CME Course: Faculty Teaching Rounds
Department of Medicine
Beth Israel Medical Center

Introduction to the Course

Serving as ward teaching attending occurs within the context of a CME course we have set up. The course centers around faculty development and practice of teaching and evaluation skills.

The course is designed to provide you with instruction and support materials to enhance your teaching skills, and venues in which to implement and reflect upon using these skills.

The course is approved for up to 27 AMA PRA Category 1 credits.

You will need to fill out the enclosed CME form and fax it to the IM Program Office at 212-420-4615 in order to receive your CME credits.

To complete the course and receive your CME, you should:

1. Attend and participate in the course sessions, which are:
    a. Beginning of the block meeting.
    b. 9 am Monday conferences in 18 Baird Hall Conference Room.
    c. Daily teaching rounds.
    d. End of the block meeting.
2. Review the course materials in this packet.
3. Review additional course materials and expectations on our website, www.bimcmedicine.org (click on the "Faculty" at top center of screen, and then follow appropriate link). USERNAME: "BIMC" PASSWORD: "TODAY"
4. Complete your house staff and medical student evaluations.
5. Complete one Mini-CEX direct observation exercise for each internal medicine house officer on your team and log this on New Innovations.
6. Complete and return the CME form by fax to the IM Program Office at 212-420-4615.

Questions about evaluations or New Innovations should be directed via email to Joan Neufeld at Jneufeld@chpnet.org

Thank you for the time and effort you put into training our house staff. The Program welcomes your feedback and suggestions on this CME course and ways to make it better.

Daniel I. Steinberg, MD
Program Director

Beth Israel University Hospital and Manhattan Campus for the Albert Einstein College of Medicine

Continuum Health Partners, Inc.

RSS Title: Medicine Faculty Teaching Rounds Series **Date:** Recurring

Topic/Speaker: IM Program Directors and Selected Faculty

Session Objective: Improving the quality of resident and medical student teaching and evaluation

TO RECEIVE CME CREDIT: PLEASE COMPLETE AND FAX BACK TO THE INTERNAL MEDICINE RESIDENCY PROGRAM OFFICE AT 212-420-4615

Beth Israel Medical Center designates this educational activity for a maximum of *27 AMA PRA Category 1 Credits™*. Physicians should only claim credit commensurate with the extent of their participation in the activity.

- **I ATTEST THAT I HAVE ATTENDED THE FOLLOWING SESSIONS (Please TALLY UP the credits earned)**

- **Attended the Beginning of Block Session** _____ **(1 AMA Credit)**
- **Reviewed the Course Materials** _____ **(1 AMA Credit)**
- **Participated in the 9am Monday conferences** _____ **(1 AMA Credit each x 4 max)**
- **Provided teaching rounds each day other than Monday** _____ **(5 AMA Credits/week x 4 max = 20)**
- **Participated in the End of Block Session** _____ **(1 AMA Credit)**

- **I ATTEST THAT I HAVE FILLED OUT MY HOUSE STAFF AND STUDENT EVALUATIONS _____ YES (Required)**

- **I ATTEST THAT I HAVE EARNED (TOTAL OF ABOVE) _____ CATEGORY 1 AMA/PRA CREDITS FOR ATTENDING THIS COURSE.**

- **DATES OR BLOCK THAT YOU TOOK THE COURSE** _____

- **PRINT YOUR NAME:** _____
  (IF ILLEGIBLE, WE WILL BE UNABLE TO PROVIDE CREDIT)

