



TEACHING TIPS

Teaching Skills

ARE YOU WATCHABLE?

Ask yourself this question: if you turned on the television and saw your presentation, would you watch it or, after a few seconds, zap it with the remote? Experts tell us that the audience decides within the first 90 seconds if they plan to listen to you for the rest of your allotted time. This is what medical students do when they hear us. To be effective, you need to grab their attention immediately.

There are several attention-getters you can use, including tell a story, ask for a show of hands, make a promise or a provocative statement, cite an unusual statistic or make them laugh (this is usually the most difficult). Imagine opening a television program with the statement, “Well, I guess we will get started.”

A smart way to become watchable is to turn the attention away from you to the audience. You can ask for volunteers to act out a skit (always good for a laugh), ask questions like, “What do you think happened next?,” have participants share their ideas in pairs, or make them the experts by asking their advice. In general, the more you involve the audience, the more they like the presentation.

Would you watch a presenter on television who turns his back to the camera to talk about the information on the slides? With today’s laptops and data projectors, there is no need to look at the projected image on screen; remember, it is on your computer screen. You now have the long-awaited advantage of being able to look at your slides and the audience at the same time. Actually, some may consider it rude to turn your back to them while you talk to the screen. It is time to get over this 35-millimeter slide habit, if this is your tendency. Continued eye contact with the audience will make you more watchable.

Sources: Pike R. *Creative Training Techniques Handbook: Tips, Tactics and How-To’s for Delivering Effective Training*. Minneapolis: Lakewood Publications, 1994.

Greenberg D. *Simply Speaking Newsletter*, May 2003. <http://www.teambuilding123.com>. (Accessed 7/19/2014)

VIDEOTAPE YOURSELF

What is the best way to view your own presentation style and to see how others see you? Videotape your presentation. It is hard to argue with your own data when it is graphically displayed on a screen.

Do you remember the first (and perhaps brutal) time you heard yourself on audiotape? “Do I really sound like that?” Do you have distracting mannerisms in your delivery that you would like to eliminate? The distraction list includes jingling change, halting speech habits such as “uh” and “you know,” and a favorite of many called the “flamenco dancer – standing on one foot behind the podium and thumping the other on the floor.”

The videotape will help you identify distractions and skills that need improvement. If you are really courageous, review the video with a

close colleague to whom you have given permission to “take off the gloves” in the critique.

Make arrangements to get yourself videotaped. It will change your presentation style for the better.

Source: Peoples, David A. *Presentations plus, 2nd Edition*. Wiley & Sons, 1992.

SWITCH GEARS AFTER 15 MINUTES

Have you felt your mind wandering during someone’s presentation after 15 or 20 minutes, even when it is a good talk? You will be happy to know that this is normal. Experts tell us that our attention fluctuates during a one-hour lecture. We are most attentive during the first 15 minutes of a talk, and then we begin to think about other things (e.g., that first OR case or whether we left food out for the cat.)

If you are the presenter, put something in your talk after 15 minutes that will shift participants’ attention back to the topic. It can be as simple as moving to another part of the room or changing to a different audiovisual format. Better yet, this is an ideal time to introduce a case example that illustrates the learning points and encourages the participants to apply the material. Most of the participants will be energized by this activity and will be eager to follow you for another 15 minutes, at which point you will need another change in direction. This “interval training” will keep your participants attentive and appreciative. Remember, too, to conclude your talk with your key teaching points, because participants remember most what they heard first (primacy) and last (recency).

Sources: Brown G, Manogue M. *AMEE Medical Education Guide No. 22: Refreshing lecturing: A guide for lecturers*. *Medical Teacher*, 2001; 23(3):231-244

Whitman N. *Creative medical teaching*. University of Utah School of Medicine, 1990.

ACTIVE LEARNING

We often rely too much on passive modes of teaching, learning and assessment. The lecture is a prime example of passive learning. Adult education experts tell us that learning has not occurred unless learners change their behavior as a result of what we do. Are you sure learners are getting your message? If people are “forgetting” your message, then you need to work on ways to help them get the message and to put the message into practice.

Case-based teaching is a powerful learning and assessment tool when it forces learners to practice the material from your talk. Audience response keypads can be utilized in larger groups to reinforce the message from cases built from the talk or in pairings of people discussing the cases. You can also use a quiz/game show format or learning prescriptions, like those used successfully at APGO workshops.

Think of ways to make the talk memorable through demonstration and practice. The bottom line is to get the learners active and to make them responsible for their own learning. Most learners prefer it that way and will respect you for giving them the opportunity.

LEAVE YOUR NOTES AT HOME

You've been developing an important hour-long presentation for days. You want to make sure you cover all the details and allay your concerns that someone might draw your attention to something you forgot to include (embarrass you). To be extra cautious, you decide to script everything you plan to say. In addition, you decide that you will print all your notes from your slide maker so you can use them in your talk.

