
APPLICATION FOR THE TEACHING
EXCELLENCE AWARD
(AS A DEVELOPING TEACHER)
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ELIZE ARCHER
CENTRE FOR HEALTH PROFESSIONS
EDUCATION
FACULTY OF MEDICINE AND HEALTH
SCIENCES

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1. My Teaching Philosophy

Being an educator is not just what I do; it has become who I am. My own journey of learning has shaped me into the educator I have become; someone with a belief that learning can, and should, challenge how and what we think and therefore what we become. The journey towards becoming a scholar in the field of learning and teaching is a lifetime endeavour and with that in mind my teaching philosophy has evolved over the years. My initial unchallenged, taken-for-granted beliefs about teaching and learning has been questioned over the last decade and gradually triggered more and more critical self-reflection that has led to me having a different understanding of my role as an educator (Cranton, 2006).

My reflection in this portfolio is over the last nine years (2009) since this was really the time that I started to become actively focusing on my teaching portfolio, prior to that my role was more of a manager in the Clinical Skills Unit. My teaching philosophy over this time has moved from a more behaviouristic learning approach to a student-centred approach.

When I was appointed at the FMHS I was the first nurse educator appointed as a lecturer in the Simulation and Clinical Skills Unit (SCSU) and it was a steep learning curve for me to become part of the field of medical education and teaching within the medical curriculum. At the time I was an experienced Critical Care Nurse and tutor for a private hospital group's nursing students and I had previously completed a diploma in Nursing Education. On reflection I realise however that I was still very much trapped in a positivistic and discipline based paradigm and I was completely out of my depth in the Higher Education context. Only after completing my Masters in Higher Education my eyes was opened for the new context I was working in.

My current teaching philosophy rests on the assumption that students learn optimally when they are actively and emotionally involved in their learning and my focus has become rather on how I can provide a conducive learning environment for them instead of me bestowing my knowledge onto them. My teaching philosophy is embedded in the notion of student-centredness; an approach that I believe is closely aligned with the principles of patient-centredness. Patient-centredness is a notion that all medical schools will probably agree to be vital and that medical students should all have by the time they graduate, yet the teaching and learning of it is complex and multifaceted. Patient-centredness can be considered in terms of two key principles; namely caring and sharing (Krupat, Rosenkranz, Yeager, Barnard, Putnam & Inui, 2000). Patients should be cared for by doctors and all other health care professionals (HCP)

in a manner that is respectful, empathic and holistic. In addition, patients should be provided with the opportunity to share in decision-making as far as their management are concerned. Patient-centredness is about understanding the perspective of the patient and allowing patients to share the responsibility of their own health. I believe there are several parallels between a health care provider being patient-centred and a teacher being student-centred. Teachers should see students as individuals and not only as course participants or even worse, as a student number. Furthermore, teachers should be encouraging students to be active in the learning process and share the responsibility for their own learning.

“Education is not the filling of a pail, but the lighting of a fire.” (W Yeats)

Another key element of my teaching philosophy is relationship building, since there are evidence that enhanced student-supervisor relationships and mentoring can increase students' patient-centredness (Krupat, Pelletier, Alexander, Hirsh, Ogur & Schwartzstein, 2009). I therefore strive to develop personal relationships with students by giving attention to their well-being and personal development as far as possible. The attached letter (**Addendum A**) is written by a previous student and gives a sense of how I walked the journey from the student's first year until his final year. I have been lucky enough to walk this path with several students.

The three learning theories that mainly underpin my current teaching philosophy are humanism (Rogers), transformative learning (Mezirow) and constructivism (Piaget). Humanism advocates learning that is student-centred and personalised with the educator acting as a facilitator. All of this should happen in a supportive and cooperative environment. Transformative learning refers to learning that can change learners in deep and lasting ways because it challenges the ways in which students are thinking. Students in some of my sessions where it is possible, are encouraged to use reflection and critical thinking to challenge their underlying assumptions and beliefs. The theory of constructivism postulates that learning is an active, contextualized process of knowledge construction. The construction happens because of personal experiences and hypotheses of the environment. The implication is that each person has a different way of constructing knowledge. The learner is not an empty slate, but has his/her own cultural context and past experiences (Weimer, 2013). My interpretation of student-centred learning supports the theories discussed above as well as the teaching strategies that I have implemented in the modules I convene. Some of the strategies that I use are peer to peer learning, blended learning to enhance a flipped classroom approach, reflection

groups, one-to-one feedback sessions and ultimately I believe in building personal relationships with students wherever possible.

