

Faculty Development and Evaluation of Teaching Performance

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Thinking about faculty development usually conjures up a variety of available approaches to improve skills as a teacher, especially those national or regional faculty development workshops, where experts can hold forth on the content or process of teaching. Further consideration might raise other possible approaches to faculty development, even including local workshops or other structured efforts to improve the quality of teaching. It is not likely, however, that *evaluation* of teaching performance will be considered initially as a first-line method of faculty development. The opposite connotation of evaluation is more often evoked—an onerous burden, sporadically applied, involving the occasional collection and filing of routine evaluation forms partially filled out by medical students and/or residents in training.

The systematic evaluation of teaching performance represents a simple, readily available, and powerful method of faculty development. Its potential, however, has been neglected by many teaching programs for a number of reasons. Learners may see the completion of evaluation forms as a burdensome task of low priority. They may doubt that candid feedback will result in improvement of faculty teaching, and they may not want to risk alienating a faculty member by critical comments. Some faculty members may not be comfortable with constructive criticism of their teaching skills, and a larger number may be reticent to actively seek such evaluation. Program directors and de-

partmental chairmen may relegate evaluation of teaching performance to a low priority compared with the many pressing needs and demands elsewhere in the patient care system and teaching program. They may also be reluctant to address known problems in faculty performance or to identify additional problems of this kind. Further, there are questions concerning confidentiality to be considered, such as where are the reports to be filed, who has access to them, and how are the results used? For these reasons, many teaching programs employ intermittent and ineffective evaluation of faculty performance, often without a consistent feedback loop to faculty members.

These problems are common throughout medical education irrespective of specialty lines. The University of Washington School of Medicine recently addressed this problem by appointing a task force to make specific recommendations for providing systematic evaluation of faculty teaching performance on an ongoing departmental basis. As a result, many departments have now implemented various kinds of regular evaluation procedures. In the Department of Family Medicine, for example, mechanisms have been established for regular evaluation and feedback of faculty teaching performance at all levels, including periodic ratings by learners (medical students, residents, Fellows, practicing physicians) and by faculty colleagues. Peer review of teaching performance is now a required part of the assessment and documentation

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of an individual faculty member's qualifications at the time of promotion and/or tenure decision. In order to simplify the process of faculty evaluation, Dr. Michael Gordon has developed an *Academic Activities Notebook*, which includes a summary of teaching activities, copies of all teaching evaluations, plans and projected timetables for career development, regularly updated curriculum vitae, and other materials which are needed to support qualifications for promotion when they are needed. (Descriptive materials are available on request from Michael Gordon, PhD, Department of Family Medicine RF-30, School of Medicine, University of Washington, Seattle, WA 98195.) Evaluation materials are confidential, except for review by the departmental chairman, and it is the responsibility of each faculty member to maintain his/her file. This simple mechanism facilitates ongoing, useful faculty evaluation with built-in mechanisms for improvement of teaching in both content and process.

In this issue, an excellent paper by Whitman and Schwenk describes an innovative approach to clinically evaluate teaching performance as a regular part of faculty development. They apply the medical model to evaluate the teaching performance through the equivalent of history, physical examination, and laboratory tests, followed by treatment based on the diagnosis of specific deficits.¹

Evaluation of teaching performance deserves more emphasis than most of us have given it in the past. Fortunately, the medical educators are showing us better ways to include the regular evaluation of teaching performance as an integral part of faculty development. Family medicine can and should take a leadership role toward improving the quality of clinical teaching through meaningful faculty evaluation based upon candid feedback from peers and learners at all levels. Concerted emphasis upon this important area can have salutary effects on the quality of patient care, teaching, and learning as well as facilitate personal growth and increased satisfaction of clinical teachers.

Reference

1. Whitman N, Schwenk T: Faculty evaluation as a means of faculty development. *J Fam Pract* 14:1097, 1982

Coly-Mycin® S Otic with Neomycin and Hydrocortisone

(colistin sulfate—neomycin sulfate—thonzonium bromide—hydrocortisone acetate otic suspension)

INDICATIONS AND USAGE

For the treatment of superficial bacterial infections of the external auditory canal, caused by organisms susceptible to the action of the antibiotics; and for the treatment of infections of mastoidectomy and fenestration cavities, caused by organisms susceptible to the antibiotics.

CONTRAINDICATIONS

This product is contraindicated in those individuals who have shown hypersensitivity to any of its components, and in herpes simplex, vaccinia and varicella.

WARNINGS

As with other antibiotic preparations, prolonged treatment may result in overgrowth of nonsusceptible organisms and fungi.

If the infection is not improved after one week, cultures and susceptibility tests should be repeated to verify the identity of the organism and to determine whether therapy should be changed.

Patients who prefer to warm the medication before using should be cautioned against heating the solution above body temperature, in order to avoid loss of potency.

PRECAUTIONS

General

If sensitization or irritation occurs, medication should be discontinued promptly.

This drug should be used with care in cases of perforated ear drum and in longstanding cases of chronic otitis media because of the possibility of ototoxicity caused by neomycin.

Treatment should not be continued for longer than ten days.

Allergic cross-reactions may occur which could prevent the use of any or all of the following antibiotics for the treatment of future infections: kanamycin, paromomycin, streptomycin, and possibly gentamicin.

ADVERSE REACTIONS

Neomycin is a not uncommon cutaneous sensitizer. There are articles in the current literature that indicate an increase in the prevalence of persons sensitive to neomycin.

DOSAGE AND ADMINISTRATION

The external auditory canal should be thoroughly cleansed and dried with a sterile cotton applicator.

For adults, 4 drops of the suspension should be instilled into the affected ear 3 or 4 times daily. For infants and children, 3 drops are suggested because of the smaller capacity of the ear canal.

The patient should lie with the affected ear upward and then the drops should be instilled. This position should be maintained for 5 minutes to facilitate penetration of the drops into the ear canal. Repeat, if necessary, for the opposite ear.

If preferred, a cotton wick may be inserted into the canal and then the cotton may be saturated with the solution. This wick should be kept moist by adding further solution every 4 hours. The wick should be replaced at least once every 24 hours.

HOW SUPPLIED

Coly-Mycin S Otic is supplied as:
N 0071-3141-08—5 ml bottle
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Each ml contains: Colistin sulfate equivalent to 3 mg of colistin base, Neomycin sulfate equivalent to 3.3 mg neomycin base, Hydrocortisone acetate 10 mg (1%), Thonzonium bromide 0.5 mg (0.05%), and Polysorbate 80 in an aqueous vehicle buffered with acetic acid and sodium acetate. Thimerosal (mercury derivative) 0.002% added as a preservative.

Shake well before using.

Store at controlled room temperature 59°-86°F (15°-30°C). Stable for 18 months at room temperature; prolonged exposure to higher temperatures should be avoided.

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