- **SIGNATURE:** _____

Regularly Scheduled Series (RSS) Session Evaluation

1. I will make changes to **my teaching of trainees** based on what I have learned. ☐ Yes ☐ No

2. I will make changes to **my clinical practice** based on what I have learned. ☐ Yes ☐ No

3. List at least one change/application to your teaching or practice that you plan to make:

4. Did you find the course materials **educational**? ☐ Yes ☐ No

5. Did you **implement** the course materials during the course? ☐ Yes ☐ No

6. Were the sessions **balanced and free of commercial bias**? ☐ Yes ☐ No

CME CREDIT WILL NOT BE ISSUED UNLESS THIS FORM HAS BEEN COMPLETED

Teaching Attending Rounds Schedule
2011—2012 Academic Year

Attending Teaching Rounds Options	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
Observe Handoff	7:00-7:30am	7:00-7:30am	7:00-7:30am	7:00-7:30am	7:00-7:30am
Walk and Work Bedside Teaching Rounds	7:30-8:30am	7:30-8:30am	7:30-9:00am	7:30-9:00am	7:30-9:00am
				(NOTE: AM Resident Report 8:00-9:00am)	
		(NOTE: Grand Rounds 8:30am-9:30am)			
Multidisciplinary Attending Rounds/Teaching Conference	12:00-1:00pm				
Other Teaching Time Options:	2:00-3:00pm 3:00-4:00pm	9:30-10:30am 2:00-3:00pm 3:00-4:00pm	9:00-10:00am 2:00-3:00pm 3:00-4:00pm	9:00-10:00am 2:00-3:00pm 3:00-4:00pm	9:00-10:00am 2:00-3:00pm 3:00-4:00pm

General Information:

1. Daily requirement of 1 hour per day, Monday to Friday.
2. Flexible teaching schedule to accommodate faculty and residents' schedules:
   - Many options—work with your resident to plan what works best for the team
   - **Early Morning (730am to 9am) or Afternoon (after 2pm) rounds preferred**
   - Avoid afternoon rounds when all team members cannot be present, including students
   - Avoid afternoon rounds on admitting days

4. GOALS
   - As much bedside teaching as possible.
   - As much direct observation of history and physical exam skills as possible.
   - Joining morning work rounds is an ideal teaching venue—allows for direct observation and demonstration of H+P skills, teaching on the fly, brief and practical management related literature/article reviews, case presentations, etc.

Department of Medicine
Internal Medicine Residency Training Program
Beth Israel Medical Center

Faculty/Resident Interdisciplinary Case Conference
Faculty Guidelines

WHEN: 12:00 pm every Monday
WHERE: 18 Baird Hall Conference Room

1. **Please be on time.** We start promptly **at 12pm.**
2. **Please sit near the front** of the room.
3. **Please do not interrupt the residents** while they are presenting**.**
4. **Save teaching points until the end of each presentation.** EKGs and imaging can be commented on as they are presented, as appropriate.
5. **Presenters change on the quarter hour** (15 minutes per case.)
6. If you ask for facts or information, explain why you are doing so.
7. Focus on the **assessment and plan**, in particular the residents' differential diagnosis and management decisions.
8. **Cite evidence** and clinical trials whenever possible.

THANK YOU

YOUR PARTICIPATION IS MUCH APPRECIATED!

Department of Medicine
Beth Israel Medical Center

Feedback in Medical Education: Definition, Importance and Techniques

What is the difference between feedback and evaluation?

Feedback is given throughout a rotation and provides the learner an opportunity to demonstrate improvement. **Evaluation** is done at the end of a rotation and is final; there is no chance for the learner to demonstrate improvement.

General principles of giving feedback

You gotta say it! Say: "I'd like to give you some feedback." Saying the word feedback clearly every time helps it register with the learner that they are receiving feedback.

ASAP: Give feedback as soon as possible. Preferably the same day an issue is noted. This gives learners the most time to implement it and demonstrate improvement. Patient safety may depend on timely feedback.

Check: Check that the expectation was understood. Have the learner tell you what the expectation or plan was. If people aren't clear on what they need to do, they can't do it. Also, asking "is everything ok today?" before giving feedback on poor performance may reveal important information (fatigue, issue in one's personal life, etc.)