What I realise after reflecting on my personal journey is that my experience with student-centred approaches over the years has transformed the way in which I believe learning happens and what my role as an educator is. I hope that my teaching philosophy and this portfolio will give a picture of where I have come from and where I am at with my teaching career. I have to acknowledge though that I have had wonderful opportunities in working in this institution and I was even more privileged to have had wonderful teachers and mentors that taught me so much. I need to give a special word of recognition and thanks to Prof Susan van Schalkwyk (my current Head of Department) and Prof Ben van Heerden (my previous Head of Department).

See Addendum B for a letter of recognition from Prof van Heerden.

"Ideal teachers are those who use themselves as bridges over which they invite their students to cross, then having facilitated their crossing, joyfully collapse, encouraging them to create bridges of their own." ~ Nikos Kazantzaki

2. Reflective narrative of my teaching and learning practice

This part of the portfolio is about my reflection on the context, students, knowledge and growth and is written from two perspectives: firstly reflecting on my role as an undergraduate clinical skills lecturer; and secondly on my role as a facilitator / supervisor of research students (both under and post-graduate).

2.1 Reflection on context

With regards to my reflection as an undergraduate clinical skills lecturer involved in the MBChB programme I would like to discuss my reflections at various levels.

2.1.1 The macro context

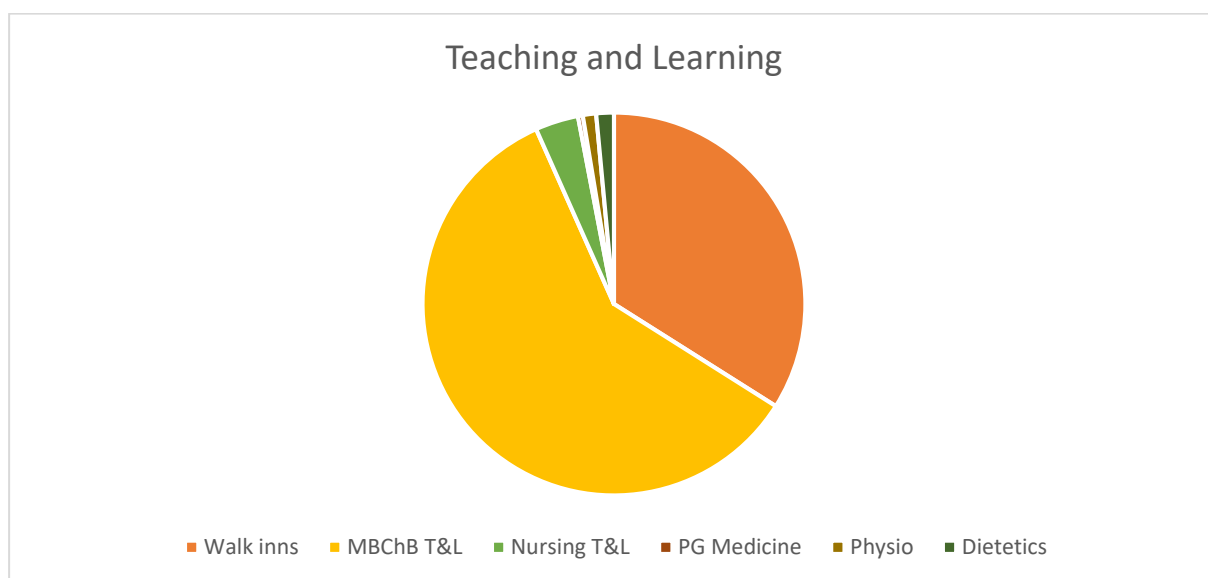
The macro context within which my work resides is one where there is an increasing awareness worldwide in Health Professions Education (HPE) to equip medical graduates with the necessary attributes to fulfil their roles optimally in the workplace and as members of society. The impetus for this drive has been the job market and rapidly changing societies amidst increased globalisation, new technologies and the need for flexible, skilled employees. The global vision for health professionals is that they should be educated to activate knowledge, participate in critical reasoning and technical conduct, and are competent to take part in patient-centred and population-centred health systems (Frenk, Chen, Bhutta, Cohen, Crisp, et al., 2010).

