Examples of Teaching Philosophy Statements from Faculty within the UW School of Medicine

Example #1

My philosophy of teaching is to create an environment that allows for supervised exploration. I believe that the most significant learning occurs in situations that are both meaningful and realistic. The overriding goal of my teaching has been to place learners in these types of situations: in the otolaryngology clinic for first year medical students learning the head and neck exam, at the patient's bedside for second year students learning to develop their clinical skills, in the operating room for otolaryngology residents learning the complexities of surgical care, even within an ongoing research project for graduate students learning the principles of bioinformatics. For situated learning to occur, the learner must be given access to the environment where the skills and knowledge will eventually be used.

For me, the best way to accomplish these goals is through small group or one-on-one teaching, particularly in a clinically relevant setting. The relevant setting is key: it allows the student to integrate knowledge into a useful framework and provides emotional resonance to the learning process. Learning in a clinical setting requires a delicate balance between safety and realism. The environment must be realistic enough so that the knowledge and skills that the student is learning are applicable to similar clinical situations in the future. However the setting needs to be safe enough so that the student feels empowered to explore the boundaries of their developing skills.

I have attempted to follow this philosophy throughout the various levels of teaching. For first year medical students, I teach the head and neck exam by having students come to the otolaryngology clinic where they learn and practice the exam in a small group with an otolaryngology resident. I teach about the doctor-patient relationship and about the diagnosis and treatment of oral cancer by having a discussion with a patient in which the key didactic points are made, but the students are free to raise questions of their own. First year preceptors are introduced to the clinical setting so they can see how their basic science and professionalism training will be utilized. In the second year Introduction to Clinical Medicine II course, the majority of the learning takes place in the hospital at the patient's bedside. This one-on-one and small group setting provides a controlled but clinically relevant environment to develop skills in history taking, physical examination, communication, clinical reasoning and teamwork. Third and fourth year students on clerkships learn as part of a team engaged in direct patient care. They are taught the relevant basic science and clinical knowledge related to their patients, but also how to identify knowledge deficits and resources to address these learning needs.

When teaching medical students, a 'safe environment' refers primarily to a setting that is safe for the learner to explore. When teaching residents however, a 'safe environment' also includes patient safety. Teaching in a surgical training environment is especially challenging, but a constructivist approach of graduated responsibility can help to meet this challenge. A constructivist approach to learning requires a diligent needs assessment to identify the starting knowledge base, and also continuing assessment of the student's learning. This includes establishing well-reasoned and specific goals and objectives for each stage of training, and a willingness to be flexible when necessary to meet the individual learner's needs. Regular formalized assessment and feedback are likewise vital. However, to really transition from a teacher-centered learning environment (such as the classroom) to a more learner-centered environment (such as the wards), students must identify learning needs in themselves, and assess their own progress. The use of portfolios, in the medical school, residency and faculty setting is one way that I have worked to foster self-assessment and help to instill life-long learning habits.

Example #2

I love teaching when the learning in my classroom is palpable: When I can sense it in the quickening pace of a roundtable discussion or a student's visible delight in using newly learned jargon; when I can hear the excitement in students' testimonials about mastering skills that "made a difference" or theories that transformed practices and perspectives. I count these as teaching successes and make it a habit to reflect on their origins so that I can recreate the conditions for their occurrence again and again. My philosophy of teaching is informed by the material I teach, relevant scholarship, and the lessons I have learned from personal teaching successes and failures.

I believe that learner-oriented teaching promotes learning that is both purposeful and enduring. As a teacher, it is my responsibility to know who my learners are, what kinds of knowledge and experience they bring to the group, and what they want to achieve so that I can tailor a curriculum that fits their needs and yet leaves enough room to accommodate topics that emerge from group discovery. By assessing where my learners are with respect to our mutual learning goals, I can provide the scaffolding they need to build connections between what they already know and the new understandings they seek to create. I embrace case based teaching and other active learning activities because they stimulate intellectual camaraderie, argumentation, and cooperative problem solving and lay the groundwork for life-long collaborative practice.

I believe that teachers who demonstrate curiosity and passion about a subject area motivate students to learn and so choose to co-teach with colleagues whose scholarship and expertise are complementary to mine. Collaborating with faculty who are enthusiastic about using instructional methods rooted in social constructivist principles models how scholarship, teaching, and learning are enhanced by diversity and teamwork. It is also great fun.

