

If I had to do it all over again – Reflections of a clinician-educator

C. Rajasoorya

Department of General Medicine, Sengkang General Hospital, SingHealth, Singapore

I. INTRODUCTION

Reflections represent exploration and explanation of events and may reveal anxieties, errors and weaknesses; they do however have positive influences highlighting strengths and successes for better future outcomes. The author reflects on his practice as a clinician-educator close to four decades and shares a perspective of his retrospectively pleasant but arduous journey into medical education.

II. BAPTISM INTO CLINICAL TEACHING

I embarked on teaching medical students because I did not want them to encounter the same struggles I had with learning voluminous medical facts and lists. Moving into clinical years and with more experience, I understood the importance and applicability of basic sciences with greater clarity. As a way of guiding juniors and preparing for my own higher examinations, I got interested in teaching clinical medicine. Repeatedly ringing in me is what a clinical-skills foundation teacher profoundly reminded us that teaching is a way to expose our knowledge gaps and help us remember better. Being fortunate to have been taught by some of the doyens of medicine as well as having a high clinical load, it surprises me on how much I learnt from both my students and patients.

III. REJUVENATION AND EVOLUTION

Once, I had wrongly succumbed to the idea “the new generation is different and is less interested in learning”. Disillusioned, I almost contemplated giving up teaching. Fortunately, I closely worked with a few brilliant, enthusiastic and hardworking interns who rekindled my

interest in teaching and awakened in me the need to customise teaching to the generation we are dealing with (not vice versa). A teacher must accept that his experience in the early years will not mirror those of his students, rather than reminisce the past. The new generation is learning and practising in a different era where patient expectations are different, knowledge has been democratised and voluminous knowledge can be easily accessed via the internet and smartphones. Clinical teachers may take benefit to emphasise on clinical application and reasoning rather than factual content.

When I had a family of my own, the similarities between teacher-student and parent-child stirred in me the importance of ownership, responsibility, and avoidance of the remark “no time to teach”. It also dawned on me the extent of pressure we inflict on our students and how it contributes to vanishment of the joy of learning. I learnt that learning can be intuitive, varied and supplanted by metaphors of daily activities of life and knowledge application.

For a long time in my career, I used to go on an ordered line of questioning whenever I dealt with clinical groups. There was predictability who was going to be asked next. I learnt subsequently such an order of questioning stops the thinking process in all except the one in the “hot seat”; the rest passively “switched-off”. I have now adopted a routine (albeit, struggled) to get to know my students by name and ask questions in a random order which allows everyone to think; besides making them feel appreciated being called by their name.

I have found it useful to open difficult questions to the entire group – letting the student know it is a difficult question and providing a challenge to the brilliant to attempt it. At times I have openly admitted that I did not know the answer to that question at their age (or even later!). This resonates very well with students who feel teachers understand their difficulties. The dictum that no question is ever a stupid question cannot be overemphasised.

An experienced teacher can sense which student is struggling and distract attention quickly to another party so that the embarrassment to the individual struggling student is removed. It is important to recognise a student with the knowledge but hesitant to answer; cajoling the answer out of him is an art that comes with experience. Where a wrong answer is provided, it would be useful to ask for the reasoning rather than brush it aside with an emphatic “no”. A couple of years ago, I asked one of my rather always quiet students why she volunteered to be in the “hot seat” for a short clinical case – her answer of not being intimidated by me and having confidence that I would not embarrass her was a powerful lesson on how fear kills enthusiasm. I was fascinated to hear in later times that she had expressed a desire to be a clinical teacher!

Experienced teachers will be bold enough to admit they do not know. Admittedly, this was never easy for me during the growing years, until recent times. An occasional bright spark student may know the answer and he or she should be given credit for educating the teacher. Mutual respect promotes learning for all involved. Time and again, I had experienced and learnt from my colleagues (particularly from my overseas stints) of how protecting ego and hiding ignorance serves only to retard the process of learning. Eating humble pie may seem daunting and embarrassing, but I now accept it as fulfilling and enriching. Teaching and learning are intertwined and run in both directions – one must break the cultural barrier that the teacher has all the knowledge and the student some or none. It took a young medical officer to unravel a misconception I had for more than 20 years that chronic malaria and tropical splenomegaly syndrome were different entities.