2.1.2 The meso context

The meso context is that of the MBChB programme, a 6-year course with about 260-300 students per intake. The push from the Department of Health to produce increasing numbers of competent medical graduates is a challenge within the context of limited clinical placement opportunities. Furthermore students are placed in clinical areas that are very busy and understaffed, leaving clinicians with little time available for clinical teaching of students. The better we can thus prepare students in simulation with basic knowledge and skills, before they enter the clinical environment, the more beneficial it can be for: the patient (safety); the clinician (they do not have to start teaching from the basics, rather building on what the student already knows); and the student (who can feel more confident to utilize learning opportunities when they arise because they have already practiced the skills in simulation).

2.1.3 The physical context

The physical context where my teaching take place is The Simulation and Clinical Skills Unit (SCSU) at the University of Stellenbosch, Faculty of Medicine and Health Sciences (SUFMHS); a highly resourced learning environment available to all programmes at our faculty. The SCSU forms part of the Centre for Health Professions Education (CHPE) and we proud ourselves in being an academic unit that strives to enhance good quality teaching, learning and assessment practices. There has been a steady increase of usage of the SCSU over the years with and excess of 18 000 students through our doors in 2017. See the diagram below for usage of the SCSU during 2017.



"Walk in" students that come to practice	6357
Teaching of MBChB students	11 114
Teaching of Nursing students	683
Post graduate students (medicine)	76
Physiotherapy	210
Dietetics	279

In order to prepare our students optimally for their clinical placements and interactions with real patients, the MBChB curriculum has two longitudinal Clinical Skills domains (part of a bigger clinical module) that runs over year 3, 4 and 5. The teaching and assessment of these takes place in the SCSU. The design and implementation of the longitudinal clinical skills domains has probably been of my biggest accomplishment in terms of curriculum development. These modules make use of various approaches to enhance student-centred learning, such as videos that have to be watched before the class, peer assessment tools that are available for students in order to critique one another when practising peer to peer clinical skills, formative assessment opportunities, etc. **See Addendum C for an example of the resources available for the students on SunLearn.**

During the simulation sessions in the SCSU the students are taught various clinical skills, but on reflection I have realised that the way in which the teaching sessions have evolved over the years, these practical skills are usually taught without taking patient communication and patient-centredness into account. My PhD study (2013-2016) was in response to the issue described above and was dedicated to understand how students learn, or perhaps do *not* learn, patient-centredness in an undergraduate medical curriculum. In order to understand students' learning experiences, Kelly's (2009) understanding of what a curriculum consist of seems to be useful in that it can provide a holistic picture of curriculum activities. The following aspects were considered: the received and hidden curriculum (from students' perspectives), the taught curriculum (perspectives of lecturers) and the planned curriculum (content of the study guides). What was clear at the end of the study was that students do not learn effectively about patient-centredness in the current MB,ChB curriculum. While there are many possible reasons for this, the most prominent barriers seem to be: a strong current focus on biomedicine, the powerful impact of the hidden curriculum, students' lack of self-efficacy, and lastly, a lack of opportunities to practise patient-centredness with feedback and spaces in the curriculum for reflection (Archer, van Heerden & Bitzer, 2017). In response to the gaps that were identified I applied for the Teaching and Learning fellowship (CTL) and I was fortunate enough to be awarded that. The work that has developed from this in order to enrich the current MBChB curriculum is described in more detail in the next section.

2.2 Reflection on knowledge

2.2.1 Teaching intervention focussed on clinical empathy

Since students have pointed out anecdotally, but also as part of my PhD data collection that they feel inadequate to deliver patient-centred communication (of which empathy is a fundamental part) to their patients I decided to introduce a new teaching session with the 3rd year medical students as part of my fellowship. While patient-centredness is a multifaceted construct and cannot be taught or learned in one or two sessions; it was decided to start with a session focusing on clinical empathy. Clinical empathy in the doctor-patient relationship has been described by Hojat, Gonnella, Nasca, Mangione, Vergare, & Magee (2002) as a concept that has both an affective and a cognitive domain. The cognitive domain is the ability to understand the patient's experiences and feelings and view the outside world from the perspective of the patient. The affective domain is about the ability the doctor has to identify

with the experiences and feelings of the patient. While many medical programmes have incorporated empathy training to some or other degree, there is a lack of literature demonstrating a standard practice or curriculum for effective interventions, so in order to design a teaching session for our context we started off by doing a scoping review of the literature. The article describing this work has been accepted by the *African Journal in Health Professions Education* and it will be published in September 2018. From this work we decided to implement the following innovative teaching strategies as part of our new teaching intervention.

