Tools to share good chairside teaching practice: a clinical scenario and appreciative questionnaire

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IN BRIEF

- Sharing good chairside teaching practice can best centre on appreciative 'talk'.
- Provocative questions can help chairside teachers find their role in sharing good chairside teaching practice.
- Features of good chairside teaching are brought to life in a clinical scenario.

EDUCATION

VERIFIABLE CPD PAPER

This article provides a scenario for analysis of good chairside teaching practice to serve as a starting point for continued discussion in this complex field. Documented issues of good chairside teaching practice are cross-referenced to a clinical scenario with explanations in the form of a commentary. This provided the context for generating a set of questions that are provided as tools to support good chairside practice. These tools are designed to be used with 'Appreciative Inquiry', which claims that there is much to be gained by discovering where excellence is possible and elaborating upon this. Although this process can be carried out in single units or departments, it is proposed that collaboration between institutions would allow sharing of valuable innovations and greater understanding of educational training, production of good practice guidance and professional development of staff. This article is the third in a series of three and provides a scaffold for a scenario and questions to encourage collaboration in evolving and sharing good chairside teaching practice. The first article investigated the perceptions of stakeholders in chairside teaching at a single dental school and the second evaluated chairside teaching on a UK wide scale. A further accompanying article reviews some of the educational methodology and innovations in teaching and learning that may be applied to dentistry.

Sharing good practice

The aims of this article are to explore examples of what good chairside teaching could be from the viewpoint of dental students, dental tutors, dental care professionals and patients (the 'stakeholders') by means of analysis of a clinical scenario. In addition, the intention is to enable readers to elicit instances of good chairside teaching practice in their own dental teaching institutions by using the questionnaire provided. The article is designed as a resource for future collaborative workshop activity where chairside teaching innovations can be developed and implemented in and across institutions.

PERCEPTIONS OF CHAIRSIDE TEACHING

1. Stakeholder perceptions of chairside teaching and learning in one UK dental school
2. Chairside teaching and the perceptions of dental teachers in the UK
3. **Tools to share good chairside teaching practice: a clinical scenario and appreciative questionnaire**
4. Educational innovations for dentistry

Background

A study of dental chairside teaching including all stakeholders at a single dental school in the UK[1] showed unevenness in the student experience and variation in dental tutors teaching that, upon subsequent evaluation appeared to be common across the UK.[2] Dental chairside teaching colleagues who made up the evaluation team indicated that it was possible to work towards a consensus view on what characterises good chairside teaching practice from the many examples of good practice that were identified. This involved attending to issues of optimising the student learning experience, tutor performance and training and working with other dental care professionals involved with clinic organisation. The second step in the sharing process was to identify specific instances of good practice that can be disseminated. Appreciative inquiry[3,4] is chosen as a suitable methodology as it can present a focus on what is most valued - integrated practice that 'just works'. Apart from identifying good practice that is already in place, appreciative inquiry encourages collaborative activity that can take innovation through from design to implementation. Since its inception it has been used primarily in organisational development but has recently been described as a tool for evaluation[5] and as a research methodology.[6]

Appreciative inquiry is not the same as positive reinforcement, which is about continually saying things that are positive, because appreciative talk is rather considering things that are valued. It quite simply avoids deficit language. There are major problems with deficit thinking because thinking and talking negatively will continually hark back to what is wrong, with the temptation for the teacher to teach by

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humiliation, placing blame on students, which does not help learning. Appreciative inquiry is based on the maxim that there is more to be gained by discovering where excellence is possible and to elaborate on this.[7] Appreciative inquiry has been described to include four stages:[3-7] to visualise where there is current excellence; to imagine what might be; to innovate; and finally to implement change.

The approach deployed here is in essence an extension of appreciative inquiry into clinical teaching behaviours, both those of the tutors and of students. The suggested tenet is the proposed efficacy of developmental dialogue, which is always learning focused and prospective. This is based upon clear commitment to a positive climate and conditions that facilitate teaching and learning around the chair and briefing and debriefing sessions before and after the clinical encounter. A useful, aspirational maxim we have adopted is one of dialogue in clinical teaching, which is characterised by '...'real talk', which includes discourse and exploration, talking and listening, questions, argument, speculation, and sharing, but in which domination is replaced by reciprocity and cooperation.'[8]

Scenario, commentary and questions

The approach in the article is to provide materials, which would allow those with an interest in dental chairside teaching to conduct a variety of development activities, from large-scale workshops to individual interviews with key innovators in chairside teaching or institutional questionnaires for all stakeholders. The appreciative inquiry sets the tone of the clinical narrative and the different perspectives are explained in a commentary that follows. The questionnaire purposefully contains open-ended questions, which are key to gaining the local knowledge that may express excellence in practice and also where excellent practice might be possible. Essentially it is a process of assisted self-evaluation and review that aligns well with the Quality Assurance Agency's current position on systematic enhancement of university practices.[9]