We often do clinical teaching on cases we already know accompanied by its inherent biases. Teaching on cases we are blinded to is a mind-boggling experience. In the last few years, I have experimented and adventured with teaching on cases where I am blinded to the findings or diagnosis. Both the student and the teacher can learn a lot and we get better as we express our thoughts and disrobe our thinking processes openly. This to me is akin to practising clinical reasoning live.

Most of my initial clinical teachings concentrated on artificial situations where we selected “good cases” — this, unfortunately creates an artificial divide of what we see as clinicians and how patients present to us. I am even more convinced, over the years, that every case is a good case to teach; choosing the slant and emphasis in every situation is critical.

We tend to cram information to students, as much as I did in the past. Now, I ask myself before a tutorial or lecture on what is the primary target of my teaching. Teaching must be customised to the audience. I used to joke with my students in the early years whenever an examiner asks you for causes of a certain abnormality – a second-year student gives two, third-year student three and final year student gives five, as a rough rule. This joke highlights the need to avoid unintentionally submerging our students in a factual journey and overloading them, forgetting how we acquired skills in a graduated manner.

Leonardo da Vinci is attributed to suggesting that simplicity is the ultimate sophistication. Great teachers have a way of simplifying complex concepts. Nobel laureates Michael Brown and Joseph Goldstein likened lipoprotein traffic to navigating the maze in the London underground system while explaining lipoprotein metabolism. Prober and Heath (2012) remind us of the importance of making lessons “stickier” by making it comprehensible and memorable. Efforts to make things “simple is often harder than complex”, as profoundly highlighted by Steven Jobs (as cited in Reinhardt, 1998).

IV. PRINCIPLES AND PHILOSOPHIES

Over the decades, I have gradually moulded myself into believing in some philosophical concepts on clinical teaching shared below:

1. Clinical teaching can be likened to planting a seed in a soil (student in the health care environment). We need to ensure the presence of sunshine, rain (stimulus) and fertile soil (conducive environment); as in nurturing, the wind (pressure and currents) cannot be too strong. A clinical teacher must look after the student welfare in preventing burnout, disillusionment or wilting away.
2. For busy clinicians, giving committed time and effort to teaching can be challenging. It is worthwhile reminding us that to be a “doctor” means “to teach”. With ownership, we never generally say we lack time or rewards to teach and guide. Sharing our experiences and difficulties make students feel they are in good company.

3. Teachers must learn to squeeze the best out of their students rather than looking negatively at their lack of knowledge. Beneath every “F-student” is an “A student” waiting in line and time to pop-out! A teacher must take part-responsibility and embarrassment for students’ failures, as much as we take pride and pleasure in their successes.

4. Teachers should take extra effort to simplify concepts and to remind themselves that if they face difficulty in understanding certain concepts, it is unreasonable to expect their students to grasp these same concepts easily.

5. Teaching should not concentrate on voluminous facts that are so easily accessible. It must be customised to deal with diversity in the audience as well as cater to the level of expertise of the student. Clinical teaching should focus on clinical reasoning.

6. We must be bold enough to try teaching methods to reflect the plasticity we have within ourselves to adapt, grow and regenerate our knowledge and its transmission.

V. CONCLUSION

Medical education has changed over the few decades that I have practised in. The fundamentals have remained – to train our doctors as future physicians and specialists. The core values must be preserved while stimulating progress incorporating new ways of practice. Experience and reflections are excellent tools in our armamentarium of methodologies. I have never regretted my adventure into clinical teaching.

Note on Contributor

Professor Rajasoorya is a senior consultant, endocrinologist, Campus Education Director at Sengkang General Hospital; clinical professor at NUS School of Medicine; and adjunct professor of Duke-NUS Medical School. He has undertaken various leadership, administrative/advisory positions in medical education, curriculum development and is the recipient of numerous education and teaching awards.

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Declaration of Interest

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*C. Rajasoorya
Department of General Medicine,
Sengkang General Hospital,
110 Sengkang East Way,
Singapore 544886
Tel: +65 6930 2221
Email: c.rajasoorya@singhealth.com.sg