I believe that W.B. Yeats captured the exhilaration of teaching when he wrote: *"Education is not the filling of a pail, but the lighting of a fire."* My goal as a 'teacher of teachers' is to ignite in my learners a passion to create an institutional teaching and learning environment that fosters a conflagration of educational experimentation and innovation at this academic health sciences center.

Example #3

My role as an educator in graduate medical education has much in common with my hobby of raising orchids. I dabbled in both until greater “collections” befell me-- in one case, several dozen orchid plants bequeathed by an acquaintance, in the other, the opportunity to direct the residency program in Rehabilitation Medicine. Raising orchids means having the right media, creating the right growing conditions for individual plants, and vigilance against weeds and slugs. I keep records and set goals and evaluate my collection. There are many parallels in teaching and evaluating residents and in the administration of a residency training program.

Resident physicians have many demands on their time. I believe they will devote more energy to the learning process if they can see the benefits of devoting time to what I have to teach. In every encounter with a resident, I try to model inquisitiveness, politeness, team management, analytical thinking, and current knowledge. I set the stage for a collegial learning setting, and demonstrate the underlying structure I use to make decisions. As I probe learner knowledge, I allow a healthy level of anxiety into the situation by asking questions and letting my resident struggle a bit for the answer--they have to make a commitment. Then I want to know what process was used to arrive at the answer. Did they use the literature, clinical experience, or ritual? Are they connecting their fund of knowledge with the clinical database? My goals in teaching are not limited to the knowledge domain. Resident physicians must learn team management skills as well. Exposing the underlying structure works when reviewing a patient interview, planning or critiquing a multidisciplinary team meeting, or making a clinical decision. This model easily leads to the important step of giving identified feedback. The learner must also give feedback to the teacher but usually the teacher needs to request it.

Resident physicians must assume substantial responsibility in the learning process. They must take an active approach to learning. I believe the successful learner evolves from just having a case repertoire to connecting their clinical experiences with literature knowledge. By the end of residency, successful learners can learn outside of the context of cases, as they strive to “master” a field.

As the director of the residency training program, my view of the learning process extends beyond my individual encounters with residents. Teachers with varied talents, diverse clinical settings, and organized didactics enter the equation. A training director can influence the educational process in many ways including organization, resident counseling, faculty development, and program evaluation and development. Teachers must have adequate skills, residents must know what is expected, the curriculum must be current, and the evaluation processes must be timely and fair. The educational process must not become subservient to the demands of clinical service. Having a vision of the program’s goals and objectives is key to avoiding this. To prevent myopic vision, it is helpful to consult frequently with graduates of the program and other program directors.

In summary, the learning process is enhanced by

- a collegial relationship between teacher and learner
- evident pride in scholarship by the teacher
- challenge of the learner’s knowledge
- elucidation of underlying structure by the teacher
- active connection between cases and literature by the learner
- and mutual feedback.

At a program level, the educational process is enhanced by vigilant planning and reassessment, fertilizing, shaping, and yes, weeding and slug-baiting. Visualize the greenhouse in continuous bloom...

It's hard for me to decide which I like better, being a student or a teacher. I love the challenges of medicine, whether learning new management, or learning about a new patient's culture. I like mastering the fundamentals, then learning to apply my knowledge to the multiple representations of real world problems. I am keen on the academic arena and being around so many other smart physicians. I try to model my own love of learning to my students.

I embrace the constructivist approach to teaching and learning. The concepts of active learning and collaboration are central to my philosophy of education. These are behaviors I seek to model every day in my interactions with students and residents. As a teacher, I most enjoy teaching in the setting of real-world patient care, emphasizing decision-making, self-reflection, and interpersonal relationships in a meaningful context. I believe in collaboration, not competition among the learners and members of my team.

In recent years, I have been fortunate to become more involved in residency training issues on a national level. Here, too, active learning and collaboration have served as guiding principles. I have helped to shape our national program directors council into a community that works together to share the latest educational and assessment tools and that has a national voice to influence residency training policies.

Through my work at the UW, on the Association of Academic Physiatrists Program Directors Council, and on the American Board of PM&R, I plan to continue studying and applying best methods of medical education and assessment. I will continue to share my knowledge and skills in a collaborative way with other program directors and educators with the goal of helping to shape the national agenda for PM&R education.

