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Developing skills for teaching: Reflections on the lecture as a learning tool for the novice midwife educator

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ABSTRACT

This paper explored how I, as a novice midwife educator in a Higher Education Institution, utilised my reflections on the preparation, delivery and evaluation of a lecture to develop my teaching skills. My personal teaching and learning philosophy was informed by humanism. Reflecting on my teaching and learning philosophy, and the teaching and learning theories that guided the session, enabled me to identify aspects of my teaching that required further development. Similarly, the process permitted me to recognise positive aspects that I could take forward and build upon in my professional development as an educator. The key learning for me as a novice educator is outlined, with an emphasis placed on preparation and strategic question formulation.

Introduction

To make the transition from my role as an experienced midwife practitioner to a midwife educator I undertook a one year part-time Post Graduate course in Clinical Health Science Education aimed at preparing experienced and appropriately qualified health care service professionals for their role of educator in Higher Education Institutions. One of the five modules focussed on the theoretical and practical opportunities to develop and reflect on the knowledge and skills required in designing, delivering, assessing and evaluating educational sessions in a classroom context. Throughout my teaching practice I reflected on my personal philosophy of teaching, the teaching and learning theories that guided the sessions and issues that emerged in the preparation, delivery and evaluation of the teaching sessions. The purpose of this paper is to explore how I used my reflections on one classroom-based teaching session as a learning experience to improve my teaching. The teaching session in question was 90 min duration and planned for 46 post graduate midwifery students ranging from ages 20 to 40 years. All were registered nurses in the first half of an 18 month post graduate Higher Diploma in Midwifery programme.

Philosophy of teaching and learning theories underpinning the session

Developing a philosophy of teaching serves many purposes, e.g., clarifying and articulating teaching and learning beliefs, professional growth and development (Schönwetter et al., 2002). Developing my personal philosophy of teaching provided me with the opportunity to explore my personal beliefs and my approach to teaching and learning and to identify factors that influence my teaching. As a novice educator I continuously reflected on and examined my teaching philosophy to enable me to monitor how my philosophy translated into practice and to identify my personal and professional teaching development goals. The concept of humanism informed my teaching philosophy. The premise of humanism is that 'education motivates the development of human potential so that they can progress towards self-actualisation' (Billings and Halstead, 2005, p. 259). Humanism in education was developed by Rogers (1969). It has been described as a philosophy, similar to phenomenology, concerned with 'self', human growth, development, fulfillment, self-direction and empowerment (Quinn and Hughes, 2007; Purdy, 1997). This is consistent with my philosophy of midwifery practice, which embraces a social model of midwifery recognising the whole person, physiologically, psychosocially and spiritually, with a relationship of respect, empowerment and self-actualisation central. Humanism addresses both the cognitive and the affective domains by placing emphasis on assisting students learning how to learn and in turn encouraging creativity (Billings and Halstead, 2005). Central to this approach is the relationship between facilitator and learner, whereby there is a mutual respect, where adult learners are viewed as motivated learners with a desire to grow and develop (Rogers, 1969). This also resonates with the philosophy of midwifery care, whereby there is mutual respect and a relationship of partnership between the woman and her caregivers (An Bord Altranais, 2010).

Andragogy, 'the art and science of helping adults learn' (Knowles, 1980, p. 43) is consistent with the humanistic approach

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to education recognising the principle of adults being self-directed and responsible for their own learning. Adult learners have experiences that serve as a rich resource for their own and others' learning (Quinn and Hughes, 2007). Inherent in Knowles (1980) process-based approach is the concept that adults are motivated to learn, with this motivation developing from life: life experiences, life's challenges and life's unpredictability's. In this instance, the learners were experienced nurses who were returning to education and in keeping with my philosophy of teaching and the espoused learning theories, I drew on both the students' professional and personal experiences and as advocated by Clynes (2009) and Lewis et al. (2008) integrating their experiences throughout the session to add depth, richness and contextualise the session on Bleeding in Early Pregnancy.

Preparation

Quinn and Hughes (2007) and Ramsden (2003) advocate the use of a lesson plan as a crucial component in preparing for teaching. Developing my lesson plan prompted me to consider the key factors in lesson preparation identified by Curzon (2004), e.g., the students, the subject matter and resources and constraints and the impact that these would have on the session. Whilst I took cognisance of the number of students, their academic level and the venue, most of my attention was directed towards the subject matter; how I was going to organise the content, the teacher and learner activities and the evaluation strategies I was going to utilise within the session.