Be specific: Never say "Great job" or "You need to be more organized." These are vague and not helpful. Instead, try "Great job identifying the S3 heart sound, your knowledge of the surface anatomy and how to elicit the sound was spot on." Or "I see that you didn't check the SMA-7 or order the CT scan as we had discussed on rounds this morning. We identified these as priorities on rounds. I think you may need to be more organized—let's review your to do list together."

Make a sandwich: Point out something positive the learner is doing, then give constructive/negative feedback, then provide clear suggestions for improvement. This is called the "feedback sandwich."

Advertise or privatize: Give positive feedback to a learner in front of others and give constructive/negative feedback one on one in private.

Tell someone! The Residency Program loves to receive positive feedback about our trainees. We often will put this into letters for fellowships or jobs. Also, we need to know about trainees that are not responding to feedback, so that additional evaluation and support can take place.

Specific and detailed comments on performance evaluations are critically important for trainee development. AND….peer and faculty comments are (appropriately) excerpted and put into letters for fellowship and jobs!

Two Approaches to Questioning Trainees on Teaching Rounds

Beth Israel Medical Center
Internal Medicine Residency Training Program

1. <u>Socratic questioning</u> develops a learner's understanding through questions that "bring the trainee along", or clearly "show the way" to the answer. Successive questions are linked in such a way that understanding is built as each question is answered. There is a narrative or story-like feel.

In Socratic questioning, **a wrong answer is the fault of the teacher, not the learner.** The answers to questions should be obvious and intuitive. Asking "guess what I am thinking" questions, or those in which the answer is unclear, are sometimes called the "traumatic Socratic" method; this should be avoided.

2. <u>Questioning for knowledge</u> is used to assess a learner's baseline, or to evaluate how well the teacher has taught previously covered material. Questions that assess knowledge of diagnostic, therapeutic or other approaches to situations are very useful. Factual recall questions can be very helpful in assessing knowledge, but these should be clinically relevant, appropriate for training level, and not used exclusively.

Example: (The type of question is labeled after each, **S** = Socratic, **K** = knowledge)

Teacher: *"So I see that Mrs. Jones, our patient with lymphoma, has a deep vein thrombosis. How do you want to treat her acutely?"* **K**

Learner: "I'm not sure if I should use IV unfractionated heparin or enoxaparin. I know that it's one of those, though."

Teacher: *"Good. Those are indeed our two options. Let me ask you this: if you had a choice between two therapies, and one was known to be better, which would you pick?"* **S**

Learner: "The one that is known to be better, of course."

Teacher: *"Certainly. But "better" is a little vague, I am sure you agree. Let's try to define what we mean a bit: what types of clinical outcomes are we trying to prevent when we treat a patient with a DVT? In other words, what <u>don't</u> we want to have happen to this patient?"* **S**

Learner: "Well, we don't want the patient to get a PE, or another DVT for that matter. I guess we also don't want the patient to die of a PE or need intubation."

Teacher: *"All great points. So would you agree that the "better" treatment for Mrs. Jones is the one that we know prevents some or all of those?"* **S**

Learner: "Sure, yes."

Teacher: *"And where might we find information on how unfractionated heparin compares with enoxaparin for the treatment of DVT?"* **K**

Learner: "In the literature? I know there are clinical trials."

Teacher: *"There sure are. Now, there are many kinds of clinical trials, right? What type of clinical trials or reviews would provide us the most reliable information?"* **K**

Two Teaching Tools

Beth Israel Medical Center
Internal Medicine Residency Training Program

The One Minute Preceptor Model

1. **Get the learner to commit. (this is the critical and most important step)**

   Example: A patient presents with acute right knee pain and swelling.

   "What do you think is going on?"

   Best answers are specific: "I think this patient has acute gout. Cellulitis, DVT or a fracture are less likely."
   Some are less focused: "It could be inflammatory, it could be trauma, or infection"

2. **Probe for supporting evidence.**
   "Why do you think that is what is going on?"
3. **Reinforce what was done well.**
   "Your reasoning is great; fever and cough with crackles on exam do point to pneumonia"
4. **Give guidance on errors or omissions.**
   "Remember to listen in the right mid-axillary line to auscultate the right middle lobe."
5. **Teach a general rule.**
   "In patients with community acquired pneumonia, systolic BP less than 100 is associated with a five fold increase in mortality, so you must always take it very seriously."

