Teaching Philosophy Statement Example #1

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.

Teaching Philosophy Statement Example #2

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...

Teaching Philosophy Statement Example #3

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.

Teaching Philosophy Statement Example #4

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.