Table 1 Features of good chairside teaching as they appear in the scenario

Feature	line
Encourage questions and be supportive non-threatening	throughout
Put yourself in the student shoes	throughout
Consistent assessment -- equal treatment for all students	throughout
Enthusiasm for teaching -- willing to teach	throughout
Keeping tutor behaviours positive	throughout
Avoid being patronising	throughout
Peer review of teaching	4-7 73-105
Relevance for the patient in briefing	10-30 57-59
Helpful and advising	13-18 60-62
Embedded preventive care for students	22-24
Recognise that they are learners	29, 78-81
approachable	36-38
Do not tell them what to do!	37-38
Organised -- be a role model	37-46
Involved peers, nurses and PCDs	39-40
Patient centred	39, 63-67
Be there to sign the paperwork	43-44
Continuity of supervision and teaching	45-46
What questions have they	60
Friendship pairs for cross year patient management	64-66
Don't humiliate in front of patients!	70-72
Cheerful	99
Relevance to the student in debriefing	106-131
Recognise that experience is needed	107-112
What students need to know more of	111-112 126-130
Tutor to know the course and what they are doing	113-114
honest feedback	114-119 126-130
Debriefing -- constructively critical -- explain -- praise	114-119 126-130
Opportunity for students to revisit procedures	117-118

Chairside clinical scenario

The dental chairside teaching scenario (Fig. 1) is derived from a compilation of favourable clinical events that have been determined as good clinical practice.[1,2] The lines of text in the scenario are numbered so that the behaviours which show where the teacher has attended to individual and collective student learning and patient empowerment can be pin-pointed as shown in Table 1.

Commentaries

The scenario is designed to be a document to promote discussion, not as some clinical ideal. However, just as the approach to students should be non-threatening, also the form of peer observation going on should be too. The peer observation method suggested by Cosh[10] is modelled here where the main focus is on the observers and what they can learn from the teachers they are observing, using the teacher and experience of teaching as a resource for **their** learning. It places the onus on the observers to relate what they see and what they discover from the dialogue they have with the teacher following the teaching session to their own teaching experience. This is quite different from the stereotype of teacher observation where the observer looks on and makes a judgement on the teacher and the teaching. Clearly it is important to have