Example #4

As I reflect on my achievements in consideration for promotion to Professor of Medicine, I believe that I have demonstrated success in an important leadership position in our institution and have achieved national recognition in medical education for my teaching activities, course materials and scholarly works. I divide my time between the Seattle VA Puget Sound Health Care System, with a busy clinical practice and weekly resident clinic attending, and the University of Washington, where I have served as the Associate Director of the Medicine Residency Program since 1995. I attend two months per year on the inpatient medicine services, one each at the Seattle VA and UW, and have achieved recognition as an outstanding teacher who is often asked by housestaff and faculty to give presentations. I have a strong commitment to care of underserved patients, and since 1996, have been frequently selected by peers as one of "The Best Doctors in America".

A major achievement in my scholarly activities has been the development of a resident teaching skills course with teaching manuals and videotape that are utilized by many residency programs nationally. I received an inaugural award for Innovation in Medical Education from the Society of General Internal Medicine in 1996 for the design and dissemination of teaching materials for this six-hour course on the role of the senior resident as a teacher, manager and team leader. The course manuals and videotapes are frequently requested for use at other institutions, workshops and precourses conducted at national meetings have been popular, and I am often asked to conduct a course at other institutions. We published a study showing benefit of the course in teaching evaluation ratings of residents by interns and students; this study was highlighted by national residency program leaders in a plenary session at the 2002 fall meeting of the Association of Program Directors of Internal Medicine. The course manuals were recently published in the textbook Residents' Teaching Skills.

Another area of academic focus is bedside teaching in ward and ambulatory settings, and I have co-produced faculty teaching videotapes and an evidence-based physical diagnosis website that are widely used. With colleagues at the Seattle VA, I studied the value of physical examination in diagnosing pneumonia. The resultant publication has been requested by many faculty internationally, and was noted in a New York Times article on physical examination skills. We have presented numerous workshops and precourses nationally on physical diagnosis and bedside teaching.

Since 1992, I have served as the co-director of the Seattle ACP Board Review Course, which is regularly among the highest rated board review courses offered by ACP, and have received ACP commendations as the highest rated speaker in national board review courses from 1995-98. I have also participated as faculty for several years in the national ACP meeting, with some of my presentations on test-taking strategy highlighted in the national ACP Observer magazine. I have served as faculty for the organization's sponsored annual San Diego recertification course since its inception in 1998. Recently I authored numerous chapters and board review questions for MKSAP 13. I have served on the national Education Committees for ACP-ASIM and SGIM.

As Associate Director of the UW Medicine Residency Program, I have worked hard to enhance the excellent quality of the program with continued recognition as one of the best training programs in the country. I have devoted major efforts to improving our educational environment for residents at all of our inpatient and ambulatory sites, and enhancing recruitment open houses for applicants. Since joining the residency program, I have developed and coordinated many new educational activities to the residency, including an overnight intern retreat, expanding resident career days and mentoring, and directing an annual resident teaching course and mini-board review courses for second and third year residents. I mentor many residents and students on career decisions and am viewed as a role model as a clinician teacher, and for those seeking balance between career and family. I am particularly

interested in the personal pressures faced by residents, co-authoring a published study of resident burnout that achieved widespread national press and recognition by educational organizations. My leadership role in the residency program continues to evolve.

In summary, I believe that I have demonstrated leadership in residency education, design of innovative teaching materials, and recognition nationally as a superb teacher. Thank you for your thoughtful consideration of my promotion.

Example #5

"By learning you will teach; by teaching you will learn" Latin proverb

I have written several philosophies of education statements. They are all different. I hope that this reflects that I continue to refine what I mean by education.

Respect for the learner and continuous refinement of the teaching process have remained essential elements though various iterations of my educational philosophy. These two are linked and how I use these elements to define my educational approach is outlined below.

Respect for the learner
In the teacher-learner dyad, each element influences the success of the educational encounter. Engaging the learner is critical. One must start by gauging the needs of the learner, tailoring the approach to the learner and insuring a safe learning environment. A central goal is to encourage experimentation and taking chances. Consistent with this attitude of respect is my willingness to accept error and correct it quickly when it occurs. Honesty about expectations, successes and mistakes is the foundation for the respect that will insure optimal learning.

Continuous refinement of the teaching process
Each teaching session is an experiment, blending unique learning needs and teaching methods. Assessment and evaluation are integral for the learning process. Both insure quality, clarify key elements to be learned and help prevent the same errors from occurring over time. Continuous refinement of the teaching process is predicated on honesty-- accepting feedback and respecting that people learn differently. Without looking back at what we have done we are not informed about what we might do.