Lesson preparation can cause anxiety for the novice educator (McArthur-Rouse, 2008) and once I started to prepare for the session I became aware of the dichotomy of the competencies I possessed as an experienced midwife versus the competencies I required as an educator. The Definition of a Midwife and Practice Standard 6 specifically outlines the educational role midwives play in health counselling, providing evidence-based information to enable informed choice and as teachers and assessors of students in clinical practice (An Bord Altranais, 2010). However, whilst I felt confident in my ability to realise the educational aspects of my role as clinical midwife, the proficiencies required for classroom teaching to midwifery students required a different skill set. The communications skills, the language used, the teaching strategies utilised and the relationships forged in the practice area and the classroom are undoubtedly different (Fourie et al., 2002). In order to combat this anxiety and lack of self-efficacy as a lecturer, I referred to the course texts and references on teaching and learning strategies and also updated myself on the subject matter for the session. I also considered my philosophy of midwifery, my personal strive to provide women with individualised, woman-centred care, which demonstrates respect for the relationship of partnership between women and their midwife. This approach was transferred into the classroom by demonstrating mutual respect for the teacher–student relationship.

The purpose and learning outcomes of the session had to be identified at the onset.

Learning outcomes are specific statements about what the student should have achieved by the end of the session (Billings and Halstead, 2005). Baume (2009) describes good learning outcomes as being active, attractive, attainable, as well as being assessable. The module descriptor and learning outcomes for the module assisted me in formulating realistic learning outcomes specific to the session, e.g., rationalise how a midwife could differentiate between a miscarriage and an ectopic pregnancy.

As miscarriage occurs in up to 30% of pregnancies (RCOG, 2006), it was possible that a number of the students may have been affected by miscarriage in some way. I felt confident that I would be able to handle this sensitive issue, and through using examples from my personal clinical practice throughout the session I would be able to convey empathy. At the start of the session I planned to advise students that if they found the subject upsetting, they could speak to me in private after the session. I also included contact details of the Irish Miscarriage Association and the Clinical Midwife Specialists in Bereavement from local maternity hospitals in the reading list.

Preparing my lesson plan made me think about and justify the teaching and learning strategies that I was going to utilise. The lecture was the chosen format as the teaching strategy for the session. It is an effective way of transmitting information to a large group of students within prescribed time constraints and is useful when introducing a new topic (Quinn and Hughes, 2007; Jones, 1990). Bligh (1998), after extensive examination of the lecture, concluded that it is as effective as other methods for teaching information, but ineffective in stimulating critical thinking, higher order thinking or in stimulating students. Ramsden (2003) and Nicholls (2002) suggest this is because students learn through active engagement with the subject matter rather than sustained low-level activity, such as listening. Clynes (2009) and Curzon (2004) contend that a well-planned and presented lecture can succeed in gaining the attention of the student.

In keeping with my philosophy of education and identified learning theories, I intended to employ student-centred strategies to avoid producing a didactic, teacher-centred lecture. Burnard (1988) and more recently Dalley et al. (2008) and Race (2008) recommend brainstorming as a tool to promote student-centred learning. They credit it with encouraging problem solving, critical thinking, exploration of feelings and as a tool to evaluate learning. I planned to use brainstorming to evaluate student's entry knowledge. Like Clynes (2009), I felt that by assessing what the students already knew, the lecture would build on their existing knowledge and help them to engage with the topic. In my pursuit to adhere to the tenets underpinning andragogy (Knowles, 1980) I wanted to acknowledge the students prior learning experiences, motivate them to learn and inculcate within the group the skills for lifelong learning.

I planned to use questions at the start of the lecture to assess the students entering knowledge. Effective questioning is universally accepted as an essential skill that educators must develop and learn to articulate all the while being cognisant of providing a safe environment (Nicholl and Tracey, 2007; Profetto-McGrath et al., 2004). According to Race (2008, 2005) and Billings and Halstead (2005), questioning has many functions: e.g., student recall, keeping the student involved in the learning activity, developing reasoning ability and providing opportunity to express ideas and thoughts. Questioning was well aligned with my educational philosophy and desired learning theories, therefore was utilised to elicit student understanding and develop student's skills of rationalising and analysing.

Nursing and midwifery educators have long debated strategies to facilitate the development of critical thinkers. Vandermause and Townsend (2010) and Mangena and Chabeli (2005) suggest that a whole paradigm shift from the traditional teacher-centred methods to a more learner-centred centred approach is the solution. This shifting away from content-driven educational processes to a learner focussed process is what I wanted to achieve. The session was scheduled for 90 min. Bligh (1998) indicates that student attention wanes after 10 min, suggesting a change of learning activity every 15 min. It was my intention to break up the session into units of learning to sustain student attention and to prevent me falling into the didactic lecture format. This would be achieved by changing the teaching–learning strategy, e.g., asking questions, facilitating discussion, encouraging note taking and using buzz group work, every 15 min. Note taking has been credited

with encouraging active processing, active listening, paraphrasing, interpreting and questioning (Clynes, 2009) and buzz groups with engaging in problem solving activities and providing student involvement (Bligh, 1998). This has the advantage of changing activity, encouraging discussion, promoting exploration of personal ideas and feelings and enhancing student recall and understanding (Huxham, 2005).