Fig. 1 Chairside clinical scenario

15 minutes yet before patients arrive for the afternoon clinic session.
All dental students making a group of six, dental nurses and allocated dental tutor have arrived in the clinic together with a colleague who is doing peer observation.
'I have come to do peer review of teaching. I think that I need to improve the way I give feedback to students. So if I may, I should like to observe your clinical teaching with a focus on how you give feedback,' says the observer. 'That's fine of course,' the tutor agrees.
They all take a look at the patients' notes
Tutor asks the students what they have scheduled for today?
Dental student A has a patient who has a small restoration on a lower premolar treatment planned. Caries is detectable on a radiograph but not visible in the mouth.
Tutor - 'Why do you need to restore this tooth?'
Student A - 'The radiograph shows that the enamel has been breached and floss catches interproximally.'
Tutor - 'So that means?'
Student A - 'There is a cavity - the lesion will no longer respond to preventive measures alone.'
Tutor - 'Good - is there anything else you would like to tell me about this patient and anything else you are looking out for?'
Student A - 'Not really - she does have remarkably good plaque control. In fact, we are part of a new teaching module that only started this year - this patient volunteer taught me how to clean my teeth because she consistently has plaque scores below 10%. All the same, she does have two very large restorations that we are currently watching.
Student B volunteers the information that his patient has chronic periodontitis – 'I'm carrying on with sub-gingival debridement. I carried out the first session two weeks ago under local with no problem, although the patient is diabetic.' He adds, 'With sub-gingival debridement I needed a little help with the instruments last time but I feel confident today.'
Tutor - 'Fine - just let me know the plaque scores first before you go ahead – Thanks.'
The tutor carries out the rest of the briefing with the group and the patients arrive.
Student A's patient has lost a large filling and fractured an additional cusp above the gingival margin from a molar tooth, leaving a large cavity.
Student A looks somewhat distraught – she goes straight to the tutor for help.
'I'm sure that if you collect enough information together you will be able to work out what it is you can do to help your patient today.' the tutor says reassuringly.
'I know she is very keen to keep this tooth - she told me on the way in,' adds the dental nurse.
'Let me know when you are ready to discuss things,' the tutor adds.
Student A - 'Thanks; I think I will need a radiograph at the start to confirm there are no fractures or pathology.' Tutor - 'That's good - I'll sign the radiographic form for you.'
Tutor – 'Make sure I'm available to see you with this patient again to keep the continuity with what we are doing here.'
...Some time later...
'You have the radiograph back?' asks the tutor.
'There is no sign of fracture or apical area. The patient is keen to keep the tooth despite its fairly poor prognosis and she is not getting any pain from it. So I have checked that the tooth is vital,' says Student A.
Tutor – 'So what do you intend to do now?'
Student A – 'I have checked the cavity where the old filling came out; there is no sign of secondary caries. here the additional cusp that has come off it leaves insufficient retention for etching composite alone, so I think it will need pinned retention.'
The tutor takes a look at the cavity. 'Yes that's right' *and then turning to the patient*, 'I think you will need a crown on this at some point if the tooth continues to be symptom free.'
'What do you think I should use as a liner?' asks Student A.
Tutor - 'Something that will give a bonding surface.'
Student A - 'OK I will use glass ionomer.' 'Fine,' says tutor.
Student A, talking to the patient says, 'Today we can try to mend your tooth with a specially pinned filling. If the tooth remains trouble free over the next few months I shall get my colleague Student C to construct a crown for you, as that is not currently part of my course.'
'That should give a longer lasting result,' she adds.
The tutor looks over and sees that Student B has just finished giving local to his patient, but he did not report to him first about plaque levels.
Tutor - 'I would like you to let the dental nurse look after the patient for a moment so that I can have a word with you over here' - *indicating a place in the clinic out of earshot of patients.*
The peer-teaching observer comes over.
'Now why do you think I need to talk with you?' the dental tutor questions Student B.
Student B – 'Oh, I forgot to check for plaque levels! I was so intent on getting on with the procedure! - I think it's OK.'
Tutor – 'There was another reason for me seeing you with the patient - you have not had that much experience treating patients and I wanted to check out your patient as he is diabetic and assess the suitability of the procedure you are about to carry out.'
Student B immediately explained 'As it is later in the day I did check that he has had sensible food and drink and has taken his insulin and feels fit and well.'
Tutor – 'So nothing is lost as long as he keeps the area sufficiently clean afterwards - You should check out the area you did before - just for plaque and that should tell you how he is doing with oral hygiene.'
Student B – 'So I'll give the necessary plaque control instruction now whilst the local is taking.' *And saying this, student B goes back to his patient.*
Peer observer – 'I would have given him a good dressing down in front of the patient just to make a point that he wasn't behaving - doing what you asked.'
And then after a moment of reflection carried on to say 'But I do see that action would not have helped matters for the student or the patient!'
The tutor turns to the observer and says 'Yes, I think you have to work decisively to protect the patient as you act as the safety net for patients and the students generally appreciate that, but the way you do this must support the student to help them progress, not pull them back. If I thought Student B was acting unprofessionally, mindfully ignoring advice, that would be a different matter.'
Peer Observer – 'Also I can see there is no bad feeling in the clinic - all the students are working calmly and fairly cheerfully - like the tutor!'
...Some time later.... dental tutor talking to peer observer 'It's nearly time for the debriefing session - this is where the focus is on the student's performance whilst the briefing session earlier is centred on the patient's requirements - the student should of course be as prepared as they can for this. I try to give individual feedback during the clinic time immediately following clinical events, at the debriefing or see them afterwards.'
Tutor – 'How did it go today?'
Student A – ' I had quite a shock today having to do something completely different than what I had expected for my patient. I did start to panic. But when I had seen the radiograph and could start to link findings with the patient's tooth, I began to settle and I could work out what to do. And with only a little prompting, I completed an enormous pinned restoration. I still find placing rubber dam difficult.'
Tutor – 'I nearly suggested you book a crown prep appointment, but realised that this is not part of your course yet. Yes you managed that patient well and from that will be more prepared for the next clinical surprise. Would you like to lead a short discussion with your colleagues on liner materials that you would use for different restorations? Try to get some practice with rubber dam on manikins before your next clinic – perhaps with some more senior students – or if you would like some help please let me know.'
Student B - 'I didn't follow your instructions about the need for checking adequate plaque control before going on with treatment. I see what you were trying to do now. As it was, the patient was doing well with his oral hygiene. But this has made me think - Should I expect the healing following sub-gingival debridement to be as good in a well-controlled diabetic? I have quite a few things to write about in my clinical record book and things to look up.'
Tutor – 'Yes you handled nearly everything well but were just too eager to get on with things. I'm pleased that you are thinking about the outcome of what you are doing and that if you document the events of the day and what you have learned that would be most useful. Otherwise it is lost and opportunity for furthering good practice missed.'
The debriefing continues and comes to a close... the students leave.
Peer teaching observer - 'I'm surprised you have not said more in the debriefing.'
Tutor – 'No, this is the time for the student to express what they have learned from the session so that they can gain from each other's experiences.'
The peer observer then explains to the observed dental tutor what had been learned from the observation session. The dental tutor then has an opportunity to add to this and they can then draw their conclusions about what they have both learned.

