1.1 The Teacher

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Introduction

We start this book with a discussion of 'The Teacher' and what that means in the context of medical education in general, and psychiatry specifically. For many, the traditional image of the teacher as an authority figure giving lectures at the front of the class persists, but in recent years there have been significant changes with regards to who delivers teaching, how this is done, and even what we are trying to achieve. Teaching is no longer delivered didactically by a handful of professors at the university, but more often by clinicians and trainees who contribute to education in addition to their clinical work. Indeed, ability to teach is a professional competency outlined in postgraduate training schemes and within *General Medical Council* (GMC) documents (Good Medical Practice, 2013). The role of 'doctor as teacher' takes many forms: formal roles at a university, informal teaching in clinics and wards, and contributions to assessment and curriculum development, to name a few (Harden and Crosby, 2000). Many medical educators don't have medical backgrounds and bring distinct points of view, diversity, and specialist expertise to the role. We believe that everyone involved in medical education should understand and employ the qualities of 'The Teacher' that are explored in this chapter.

What Does it Mean to 'Teach'?

This may seem like a simple question, but it is worth considering the following two definitions:

Teach /tiːtʃ/

Verb

1. Impart knowledge to or instruct (someone) as to how to do something.
2. Cause (someone) to learn or understand something by example or experience.

www.lexico.com/definition/teach, powered by *Oxford English UK Dictionary*

The first definition might be considered the *act* of delivering a lecture or a tutorial to students and is independent of whether any learning takes place. Within medical education it might seem reasonable to have the view that, while the audience may be diverse in terms of age and background, they are all 'adult learners', and as such the onus should be on them to pay attention and to learn from what is being offered. Even without exploring the psychosocial factors which might influence learning, we know that the brain is still developing

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biologically though our twenties, and this can have a significant impact on factors such as motivation. As such, although there may be a degree of truth in this idea, it is also a bit naïve to think it is as simple as that, particularly for a psychiatrist who is supposed to be an expert in such things.

The second definition may be more helpful and defines teaching as an *outcome*, with teaching only occurring if learning takes place. Adoption of this view means accepting that if the students didn't learn what you wanted them to learn, then you didn't actually teach them, regardless of how much information was in your slides. For the medical educator, adoption of this definition shifts their objective from 'I need to deliver a lecture' to 'I need to help the students understand X.' With this new objective the teacher is able to consider how best they might achieve that aim given the topic to be covered, the audience, the resources available, etc. The aim of this book is to help with that.

Shifting to this second definition opens us up to reflection on the factors that might influence a student's engagement and motivation to learn. The parallels with the doctor–patient relationship in psychiatry are worth considering. This is a partnership in which we work with the patient and provide them with the information they need to make healthy choices. When this isn't working, we may talk to the patient about taking more responsibility, but we also recognise that this may be difficult for the patient for many reasons related to their background, personality, and life experiences, and that to some extent they are acting how they have learnt to act in certain circumstances. In such cases it is necessary to then consider how the circumstances or environment might be modified to make it easier for the patient to make better choices and ultimately have better outcomes. An example might be a patient who regularly forgets to take their medication: the solution might be to arrange for someone to remind them every day; alternatively, you might provide psychoeducation about their condition and information about the medication options in order to improve the patient's understanding. Both options have their place but the point is that as doctors we do not adopt a 'take it or leave it' approach to care; we recognise that there are factors under our control which could lead to better outcomes, and the same is true of teaching. What is taught, how it is presented, context, relevance – these are all determined by the teacher and will have a big impact on whether learning takes place. There are of course other factors over which we don't have control, such as student personality, learning style, pressures from personal life, and pressures from other parts of the curriculum. Ultimately, students do need to learn to manage their own learning, but as teachers we need to consider whether the environment we are creating is making this easier for them or harder.

Lived Experience Inputs to Teaching

Gordon Johnston

Teachers do not have to teach alone or teach every element of a course themselves. Other inputs can both provide differing perspectives for students to consider and enable them to develop a wider view of psychiatry.

It can be extremely useful in the teaching process to involve people with lived experience of mental ill health at all stages as part of an extended teaching team. Their valuable input can enable greater understanding among students of the effects of living with mental illness on individual lives, thinking beyond the symptoms which can be memorised from a textbook.

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Throughout this book there will be inserts like this to provide suggestions for roles that people with lived experience could play and inputs they could provide to support the teaching process.

What Else Are You Communicating?

