

On Teaching

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I am a clinician-educator in Seattle. I spend about 60 to 70 percent of my time either doing clinical work where I am teaching or in more formal teaching settings like the medical school classroom or in resident teaching sessions. The rest of my time I work on scholarly activity doing limited clinical research and writing. I chose this path because I very much enjoy taking care of patients and find great satisfaction in stimulating curiosity in others about health and disease. I find that whenever I am working with students, the “aha” moment is worth all of the work of preparing cases, talks, or small group activities.

The most important thing that I have learned about teaching of any kind is that you must know the knowledge level of the students you are working with and aim at that level. I have seen miscalculations in this area on many occasions that have led to confusion, frustration, and a definite lack of learning. I will push students to move ahead, but we must start together at a level congruent with their knowledge base.

As far as possible, whether in lecture situations or small groups, I always try to use cases and clinical examples. For instance, when I give the pulmonary mechanics lectures to our second-year students, I constantly intersperse clinical examples and radiographs to explain what compliance and airflow resistance really are and how they are affected in disease processes. A radiograph of a complete pneumothorax does a great deal for the student to understand pressure volume curves of the chest wall and lung.

In the ICU, I have presentations, if at all possible, made at the bedside. Being near to and touching the patients while their history is told establishes a human connection even if they are comatose. Modeling compassion at the bedside is very important to me, equal to the physiologic facts that I teach my team.

“Pimping” of the classic variety by asking minutiae is, in my view, counter-productive. Embarrassing the students will often lead to a lesser likelihood that they will ask questions in the future. Asking questions about clinical scenarios that are more open-ended and allow the student to develop hypotheses are more effective, in my view. It can allow others to join in the discussion more readily so that there is a “team” development of knowledge.

I often give feedback during the rotation as well as at the end, especially if the performance is not up to par. I think it is important to see if development can be achieved during the rotation with some guidance. I always start feedback sessions by asking the students how they feel they are doing. I then emphasize the positive aspects of their care that I have witnessed, finally arriving at areas that need work, and try to establish specific goals and suggest resources that might be helpful. Also, when giving feedback to the housestaff, I include the pulmonary and critical care fellow both to observe and to give his/her input.

Lastly, and perhaps most importantly, I try to share with the trainees experiences that I had at their level to let them know that I was once exactly where they are now, struggled with the same issues, and yet survived to have an academic career based in teaching that has been deeply satisfying.

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