These two basic approaches to teaching are embodied in the active and reflective style of teaching I feel most comfortable with. I ask questions of my students; probe what they know, what they think and why they chose a specific course of action. I resist giving "the answer", working toward "an answer", building on what they know and helping them discover their own ability to solve problems. This approach empowers students to take the next step in the learning process, regardless of level of training.

"Tell me and I'll forget. Show me, and I may not remember. Involve me, and I'll understand."
--Native American saying

Example #6

Teaching is a high priority for me. It is also a source of great job satisfaction. A main focus of my teaching efforts is based on actual patient care in the ED. I enjoy being able to connect learning to actual patients. As a teacher in the ED, I like to think of myself as a coach to the students, residents, and fellows as well as the nurses that I work with. I believe this leads to better patient care in addition to energizing the entire patient care team. Because of this, the case-based approach has proved very successful. In addition, I provide lectures not only to pediatric emergency medicine fellows, residents and medical students, but also to nursing staff, community physicians and colleagues within the academic medical community. Over the past several years I have focused on my role as an educator to the larger medical community. This has led to presentations at numerous national venues. Although I am most comfortable teaching in the small group setting and one on one, I feel I have been effective not only in small groups, but in the large lecture hall also.

I have taken my love of teaching to a higher level by participating in the University Of Washington School Of Medicine Teaching Scholars Program during the 2005-2006 academic year. This program focused not only on how to enhance my teaching skills, but how to maximize my impact as an educator through curriculum development and educational research. I have tried to use these skills in a number of ways. First, I continue to work as a coordinator for the yearly 5 day pediatric intern retreat. I help to refine current sessions and develop new sessions to ensure that what is discussed remains fresh and relevant for the pediatric interns. Beginning the year I participated in the Teaching Scholars Program, I took on the role as Co-Chair of the planning committee for a now annual regional conference on Pediatric Emergency Medicine for the Primary Care Provider. This conference has been very successful and had the added benefit of forging relationships between community physicians and the emergency group. Currently, I am working on an ambitious project with James Stout, MD, MPH in the Division of General Pediatrics to create an interactive web-based educational program on sedation of the pediatric patient. This project has required me to partner with national leaders in pediatric sedation from the anesthesia, pediatric emergency medicine and dental communities. The goal of this project is to create an educational product that will be useful for physicians, dentists, nurses, and respiratory therapists. We plan to complete the prototype of this program within the year.

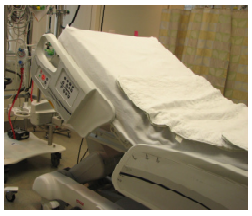
As the pediatric emergency medicine fellowship director and as a researcher, I focus on my role as teacher and mentor to the fellows I work with as well as medical students and junior faculty members. Not only do I feel it is my responsibility to mentor, I gain great joy from the success of those around me. I have worked to mentor fellows in pediatric emergency medicine not only to research success, but also to career success. I have sought out opportunities to mentor medical students with research projects and mentored an MSRTP student this past summer. Residents often come to me to discuss research ideas and I will either work with them on their project or help to find a mentor for them with similar interests and experience. I seek out junior faculty members and work to ensure their success in the academic environment by providing opportunities, advice, and support.

Example #7

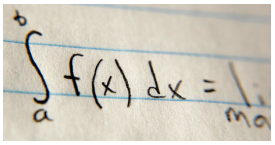
For years, I have wanted to teach and inspire others in the same ways that my favorite high school and college teachers inspired me some time ago. Although I took a long and often circuitous route to finally becoming a teacher in the School of Medicine my journey provided me experiences and opportunities to observe teachers from many disciplines and of many skill levels that shaped my teaching philosophy. This philosophy is rooted in four central concepts that are perhaps best captured by the accompanying photos as metaphors:

Enthusiasm: When asked to describe my approach to teaching, I immediately think of the Spartan Cheerleaders played by Will Ferrell and Sheri Oteri on Saturday Night Live. Enthusiastic to a fault, these cheerleaders could get excited about just about anything. While I am not as "over-the-top" in my teaching approach as these characters I believe that most of my students would say I bring a similar level of enthusiasm to my work. It is a rare moment when a student interacts with me and does not come away excited about the interaction or having learned from the experience. Regardless of how busy I am in my work, I set aside time to ensure that my learners benefit from working with me.

Flexibility I strive to be as flexible as the beloved Gumby - adapting my teaching to deliver lectures or other teaching modalities that are perfectly pitched for particular audience. I know that every learner is different and an explanation or approach that works for one learner may not work for another. Similarly, I know that I need to adapt my style to the different contexts in which I teach – whether at the bedside or in large and small classrooms.