2.2.1.1 Didactic session

During the introduction session the definitions of patient-centred care and empathy, as well as the value of empathy within a therapeutic relationship are presented to the students. It consists of a short didactic session during which the neuroscience of empathy is explained. In preparation for the session the students have to watch two short videos and read an article which underline the importance of empathy in clinical practice.

2.2.1.2 Sharable Content Object Reference Model (SCORM) package

As part of the flipped classroom approach used for the second contact session the students have to watch a SCORM package before they attend the class. This package comprise of a PowerPoint slideshow as well as some videos and theory related to clinical empathy. **See Addendum D for some parts of the SCORM package.**

2.2.1.3 Simulated patient (SP) case scenarios

Students have the opportunity to rotate in small groups of 4-5 students through stations where they can practise clinical empathy skills with simulated patients (SPs) using 4 different patient scenarios. In these sessions students had 7 minutes to engage with an SP and after that they get individual feedback on their interaction from a facilitator, SP and peers.

2.2.1.4 Various practical exercises

Other practical sessions that students are exposed to are listening exercises, charades, perspective-taking and a discussion of mindfulness-based self-care with a short-guided meditation. The listening exercise focuses on active listening skills, while the charade exercise is about non-verbal communication skills and on recognition of emotions and body language. The perspective-taking exercise involves students to understand the perspectives of others and to identify emotions experienced. The mindfulness and self-compassion exercises involve physical and emotional self-care. Finally, at the end of the session all students take part in a group reflection session where they have the opportunity to speak about key learning and how

they plan to implement these into both their personal lives and clinical practice. The photos below were all taken as part of a contact session and shows the various activities utilised.



As an educator and a scholar it is important to be critical all the time and I am currently heading up an evaluation study of these interventions in order for us to see what the students experienced worthwhile and what could be improved for the future. It would seem as the success of the innovation was not only the use of interactive sessions, but also the combination of such a big variety of teaching strategies. See below for some comments extracted from the transcribed focus group interviews. (This is provisionally data, the article on this will be submitted within the next 2 months).

While some students initially thought the sessions will be a waste of their time, they reflected afterwards and said that it was a valuable learning opportunity:

Before the teaching session	After the teaching session
<p><i>"In the beginning when they told us we were going to learn about empathy, I thought well, I mean, we all know how to be empathetic. We have learnt this, we've done it before, we've dealt with patients a little bit, so we should be able to do it."</i></p>	<p><i>"You want to care for people, and this brought me back to that. Because I think I definitely have lost, not a bit of myself, but I have lost a bit of, like gone off track, being so focussed on academics. The session just brought you back."</i></p>

The various learning strategies used in the sessions are intended to engage the students and according to the feedback we are successful in achieving that.

"It was the most fun I had. It was interesting. I learnt actually a bunch of new things. Wow, there are certain ways that you can show other people that you are caring. I found it very helpful, very interesting and I had a lot of fun."

"I particularly enjoyed the session in the skills lab. I think this was particularly nice. It makes it more focussed. I like that it more modern, the technique of how all the sessions went about. This session was definitely thought about quite well, there was new ways of teaching and learning that was implemented, this session really stuck with me. I think generations change."

Students value opportunities they can acquire general life skills and feel cared for.

"I liked that there was that self-care section, because it's always about us taking care of patients and all that stuff. But it was nice to be like actually you also matter and now you are going to try and tackle someone else's issues."

These comments from the students that we received during the focus group interviews gives me a lot of pleasure and has definitely made all the long evenings and early mornings' work and preparation worth the while.

2.3 Reflection on students

The students that I teach in the MBChB programme are generally highly motivated individuals, yet they come from diverse backgrounds such as race, gender, language and schooling systems. Another factor of variance is the fact that some students are more inclined to learn clinical skills (for example technical skills or communication skills) than others. Acknowledging that medicine is a wide field, it is important to recognise that some students will be able to put in sutures on a plastic model after only a single demonstration and practice opportunity, while another student might have to practice this several times before getting it right. The simulation environment however allows us with a safe and stress free environment where students can learn at their own pace without doing any harm or putting patients at risk.



Since all students are required to develop competence with clinical skills by the time they graduate, the Clinical skills domains has several opportunities available for students to learn at their own pace. Students are invited to come and practice at any time that they want to, and for this they are encouraged to bring along a peer with whom they can practice. We have developed peer assessment sheets with a summary of how the skill should be conducted and students are encouraged to practice with the help of these. If however they get stuck, they are welcome to come and call the staff working in the SCSU to assist them, however they have to attempt to do it themselves or ask a peer first **(See Addendum E for an example of a peer assessment sheet available on SunLearn)**.

