



Paul Rogers lets students make mistakes in a safe setting. His critical care simulation course has the highest enrollment of any Pitt med elective.

PERCHANCE TO TEACH

INTERVIEW BY MAUREEN PASSMORE

As a medical educator, Paul Rogers isn't in a class by himself, but as the University of Pittsburgh's first recipient of the Robert J. Glaser Distinguished Teacher Award from the Alpha Omega Alpha medical honor society and the Association of American Medical Colleges, which selected the MD for this national award in 2008, he clearly stands apart.

Rogers, the Ake and Inger Grenvik Professor of Critical Care Medicine and Education, is also director of the School of Medicine's Multidisciplinary Critical Care Training Program, a founding member of its Academy of Master Educators, vice president of the VA Pittsburgh Healthcare System, and director of the surgical care unit at the Veterans Affairs Medical Center. His critical care simulation course has the highest enrollment of any elective course in the School of Medicine.

Here he reflects on what he does so well.

Where did your path in medical school education begin?

I had no idea that education would end up being such a large part of my job. When I started here in 1987, the chair of our department asked if I would develop a fourth-year elective in critical care medicine—one didn't exist at that time. I had no idea how to go about teaching. I learned from several of my mentors here how to create a curriculum so that it fit adult learners and wasn't a typical didactic session. I sort of lucked into this role because, back in the early '90s, the anesthesia department got [Pitt's] first human simulator, and I thought it would be a great tool to use with teaching.

We could create rare, life-threatening situations that students could go perhaps their whole careers in medical school and never see until they're expected to manage such situations as interns. There's a difference between sitting in a classroom, taking notes, and watching a PowerPoint presentation and actually being in a simulated crisis situation where the mannequin can reproduce physiology so that, if you're doing the right management, it will respond appropriately. When I first started, I was teaching maybe 20 to 25 students a year, and now I teach 120 or more per year. We cover things from patients with critical illnesses to more common cases, and the students learn communication skills

and motor skills with various pieces of equipment. It's very lifelike. The more they practice, the more confident they are in any situation, and that's what medical education should be about—training in a manner that's safe for our patients and that doesn't allow students to get into trouble. I just wish we'd had it when I was in my training.

What do you think makes you successful as an educator?

I just remember how I wanted to be treated as a student, and I try to hang on to those values of respecting the students, respecting their time, wanting to see them succeed, and not wanting them to fail at all. I can remember some of the things that happened to me, and I want to make sure these students don't end up in the same kind of situations. Most of the scenarios we simulate in class happened to me at some point in my training.

What are some of the challenges facing medical education today?

One is finding the time to be able to teach. Actually, the University of Pittsburgh has some unique opportunities that have allowed me to be a successful teacher. The dean's educational credit units reimburse departments for the hours their faculty members teach. So, I get freed up for an hour a day. Another thing that is a challenge, but that Pitt does well, is recognizing and promoting people based on teaching effectiveness. When I started here, people told me that I'd never be promoted if I wanted to teach. Now, with the educational track, if you create curricula and have a means of evaluating their effectiveness, you can be recognized for that here. They've created the Academy of Master Educators to recognize good teachers. I gave a talk at the Society of Critical Care Medicine [in 2009] on the importance of valuing the teacher in the academic setting, and most people who spoke with me did not have the same situation I have. I was hearing more people speak of teaching out of obligation at the end of their shifts; it's not woven into the fabric of their day. Not everyone is so lucky.

Have medical students changed since you first started teaching?

I don't think so. They all have a great fear that suddenly, at the end of the fourth year, they won't know all there is to know. And I tell them that's okay; they'll be learning the rest of their careers. The only thing they have to remember is that there are people around them who know more than they do, and they should feel free to go to those people and ask for guidance.

Do any particular teaching moments stand out for you?

I hear a lot from former students that they've found themselves in real-life situations where none of the other interns knew what to do and hadn't experienced anything like it before, but they did because we had gone over it in the simulations. I'm very fortunate because I don't have to convince students that they need to learn these basic management skills. I know that it works because I get plenty of e-mails from people saying how they had to deal with someone who had, say, respiratory distress, and all the stuff we talked about in class came back because we had practiced it so many times.

What are your goals now as an educator?

Well, I used to say that I'd retire when I was 50—but 50 got here in a hurry! What I would like to do, and have had opportunities to do, is mentor junior faculty so that when I do retire, this method of teaching continues. It's a style that anybody who wants to put time into being an educator can do. They just have to be given the resources and opportunity. I have a pact with students not to embarrass them; my goal is to let them make mistakes in an environment where it doesn't hurt anyone. They tell me that they want to see the consequences of their decision-making played out, so they can see what happens if they don't manage patients' care correctly.

So, I tell them on day one that this is their opportunity to show me what they don't know, and they need to feel comfortable getting up and making mistakes because it's a much better place to make a mistake than in the real world.

If you think about being able to teach one person to do something better than you did when you were an intern, it is a rare opportunity. The chance to teach 100 or more people to do something better is an honor. ■