How did it go on the day?

As the teaching environment was a new to me, time was spent organising and checking lighting, electronic equipment and the layout of the classroom. Chairs were free standing and easily moved to facilitate buzz groups.

Self-assessment is a powerful tool for professional development and self-improvement (Ross and Bruce, 2007; Kwansa, 2006). It has become habit to note my immediate thoughts and reflections after classroom or clinical teaching sessions. My immediate thoughts on the session were concerned with time constraints.

I focussed heavily on the subject content. There was a large number of slides (36 in total) laden with information. As a result of my lack of confidence, I fell into the trap described by Clynes (2009), of focussing on teaching rather than learning by attempting to cover every aspect of bleeding in early pregnancy.

I thought I had managed brainstorming fantastically. I praised the students pre-existing knowledge and proceeded to outline the learning outcomes for the session. After the session I noted the flip chart with the themes brought forward by the class during the brainstorming session. I had omitted to refer back to these themes before the session ended. This had the potential to give little or no value to the students' contributions and discourage them from participating in the future (Dalley et al., 2008; Burnard, 1988).

I anticipated that effective questioning would 'just come to me', through rationalizing that I had been using questioning professionally as a midwife for over ten years. On the contrary, I fell into the category who asked low-level questions that determined knowledge, comprehension and application (Profetto-McGrath et al., 2004), as opposed to asking high-level questions that support analysis, synthesis and evaluation (Philips and Dukes, 2001) as reflected in the learning outcomes.

I used a number of questions that I had prepared and felt that these were the only questions that prompted critical thinking, opened debate and represented the cognitive levels I aspired to during the session. For example, 'explain how you would distinguish a woman suffering from a miscarriage from a woman with an ectopic pregnancy?' Likewise I developed probing questions that related to previous learning, such as, 'can you identify the signs and symptoms of an ectopic pregnancy?' followed by 'why is there increased abdominal pain?' Follow-on probing questions have value in confirming understanding, enabling students to think in a logical manner and promote higher order thinking skills (Nicholl and Tracey, 2007; Myrick and Yonge, 2002). Questioning was used to ascertain learning and comprehension (Race, 2005). Nevertheless, asking 'Is it ok to move on?' or 'Are there any questions?' is simply requesting a 'yes' or 'no' answer and not probing to illicit a deeper notion of the students understanding (Kelly, 2005). I resolved to reviewing the learning outcomes when concluding the session, where verbal feedback demonstrated knowledge and understanding.

I utilised buzz groups once mid way through the session and encouraged note taking by leaving some blanks in my handouts, which were made available prior to the session. In hindsight my obsession to get the content covered may have limited effective use of both strategies. Consequently, I was edging towards didactic, teacher-centred learning. The use of examples from my own practice engaged the students, whereby I linked the theory of recognising a woman with an ectopic pregnancy with an example from my own clinical experience. The literature supports this with Wrenn and Wrenn (2009) indicating that using examples from practice stimulates learning and a desire for further learning.

Student behaviour was observed throughout, noting if students' facial expressions indicated confusion. Fink (1995) accepts some value in this form of self-evaluation. Nevertheless, it is still a considerably subjective activity. Therefore self-evaluation in the classroom, whilst it has its place in enabling the teacher to change strategies if there appears to be a lack of understanding, or loss of interest, can also be difficult to manage as a novice. On reflection there were periods when I thought I had lost a minority the students, but due to my lack of confidence I asked some low-level recall questions and moved on. A more structured self-evaluation after the teaching session also has its merits. Race (2008) has developed a succinct post lecture self-evaluation. This approach questions ones personal performance as an educator. Albeit subjective, it enables a less hurried reflection on the effectiveness of teaching strategies used and promotes self-development (Burke, 1994).

The hallmark of constructive evaluation of student learning is to involve the students themselves, as the consumers of the teaching (Kwansa, 2006). Quinn and Hughes (2007) and Fink (1995) suggest that this information can be obtained by questionnaires and/or through interviews. An evaluation tool was utilised to access the students' feedback on the session. It was composed of sixteen Likert-type questions ranging from 1 to 5.

The findings of the evaluation (Table 1) were used to inform future sessions. It was no surprise that there was too much content or a shortage of time. I needed to consider the content of other core modules, taking into account previous knowledge, clinical exposure and the integration of several modules, e.g., Biological Sciences, Adaptation to Pregnancy and Unexpected Outcomes of Pregnancy. Similarly, I needed to bear in mind my haste to teach everything on bleeding in early pregnancy (Clynes, 2009).

Implementing my learning

I had the opportunity to teach this subject to a different cohort of student midwives two months later. Based on my reflections and student feedback from the initial session, I was able to make a number of changes.