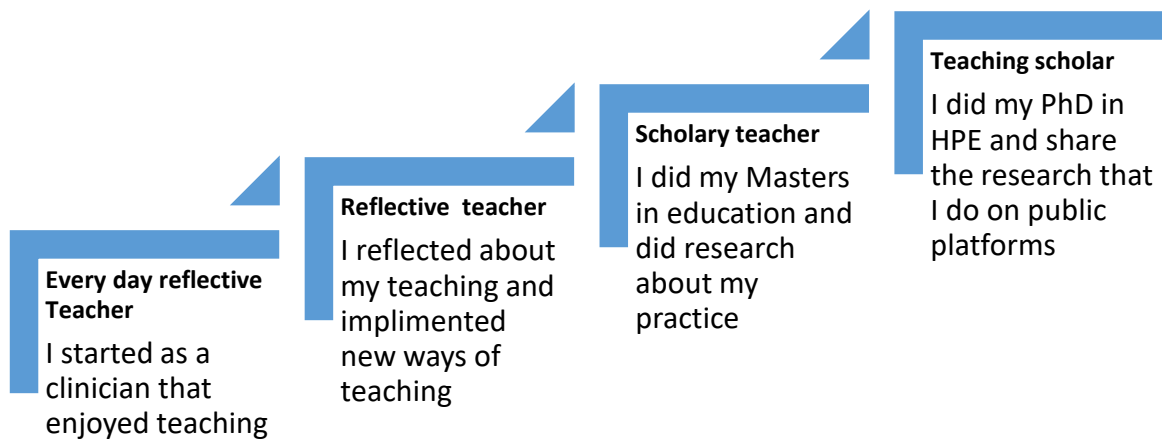
A way in which we have attempted to interest the young generation of students we deal with, was to add technology to our module. Students are asked to record a video of themselves performing a clinical skill and they must then upload this video onto SunLearn as part of their continued assessment marks. In order to allow each student to learn at his or her own pace they can practice as many times as they need to and only upload the video once they feel they are competent in doing the clinical skill. Another very successful opportunity we have created is a formative individual face-to-face session where students make an appointment to perform one of the more difficult clinical procedures so that they can get individual feedback from a clinical tutor. This opportunity was implemented after students were verbalising that they do not get individual feedback in the clinical areas and that they were not sure whether they were performing some of the more difficult clinical skills correctly. While this a very labour intensive activity, we as clinical skills lecturers have experienced the benefits of it over the last 3 years. As described above, the teaching sessions that we as a team of clinical lecturers have implemented in the SCSU over the past years aim to be student-centred and challenge students' way of doing.

See Addendum F for feedback recently given by a MBChB graduate.

2.4 Reflection on growth

2.4.1 Personal growth

My growth into a teaching scholar (see diagram below) can be explained when looking at the growth framework that was published by van Schalkwyk, Cilliers, Adendorff, Cartell and Herman 2013).



I view my scholarship role as a dynamic process and therefore it is required of me to keep on reflecting on my teaching while discussing issues with colleagues and peers. In order to stay a true scholar I need to produce research related to current teaching and learning issues, act as a reviewer for peer reviewed journals, present my research work to peers at conferences and seek to publish it **(See Addendum G for presentations and publications)**.

My journey towards becoming a teaching scholar was greatly fuelled by several FIRLT funded projects and lately the Fellowship for Teaching and Learning from CTL that I was fortunately enough to be awarded.

I also see my regional and national involvement in SAAHE (South African Association of Health Educationalists) as a way in which I publicly share in the community of practice. **(See Addendum H for a letter from the President of SAAHE)**.

2.4.2 Supervisor of undergraduate student research projects

During my own research journey I have been privileged to work with both undergraduate and postgraduate students. The undergraduate MBChB students can do an optional research

project in their final year and I was fortunate to be approached by three students in the past to be their supervisor. In both 2015 and 2016 the student that I supervised won the award for the best research project. I find it very inspiring to see how students move from simply users of knowledge to become contributors of knowledge. One of the students even managed to co-publish an article with me from his research project.