In many ways the teaching of knowledge and skills is the easier part of being a teacher; it is certainly easier to talk about and explain. However, in recent years there has been increasing interest in what students learn from a teacher or an institution indirectly. The topics which are taught, which ones are prioritised, how ethics are discussed and considered: these all communicate something to the student about the values of the teacher and, by extension, what should be expected of a doctor and a psychiatrist. The awareness and sensitivity of the teacher to issues such as equality and diversity will also be picked up by the students and internalised. Do all your case vignettes revolve around Paul and Mary, a white, British, heterosexual couple? Are you openly critical of the curriculum, faculty, or other specialties? Mahood (2011) observes that everything we say (and don't say), every action, joke, and irritation, conveys values and attitudes to the students, whether we mean them to or not. This is often referred to as the 'hidden curriculum', and students may learn more from these modelled behaviours than from the formal teaching they receive (Mahood, 2011). Doctors may be aware of their position as role models in clinical settings, but it is just as important in the teaching role. Teachers acting as role models in the undergraduate setting can have a significant impact on reducing stigma (Martin et al., 2020) and improving recruitment to psychiatry (Appleton et al., 2017). Furthermore, how we react and respond when we make a mistake or don't know an answer can have a huge impact on the students' understanding of what it means to be a doctor and how they are supposed to act. Psychiatrists should be better than most at recognising what they might be communicating through their appearance and behaviours, in addition to what they are saying, and as such we have the power to make an important impact. Similarly, any disparity between what an institution says and does will be picked up by the students. Hafferty (1998) gives the example of a medical school with a mission statement to 'train excellent, compassionate physicians rather than the most knowledgeable physicians', but which has an awards system for the highest grades without any recognition of skills related to empathy or compassion.

'Know Thyself'

– Temple of Apollo at Delphi

Just like the students and patients described earlier, teachers and doctors are human beings with their own backgrounds, perspectives, and biases. If we are to have any control over the hidden curriculum it is essential to be aware of this as, unchecked, they can easily seep into and colour our teaching without us realising. While this is true for all teachers, it is worthy of specific mention when it comes to teaching psychiatry. Mental illness as a concept can be difficult to pin down, and we use a number of different models to conceptualise and explain symptoms. Some of these are more comfortably couched within a biomedical model, for example, Alzheimer's disease, but others are more helpfully considered in psychosocial terms – for instance, symptoms arising due to an individual's difficulties functioning in

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a specific social setting, as we see with the personality disorders. Going beyond this, we know that there are groups of conditions specific to certain cultures – so-called Cultural Concepts of Distress – where groups of symptoms have been observed and explained using local models for mental illness. In many cultures across the world, it is not uncommon for psychiatric symptoms to be explained as being caused by magic or possession by evil spirits, and it would be very arrogant of western psychiatrists to dismiss these models of mental illness as simply 'wrong'. The point is that it is important to recognise the perspective you are coming from and the associated biases that you might have, in order to acknowledge that students (and patients) may differ in their views and understanding. It would be arrogant to assume that 'I am right and you are wrong', as there are many ways to conceptualise mental illness – who is to say which way is the most 'correct'? Sensitivity to and respect for the different beliefs and cultures of others is another part of the hidden curriculum that should come through when you are teaching, and the topics in psychiatry are a rich vehicle with which to achieve this.

What's in it for Me?

Lastly, it is important to acknowledge the benefits that can come from choosing to develop as a teacher in medical education, including the development of transferable skills. Dayson and Hill (2011) discussed this as part of their medical teaching skills programme at the University of Southampton. They recognised that teaching forces us to examine and organise our existing knowledge, and that questions from students highlight the gaps in our own learning. Rather than worrying about this, they proposed that we should try to accept it. Instead of presenting an illusion of omniscience, we should aim to engage authentically and honestly with the students and participate in the process of learning and enquiry with them.

Communication skills are also vital, and a large part of the role of a psychiatrist is psychoeducation: explaining a diagnosis or a formulation to a patient in a way that they can understand, providing information in digestible chunks, and checking understanding. We aim to give them information to allow them to weigh up options and make informed decisions about their care. These same skills can be used and developed in your role as a teacher if done correctly, with clear benefits for both your clinical and non-clinical work. The ability to explain complex ideas in a way that people can understand and retain is a valuable skill, and choosing to develop as a teacher of psychiatry is the perfect setting in which to hone it.

The chapters in this book will give advice on how you can get more involved in medical education as you progress in your career.

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