On request I obtained 2 h for the session, which was broken down into 50 min × 2. This enabled more frequent use of buzz groups, more note taking and facilitated discussion. The overall pace of the session was significantly slower. I reduced the amount of theoretical content, with a subsequent one-third reduction in slides and focussed on two main aspects: miscarriage and ectopic pregnancy. Students were directed to recommended resources to read about throphoblastic disease. Following brainstorming to elicit entry knowledge, I put the themes identified by students into groups and proceeded to outline the learning outcome related to the group. Any theme that was not going to be covered in the class was given a brief explanation and the students were directed to further reading.

I developed my questions prior to the session, making notes on my lesson plan as to when I thought these questions would be appropriate. Questioning was much more effective on this occasion. Having prepared several questions in advance, and as my confidence developed, I became more comfortable with the silence that ensued while the student considered the question. I utilised buzz groups of five students on three occasions and incorporated case studies into this. Short tasks, such as, 'identify how a woman experiencing a miscarriage may present?' were given to the buzz

Table 1
Midwifery student evaluation.

									Mean	SD
(A)	Module content and organisation									
1	Prior knowledge assumed	Too little	5	4	3	2	1	Too much	2.77	0.728
2	Amount of material covered	Too little	5	4	3	2	1	Too much	2.93	0.868
3	Degree of difficulty	Too easy	5	4	3	2	1	Too difficult	3.07	0.530
4	Was there a coherent progression of the module from beginning to end?	Yes, always	5	4	3	2	1	No, seldom	4.47	0.730
5	Was the content appropriate in terms of the language used and examples given?	Yes, always	5	4	3	2	1	No, seldom	4.70	0.535
6	Statement of learning outcomes	Very clear	5	4	3	2	1	Very vague	4.60	0.675
7	Organisation of teaching	Very good	5	4	3	2	1	Very poor	4.60	0.563
(B)	Teaching and learning support									
8	Helpfulness of teaching staff	Very helpful	5	4	3	2	1	Very unhelpful	4.37	0.850
9	Availability and accessibility of module material (e.g., reading lists, handouts, etc.)	Very good	5	4	3	2	1	Very poor	4.77	0.430
10	Usefulness of material	Very good	5	4	3	2	1	Very poor	4.67	0.547
11	Clarity of presentation	Very good	5	4	3	2	1	Very poor	4.53	0.629
12	Interest in the subject as a result of the module	Significantly increased	5	4	3	2	1	Significantly decreased	4.43	0.774
(C)	Overall evaluation									
13	Overall, how would you rate the module content?	Very good	5	4	3	2	1	Very poor	4.53	0.571
14	Overall, how would you rate the organisation of the module?	Very good	5	4	3	2	1	Very poor	4.57	0.626
15	Overall, how would you rate the quality of teaching?	Very good	5	4	3	2	1	Very poor	4.60	0.621
(D)	Lecturer evaluation									
16	Overall, how would you rate the Lecturer(s)?									
	Lecturer A	Very good	5	4	3	2	1	Very poor	4.73	0.450

groups. As the session developed the students were later asked to utilise more probing questions. This also facilitated discussion, as feedback was opened to the floor with the class invited to add to the themes identified by classmates. Note taking was encouraged by leaving blanks on the handouts, with students directed to take notes on feedback from the buzz groups.

As a result of my learning from the classroom session, I now carry out a brief self-evaluation prior to, during and after the lecture. If something goes well during the session, or if I find some questions work better than others, I indicate this on my lesson plan. I continue to use Race's (2008) post lecture evaluation, since the questions help me to reflect upon my teaching.

This second session felt poles apart from the first time I taught bleeding in early pregnancy. I felt more confident, better prepared, I used more effective questioning, my slides were less busy and the delivery was less rushed. This reflection was based upon the learning outcomes the students used to differentiate between a woman presenting with a miscarriage and an ectopic pregnancy. A review of the learning outcomes at the end of the session clearly indicated that students had developed a good understanding of the two conditions. This in turn felt personally rewarding and boosted my confidence as a novice educator.

Conclusion

As a novice educator, the purpose of this paper was to utilise literature to explore my reflections on a teaching session for the purpose of developing greater understanding of the teaching–learning process and of my own teaching practice. On considering the two teaching sessions I conducted, I feel I remained more faithful to my humanistic teaching philosophy in the latter session. Strategies to keep the session learner focussed were more successful, with brainstorming, buzz groups and questioning more effectual. Similarly my confidence as an educator has improved. I can now tolerate the silence that ensues after posing a probing question, and am better equipped to provide students with more time to rationalise and consider their responses. Being adequately prepared was the principal learning point, in particular the preparation of high-level questions that leads to rationalizing, analysis and synthesis within the student. I will continue to build on my reflections as a novice educator. I will also remain open to student and peer feedback and in future teaching sessions continue to make improvements to facilitate student focus.

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