Relevance: Learners have better retention and more interest when they see the relevance of material to the care of patients residing in beds such as the one in the photo. Medical students, for example, are more engaged when they know that material will come into play when they work on the wards. Similarly, bedside teaching is more effective when it reinforces concepts learned in didactic sessions or reveals the clinical applications of seemingly unimportant details. I therefore anchor my teaching to patient cases and focus on key concepts to make learners better practitioners.



Integration: The last time I formally integrated any equations or did any calculus, for that matter, was in college. Nevertheless, integration plays a key role in the way I teach. I like creating scenarios that encourage students to draw on multiple disciplines to solve problems. These include cases about critically ill patients that require students to interpret chest x-rays or clinical images. In my second year medical student course, Introduction to Critical Care Medicine, I mix classroom experiences with significant clinical exposure, as the integrative experiences greatly enhance learning and retention.

One final metaphor for the way I approach my work as an educator is that of **evolution** - not because I look at teaching as a question of "survival of the fittest," but because I see the capacity to evolve in my role as a critical trait. I don't anticipate that the core principles of my philosophy will change significantly, but I do I expect that I will adapt other principles as I continue to interact with students and other educators. As detailed in the Long-Term Goals section of my portfolio, I am committed to improving my performance over time as it is this improvement that will allow me to look back at the end of my career and say that I have had a comparable impact on students and learners that some of my best teachers have had on me.

Example #8

As a teacher, my goal is to create a learning environment that is conducive to active, engaged learning. I strive to be evidence-based, to create a safe space for learning and to make the educational experience fun. This is true whether teaching formally or informally, and whether my audience consists of medical students, residents, colleagues or patients. My style of teaching is practical, experiential and occasionally humorous, which I believe leads to a collaborative learning process that benefits everyone involved.

I am dedicated to always striving to be a more effective educator. Toward this goal, in 2010 I completed the Teaching Scholars Program at the University of Washington, which offered formal instruction in how to provide medical education. Team Based Learning (TBL) was one teaching technique that was introduced, and there is strong evidence from other programs that student performance and retention improve with TBL. This past year I worked closely with Robert Steiner, the course director of the Reproduction course for second year medical students (HUBIO 565) to implement TBL for the first time. This required educating other faculty and revamping course materials to accommodate the TBL format, moving away from a power point/lecture format and to working in teams to solve case-based problems. This was a major effort requiring approximately 100 hours of my time during the past academic year, but was well worth it.

Nationally, I have been involved in improving family planning education for a broad audience for 7 years. As a member of the national Council on Resident Education in Obstetrics and Gynecology (CREOG) Education Committee, I drafted, with editorial assistance from the Committee, the family planning material for the CREOG Educational Objectives which, under direction from the American College of Obstetricians and Gynecologists (ACOG), serves as a national education guide for OBGYN residents during their 4 years of training.

My area of expertise is family planning, a topic that has the potential to be divisive. To overcome this challenge, I make family planning relevant to all, often asking learners to reflect on their experiences with contraception and/or unintended pregnancy. At the beginning of each residency year, I hold a 2 hour values clarification session around family planning issues, which allows residents to speak frankly about their beliefs in a non-judgmental atmosphere and allows us to set personal goals for each one (quote from a resident evaluation: “I think Dr. Prager makes an excellent effort to meet people in their comfort zone and probably does far more for termination training for those that are less comfortable with procedures than taking a more hard-line approach would do. I am very grateful for her thoughtful approach to things"). In clinical settings, I model compassionate, high-quality patient care, providing the residents (or medical students) with tools and words they can use in various – often challenging - clinical situations.

Exposing students to a subject early and often and teaching subject matter in context also improve learning and academic interest. I direct two medical student electives designed to introduce learners to OBGYN in practice settings and get them excited about the field before arriving in the clinic. OBGYN 550 allows students to observe in family planning clinics and also involves some directed reading and an essay test. OBGYN 505 (created and run in collaboration with Vicki Mendiratta), is a clinical preceptorship exposing first and second year medical students to a variety of OBGYN clinical situations. Only these two electives allow clinical exposure to OBGYN prior to the third year.

Teaching is a part of my daily life as an academic clinician, and I enjoy it tremendously. I take very seriously the responsibility and privilege of educating patients, students, residents, colleagues and myself. Given the frequent innovations and discoveries in medicine, both teaching and learning are on-going processes to which I will continue to dedicate my utmost attention.