All this effort is fine when you are planning your talk; however, you need to be far more prepared than this when you actually present your talk. Remember, your audience is likely to retain only three to four main points in an hour-long presentation, so you should focus on these main points in your planning. First, decide what these main points will be, then add supporting statements and critical supporting research (only if needed) to demonstrate these points. Also, remember to add actual cases from your experience, as people respond to and recall stories better than facts alone. Include a handout that addresses the main points.

Rehearse your talk several times until you feel comfortable without notes, and then rehearse it with a colleague or friend. After these rehearsals, you will be ready to present your important talk. You will know your main points and transitions by heart at this point, and your slides will help you remember. Leave your notes at home - trust the (energy) force that you have used to prepare your talk. Your audience will quickly recognize that the force is with you.

CHOOSING A DELIVERY STRATEGY

All teachers face the question of "what is the best method to teach this objective?" The usual choices are lecture, discussion or demonstration. The emphasis here isn't so much on how to do it but, rather, "why" choose a particular approach. Demonstrations are especially good for teaching skills, so this teaching tip will concentrate on those.

While demonstrations are generally teacher-centered, there are several techniques available, such as peer tutoring, actual practice, research papers, on-the-job training (in clinics or the surgical suite) and, of course, simulation labs. Keep in mind that if demonstrations are to be successful, much preparation is needed. It isn't simply a matter of inserting the videotape or DVD and sitting back. This holds true for clinic and surgical demonstrations, also. Here are some questions you might ask when considering demonstration as a potential delivery strategy:¹

1. Does the learner need to see the process?
2. How many students need the content now?
3. How much preparation time is available and how much is required?
4. Can you tell and show the content?
5. What "other" senses can be involved in this learning?
6. Do you want the students to imitate you?
7. Is there AV support available?
8. How long will the demonstration last - more than 20 minutes?
9. Can you ask questions during the demonstration?

10. Can you stop and start the demonstration?
11. Can the student take notes?
12. Will there be practice time for the students?
13. Can the student easily identify the steps?
14. Will you permit the students to ask questions?
15. Is there only one right way?
16. Will you support the demonstration with handouts?
17. Have you ever listened to or watched one of your demonstrations?

Your response to these questions should tell you whether you should use the demonstration method and may alert you to some of the issues if you do choose it. Demonstration is a great way to teach and learn, but it needs to be used wisely, not as a default to lecture or discussion.

Source: Chickering, A.W., Gamson, Z.R. Development and Adaptations of the Seven Principles for Good Practice in Undergraduate Education. New Directions for Teaching and Learning 1999;80:75-81.

PRACTICE MAKES PERFECT (SENSE)

Can you imagine being a complete novice sitting in the cockpit watching the pilot and, after a few brief instructions, being told to fly and land the plane? How much different is this experience from those that students receive in the operating room (i.e., see one, do one)? This apprenticeship model of education can be significantly improved and less anxiety-provoking if learners have a chance to learn and practice their psychomotor skills in the classroom or lab.

Barbara Goff, MD's work has demonstrated the validity of this approach for a variety of surgical skills.¹ Virtual reality and computer simulations also make learning these skills easier and less threatening.² Importantly, learners can learn this information even on their own; however, those who receive feedback on their performance usually do better.³ Increasingly, we are seeing surgical educators use more models outside the operating room to help learners practice their skills.⁴

Surgical educators in the specialty of obstetrics and gynecology have come to realize the benefits of teaching the basics to novice residents during their orientation phase. The Council on Resident Education in Obstetrics and Gynecology (CREOG) now has a comprehensive curriculum for surgical beginners available to program directors and residents on the CREOG Web site.

We can still appreciate that surgery is an art form, much like flying a plane; however, it is important to recognize that each procedure consists of a series of steps that can be further divided into discrete skills to be learned in a progressive fashion. Helping learners build their surgical skills in a less hurried, nonthreatening manner can dramatically improve their confidence and preparation for real-time surgical experiences. You will appreciate seeing them fly solo one day, knowing that you helped them get there, step-by-step (flap-by-flap).

Sources: 1. Lentz G, Mandel L, Lee D, Gardella C, Melville J, Goff B. Testing surgical skills of obstetric and gynecologic residents in a bench laboratory setting: Validity and reliability. AJOG. 184(7):1462-1470, 2001.

2. Letterie G. How virtual reality may enhance training in obstetrics and gynecology. AJOG. 187(3, Part 2)(Supplement):S37-40, 2002.

3. Rogers D, Regebr G, Howdieshell T, Yeb K, Palm E. The impact of external feedback on computer-assisted learning for surgical technical skill training. Am J Surg. 179(4):341-343, 2000.

4. Wanzel K, Matsumoto E, Hamstra S, Anastakis D. Teaching technical skills: Training on a simple, inexpensive, and portable model. Plastic & Reconstructive Surgery. 109(1):258-264, 2002.

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