

## Some Thoughts on Clinical Teaching

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While ago, I spoke with some fourth-year optometry students who were completing an externship at our VA hospital. I wanted to determine what they felt was positive and negative about their experiences in order to perpetuate the strengths of the program and shore up its weaknesses. It was gratifying to learn that they were generally pleased with the externship and compared it favorably to a number of others they had previously attended. I also asked them to compare their clinical experience in the current program with what they had encountered in the clinics of their optometry schools. I was startled at the severity of their responses with regard to the attitudes of what they described as a sizeable percentage of their clinical instructors.

They described an atmosphere in which they were afraid to express themselves for fear of being told they were either stupid or incompetent. They told of supervisors who expected perfection both in knowledge and performance even in the early stages of their clinical training when they had not yet been exposed to certain material either didactically or clinically. They described situations in which a particular instructor insisted that certain formats be followed only to be castigated by a succeeding supervisor for doing what they had been previously taught. They noted little consistency from one instructor to the next and little tolerance by instructors in their acceptance of alternate methods

for achieving a goal. They also noted that what was taught to them in their initial clinical education was altered in subsequent courses because of the inherent inappropriateness of the original material in actual clinical encounters.

It should be noted that these were intelligent and highly competent clinical externs, far from the worst I have encountered in more than 30 years of clinical teaching, and that subsequent surveys of other students, residents and graduates of a number of schools have found these impressions to be generally consistent.

### **We Have All Experienced How Not to be Taught**

I was reminded of two incidents from my own experience. The first occurred during one of my own externships, at an institution other than the one I attended. A friend and I were being supervised during patient encounters by a supervisor who had lectured to us about ways to perform certain clinical tests. I felt the methods I had learned previously were better and I performed the tests accordingly. Apparently my classmate had done the same thing because the supervisor took us into a room and berated us for not performing the tests his way and accused us of not paying attention during his lecture. Neither of us offered a defense or explanation, but we left the encounter with little respect for the instructor. Two years later I joined the faculty of that institution and discovered that particular individual was one of a few who prided themselves on their ability to “break” students. He continued to teach until his voluntary retirement.

The second incident that came to mind occurred a number of years ago while

I was supervising in a first-year clinical methods laboratory. One of my students approached me with a question, which was overheard by another faculty person who chastised the student for asking the question. In front of other students and faculty he loudly proclaimed that the student should not be asking that question because he himself had taught her the material. He informed her that she must be stupid if she did not understand. When he walked away I explained the material to the student who asked the question as well as others who witnessed the encounter. I told them I would explain it as many times in as many ways as I could to help them understand. Because he was tenured, the instructor taught for many years and was probably the only person on staff who was unaware of his inability to disseminate information effectively.

I am sure anyone reading about these experiences would be appalled that such behavior exists in institutions of higher learning. By the same token, I doubt if anyone can think back on his or her own education and deny they encountered such individuals or situations. While I in no way feel that professional students should be coddled or overly protected, I do feel they should be treated with respect and dignity. I am pleased to say that many of my colleagues for these many years have not been guilty of such sins. But there have been, and remain, a significant number of individuals, both in institutional and private practice, in and out of optometry, who could benefit from a reassessment of their positions and responsibilities.

### **Concepts Worth Considering**

With this in mind, I offer the following perspectives on clinical teaching.

1) Teach it correctly the first time. If material changes, change with the times. If new or different techniques or methods are more efficient or appropriate, incorporate them into the syllabus and delete older or less effective material. It is incumbent upon teachers to keep up with new and alternative information and be open and honest enough to change accordingly. It is incorrect to pass outdated or mistaken concepts or methods to another generation. What was new in a text 30 years ago is old today and should be re-evaluated for its effectiveness and timeliness. This is especially true in the education of new practitioners who must learn material one way only to have to alter their methods appropriately in the future. This is unnecessarily confusing and time-consuming in an ever-expanding curriculum. For example, teaching a certain cross-cylinder test to first-year students in a particular manner was demonstrated to be of little value more than a decade ago, yet it remains in this form in some curricula. If you are even aware of the Humphriss technique, when was the last time you used it? It, too, remains in some curricula.

When and how should curricula be changed? The first part is easy to answer – as often as necessary to stay current in the field and reflect the most efficient model of patient care delivery. The second part is more difficult to answer. Having worked on a curriculum committee at an optometric institution I am keenly aware of how difficult it is to make curriculum changes. The major obstacle is obtaining the cooperation of instructors. Each instructor feels that his or her course is infinitely essential to the proper education of students and, therefore, declines to allow even one hour of coursework to be eliminated from its material. This is understandable. Job security is important to everyone, and to admit material is not essential or is outdated is to admit, perhaps, that the individual teaching the class may not be essential.

So, how to proceed? Maybe it is time for our schools to employ a

modality used not only in private healthcare practice but in the business world in general – outside consultancy. The schools should hire people, perhaps successful private practitioners, to dispassionately evaluate what is and is not essential to produce good practitioners. These people should not be graduates of the school being examined. They should not be employees of any school. Our schools already tend to hire their own graduates, which prevents a healthy infusion of new ideas and methods into our training.