the patient as the main focus of attention at the briefing to ensure that the most appropriate treatment is carried out - urgent care in the case of patient A and related to oral hygiene compliance in the second. The tutor was helpful in giving a level of support to allow student A work out and complete treatment in a way she had never achieved before. Prevention is the keystone of good practice and here a patient empowerment option is in operation. The tutor is aware of the limitations

of the students' experience and prepares for this. Despite coming in some distress to the tutor the response to the student was one of reassurance and further carefully placed questions rather than simply telling what to do. The sequence of the tutor's questions and help showed an underlying organisation and a calm role model. The interjection of a dental nurse indicated the great deal of direct help and behind the scenes help that support staff should be encouraged to give. The interests of the patient were continually taken into account and continuity of support was achieved in these cases. Some collaboration between students at different levels in their course should be organised if they are not working together in practice teams (ie for one particular patient junior students carrying out patient education and motivation, intermediate students carrying out relatively simple treatments and senior students more complex treatments). The key feature of good modern teaching is not to humiliate students. The teacher does not need to gain points - students need help to progress and learn even when they do not perform well at all times. Did gentle handling of student B produce the best learning outcomes? The main focus following the practical clinical session is debriefing possibly for a time with the whole dental team, including feedback from patients and dental nurses. Here the focus was on the student talking to the dental tutor and other students of their experiences and what they have learnt from them. The fundamental aim is for the students to start the process of life long learning, to realise their strengths and weaknesses, and to act to strengthen their overall working practice. It is suggested that this can only be inculcated in an environment that offers a positive climate and conditions commensurate with such dialogue.

The intention is that this scenario will serve as a starting point for discussion on chairside teaching. The work of drawing out more concrete examples of good practice lies in questioning specific instances of practice on issues that this scenario approach has raised.

Questions

A major focus is on what it is you value in chairside teaching and why you do so. This produces a resource for asking appreciative questions[4] in order to work on what *is the best* of current practice; then with *what might be* the best of possible practice; then *ask provocative questions* to develop innovations and finally to help *navigate change and implement it*. What good practice is already in place and innovation about to be implemented as a future opportunity at an institution? Is this good practice useful? Could it be transferable and provide a valuable innovation at another institution now? Finally, the questions elicit details about the people involved in chairside teaching (Box 1). An analysis of these findings may help provide the right emphasis in projecting training provision to improve teaching. Sweet, Wilson and Pugsley[2] produced five categories of chairside teacher suggesting that each has an important and sometimes unique role in chairside teaching. They suggest that gearing training and professional development towards type may improve allocation of resources. However, they also illustrated that a stakeholder mix at a workshop could produce valuable learning for the group members and consensus views as outcomes. This is a further reflection of our position that appreciative, developmental dialogue is an essential component of maximally functioning educational environments.

Box 1 Good chairside teaching practice

A) In our Institution what are the best ways in which we:
1) enhance student learning?
2) improve teaching or knowledge about it?
3) use ancillaries in chairside teaching?
4) organise the clinics?
5) utilise clinical or media equipment?

B) What might we put in place in the future to:
1) enhance student learning?
2) improve teaching or knowledge about it?
3) use DCPs in chairside teaching?
4) organise the clinics?
5) utilise clinical or media equipment?

C) How can we share best practice within the Community of Chairside Teachers?
In our institution what good practices do we have to offer the wider chairside teaching community?
In our institution what good practice could we gain most from the wider chairside teaching community?

D) What can I best contribute to good chairside teaching practice?
1) hands on supervision of students in the clinic?
2) playing a major role in the support and furtherance of my discipline in dentistry?
3) using my natural understanding of patients and students?
4) using my training in education to help students learn?
5) developing an overall understanding of chairside teaching and work on changes to improve it

E) I have experience and knowledge that would enable me to tell others about:
1) good teaching practice?
2) specific clinical subjects?
3) how to use educational theory to improve student learning?
4) how to help other staff improve their teaching?

F) Further training and professional development most useful to me would be:
1) protocols and methods that should be used in chairside teaching
2) teaching methods
3) education theories
3) dentistry specific knowledge
4) how I can help my colleagues teach.

How do you think you would seek these opportunities?

Conclusion

This article is a working document based on a case study of chairside teaching at a dental school in the UK and follow up dialogues with colleagues as a UK workshop. It is designed to provoke interest and discussion in chairside teaching by means of a scenario and complementary commentary. The questions that follow provide a resource for an appreciative inquiry into best practice in chairside teaching which could result in the sharing of hard won initiatives and innovations.

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