2.4.3 My role in the MPhil in Health Professions Education programme

The MPhil in Health Professions Education (HPE) was implemented in 2008, and more than 50 students have already graduated with this qualification. The MPhil programme spans over two years, and while the students typically complete all their course work on time, they found it difficult to finish the research project in the required time. This was the reason why we embarked on a curriculum renewal process during 2014 and 2015. The 'new' curriculum was implemented in 2016. It is during this same time that I took over the role of the program coordinator. The structure of this new programme was adapted in order to enable students to complete the majority of the core modules during the first year, and then have the bulk of the second year available to complete their research assignments. This should allow more students to complete the programme within the planned two years. A research project for which we received FIRT funding, to evaluate this curriculum renewal is currently in progress, and we will be presenting our results at SoTL in October 2018.

Below are the group photos of our 2018 class.



Class of 2018: Professions represented Dentistry, Medicine, Nursing, Paramedics, Pharmacy & Physiotherapy

To supervise Masters students with their research projects in Health Professions Education is always a humbling and satisfying process for me. The students that enrol in our programme are all people with degrees in either Medicine, Physiotherapy, Nursing, other health professionals. For most of them the territory of Health Professions Education and the qualitative research methodology that often goes with it is foreign. Furthermore, I have often experienced that academic writing in English and tight work schedules are barriers that make it difficult for these students to progress. I have already supervised 16 students successfully and currently have 9 students that I am supervising. When I am reminded by the students of how difficult this journey is for them, I think back to my own and have a lot of empathy. I try to provide a safe space in which they get as much constructive feedback as possible.

Addendum I is an email from a current MPhil student I am co-supervising as well as a letter of recognition from a previous MPhil student.

Addendum J is a table with the MPhil research topics that I have supervised to date.

2.4.4 My role in faculty development as part of the CHPE

During the process of implementing and formalizing the clinical skills modules in the MB,ChB curriculum I soon realised that lecturers also needed guidance and support to enhance their own teaching skills. The fact that many of the lecturers (doctors, physiotherapists, etc.) were good at being clinicians did not mean that they were good teachers and that they necessarily would have the knowledge and skills to assist students to develop their clinical skills. This led to the design of an accredited one day short course in clinical supervision. I then lead an inter-professional team of staff that presented the Clinical Supervision Course from 2008-2013 to the various professionals at the FMHS. During this time we had 273 people attending the course and a few conference presentations and 2 articles were born from this initiative.

What we realised by then was that although the course has been attended by a lot of staff, few of them were medical doctors, yet the biggest programme at our faculty are the MBCB program. During 2014 one of the MPhil students that I supervised did a research study to evaluate a "Registrar- as Trainer" short course that was based on the original short course in supervision. Her results emulated in the implementation at the faculty where this course is presented twice a year and it is compulsory for all Registrars in training (RaT). This course is presented by a small team of clinicians and myself since 2014 and the topics we include in the

half day course are aspects around role modelling as a teaching strategy, the one minute preceptor and how to give effective feedback. up to date we have trained 105 Registrars in the RaT course.

2.4.5 Concluding comments

Finally, I acknowledge that the compilation of this portfolio and the reflection that went along with it made me realize that I have been blessed with wonderful mentors, colleagues and opportunities. The Teaching and Learning fellowship from CTL has also been a wonderful enabler. Looking back over the last two years of having this Fellowship I am very grateful that I am able to report that am able to build the scholarship around the teaching and learning of empathy (and patient-centredness). Looking forward my next goal with this work is to develop a faculty development plan so that the students' role models (lecturers and clinicians) can also display the attitudes and skills we require of the undergraduate students.

Please click on the link here to see the [Article](#) that was recently posted on the SU website about my PhD and my SU Fellowship.

When people get asked about success in their careers some might say that they were lucky to achieve it, I however agree with the wise words of Colin Powell *"There are no secrets to success. It is the result of preparation, hard work, and learning from failure"*.

Thanks for the opportunity to apply for the Teaching Excellence award.

Elize Archer



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See separate document for my Addendums

Addendum A: A letter from a previous MBChB student: Koot Kotze

Addendum B: A letter of recognition from Prof van Heerden

Addendum C: Example of content on SunLearn for the Clinical Skills

Addendum D: Extracts from the Empathy SCORM package

Addendum E: Example of a peer assessment tool used in the SCSU

Addendum F: Feedback from students about the Clinical Skills domain

Addendum G List of presentations and publications

Addendum H: Letter from the SAAHE president: F Celliers

Addendum I: Letters from MPhil students

Addendum J: List of past MPhil student projects that I supervised