213-5
7. Irby DM, Wilkersen LA. Teaching when time is limited. *BMJ.* 2008;336:384-7

Further reading

Hays R. Practice-based Teaching. A Guide for General Practitioners. Royal Australian College of General Practitioners. Melbourne, Australia: Erudition Publishing, 1999

FPIN's Clinical Inquiries

This regular column in *American Family Physician* is provided by the Family Physician Inquiry Network Consortium, a "grassroot" EBM movement based at University Departments and Residency Programmes. The inquiries provide evidence-based answers for clinical questions arising from family practice. To access the series, go to www.aafp.org/afp, look for "FPIN's Clinical Inquiries".

2007

Best alternatives to statins for treating hyperlipidemia (October 1, 2007)
Angiotensin blockade in patients with diabetic nephropathy (August 1, 2007)
Evaluation of apparent life-threatening events in infants (July 1, 2007)
Monitoring therapy for patients with Alzheimer's disease (June 1, 2007)
Glycemic control in patients with type 2 diabetes (April 1, 2007)
Treatment of impetigo (March 1, 2007)
Which lipoprotein measurements are clinically useful? (February 1, 2007)
Treatment of acute sciatica (January 1, 2007)

2006

Risks and benefits of combination contraceptives (December 1, 2006)
Psychosocial interventions delivered by primary care physicians to patients with depression (November 1, 2006)
Treatments for chronic prostatitis (August 1, 2006)
A1C testing in the diagnosis of diabetes mellitus (July 1, 2006)
Warfarin for prevention of ischemic stroke recurrence? (June 1, 2006)
Glucosamine and chondroitin for osteoarthritis (April 1, 2006)
Treatment of herpes zoster (March 1, 2006)
Vaginal misoprostol for cervical ripening in term pregnancy (February 1, 2006)
Urine dipstick for diagnosing urinary tract infection (January 1, 2006)