- 2) If you don't do it, don't teach it. Many people involved in clinical education are teaching or supervising methods with which they have no immediate experience. A clinical instructor who has no background in the implementation of contact lens care should not be instructing in a clinic where contact lens care is provided. A didactic teacher who teaches clinical methods who does not interact with patients has no frame of reference to know whether what he or she is teaching is appropriate in a real clinical encounter. Quite simply, a student should be taught to remove an appendix by someone who actually performs appendectomies rather than by someone who has read or heard about appendectomies.
- 3) Leave your ego at home. It is easy to know more than your students. Do not make this a source of pride to be dangled before them. A teacher is expected to know more than his students and it is this knowledge that should be passed along in an open, nonthreatening manner.
- 4) Allow for the fact that there might be alternate approaches to solving a problem. When confronted with alternative methods to handle a particular issue, be open to these concepts and consider allowing another person (student) to implement them as long as no foreseeable harm may arise from such action.
- 5) Customize your teaching. Explain material at a level that students can understand, not necessarily at the level at which you may con-

verse with your colleagues. Students do not have the same level of knowledge or experience as do their teachers, and much material is new and potentially confusing. Furthermore, what is obvious to one student may not be obvious to another. Try to communicate with each student at whatever level is necessary to convey information effectively.

- 6) KISS – Keep It Simple, Stupid. It is easy to confuse and confound. It is not always easy to get to the simplest mode. Take a moment to consider the situation with which you are confronted and try to come up with the simplest explanation, diagnosis, answer or approach.
- 7) Allow, nay, encourage students to say “I don't know.” Not to do so engenders fear, deceit, and fabrication. This should be followed by clear explanations and/or assignments for students to ferret out the answers to enhance their own education. Of course, this allowance should not be overly relied upon by students. The continued demonstration of ignorance cannot be tolerated.
- 8) Students can learn as much, or more, from mistakes and poor performance as they can from good episodes, if handled properly. Try to make every learning experience a positive learning experience by demonstrating how performance can be improved rather than harping upon how poorly things have already been done.
- 9) Do not spoon-feed students. They should be encouraged to learn for themselves. Give them the basics then ask and expect them to research and think about what they are doing. Students all too often learn things by rote in order to answer a question on a test and when asked how that information can be clinically applied have no idea. Try to ask questions that require thought and the assimilation of various pieces of material that must be incorporated into a whole in order to arrive at answers. Encourage research. MAKE THEM THINK.
- 10) Do not teach students merely to en-

sure they pass boards. While board scores seem important to school administrators, they are not necessarily advantageous to the public. Students who pass written tests do not necessarily become good clinicians. The current approach to board certification fails in this regard as it does not ensure a doctor can perform appropriately in the arena of patient contact. All too often students examine data as if contained in little boxes, ignoring other information in other little boxes that should be combined into a unified whole. Students should be trained to be efficient, effective doctors capable of integrating material from all disciplinary areas into cohesive assessment and treatment plans.

- 11) It is okay for students to be wrong. They are still learning. In that sense, each of us is still a student. If teachers think they have nothing more to learn, they probably should not be teaching. Excessive criticism and overbearing demeanor most likely engender a bad impression of the supervisor and not necessarily encourage the pursuit of knowledge.
- 12) Teachers can be wrong. They must be able to admit fallibility when it is appropriate.
- 13) Teachers can learn from students. It is just as important to listen as it is to talk.
- 14) Teachers and students do not necessarily have to like one another, but teachers must continue to teach and students must continue to learn. Personality conflicts and unhappy interactions are bound to occur at some point. In such situations the teacher must put aside

personal prejudices and handle the educational process professionally. The student must be able to be mature and put personal feelings aside and concentrate on the matters at hand, be they didactic failures or poor clinical performance. The teacher must be able to present the facts of the instance as clearly and unemotionally as possible and not use his or her position of authority as the sole basis for demanding obedience.

- 15) Students should be allowed and encouraged to question everything. They should not be expected to accept a concept simply because the teacher says it is so. It is incumbent upon teachers to provide a rationale and a logical context for anything presented to the student. Teachers constantly challenge students and it is unwise and unfair to disallow challenges from students if presented honestly and maturely.
- 16) Sometimes students deserve to fail. This is included in this treatise because I have seen a number of students passed along because instructors do not have the heart or fortitude to fail them when it is appropriate or because an institution needs to protect its capitation funding. Failure should be accompanied by explanation and encouragement for improvement. However, when students really cannot meet certain professional or personal standards, it is unfair to them and to the public to allow them to continue in a program.
- 17) Discuss with, rather than lecture to, students whenever possible. They are people, have brains, and deserve respect.

- 18) When you become a teacher or supervisor, do not forget what it was like to be a student. This will make you a better and more compassionate teacher.

### **Improving, Not Hindering, the Educational Process**

If all clinical teachers were committed to being thorough and treating their students like people by showing concern for them, listening to them, encouraging communication in two directions and promoting learning, the educational arena would be more effective, efficient, human and humane. Doctor (teacher), heal thyself.

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### **Send Us Your Comments**

*Do you agree with Dr. Vogel? Have you had similar experiences? Did you come to the same conclusions? Send your comments to Dr. Aurora Denial at [DenialA@neco.edu](mailto:DenialA@neco.edu), and we will publish them in the next edition of the journal.*