The "Why, Why, Why…" Model

This approach probes for reasoning by asking the question "Why?" repeatedly until the underlying cause of a process is revealed to the learner.

In the example below, the underlying cause of DKA in a patient is revealed, and the "treatment" for this patient's DKA is actually to start methotrexate…..

Learner: "So in summary this is a 52 year old male with DM2 and rheumatoid arthritis, who presents in diabetic ketoacidosis."
Teacher: *"Why do you think they are in DKA?"*
Learner: "I think its non compliance with his insulin."
Teacher: *"Certainly possible. Why is the patient not taking his insulin?"*
Learner: "The patient says he can't manipulate the syringes well."
Teacher: *"Why might that be?"*
Learner: "He said his hands get too sore and painful."
Teacher: *"I see you've taken a careful history, which is great. Why might his hands be hurting?"*
Learner: "His rheumatoid arthritis could be out of control."
Teacher: *"That's an excellent thought. Why might his RA symptoms be uncontrolled?"*
Learner: "Hmmm…he doesn't seem to be on methotrexate, we should probably consider starting it"
Teacher: *"I agree. Why would you pick methotrexate for this patient?"*……

CME Course: Faculty Teaching Rounds
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Assessment and Evaluation by the 6 ACGME Core Competencies

1. Patient Care

"Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health***."***

Ways to evaluate: H+P skills and accuracy, patient assessments and plans/medical decision making, resident admission notes, counseling, leadership and team management skills.

2. Medical Knowledge

"Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social behavioral sciences, as well as the application of this knowledge to patient care."

Ways to evaluate: Quality of differential diagnoses, ability to appropriately select and interpret basic tests, knowledge of medications and other therapies, IM "core content" knowledge.

3. Practice-based Learning and Improvement

"Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning."

Ways to evaluate: Able to implement feedback into practice? Awareness of strengths and weaknesses? Use of information technology, ability to search, appraise, and apply literature to clinical practice. Inquisitiveness, willing to look things up.

4. Interpersonal and Communication Skills

"Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals."

Ways to evaluate: Observation of communication skills with patients, families, social workers, nurses or other physicians; ability to work as part of a team or be a leader, clarity and timeliness of notes, quality of discharge summaries and instructions, clarity of topic/case presentations.

5. Professionalism

"Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles."

Ways to evaluate: Compassion, integrity, respect for colleagues and for patient privacy/autonomy; sensitivity to age, religion, race, culture, gender, sexual orientation differences; responsiveness to patient needs, accountability to patients, peers and the profession.

6. Systems-based Practice

"Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care."

Ways to evaluate: Ability to work in a multi-disciplinary team, coordination of inpatient with outpatient care, commitment to patient safety and quality improvement, apply cost, risk/benefit and resource allocation considerations to practice.

Source: ACGME Program Requirements for Graduate Medical Education in Internal Medicine, July 1, 2009, www.acgme.org

Department of Medicine
Beth Israel Medical Center
Faculty Development Workshop

Assessment and Evaluation of Trainees by the ACGME Core Competencies

Please circle the Core Competencies that can be assessed and evaluated in each scenario:

1. Observing a resident inform a patient that they have colon cancer.

Patient Care Medical Knowledge Practice Based Learning and Improvement Interpersonal/Communication Skills
Professionalism Systems Based Practice

2. Reviewing a resident's discharge summary.

Patient Care Medical Knowledge Practice Based Learning and Improvement Interpersonal/Communication Skills
Professionalism Systems Based Practice

3. Listening to a case presentation that includes a reference to a randomized controlled trial.

Patient Care Medical Knowledge Practice Based Learning and Improvement Interpersonal/Communication Skills
Professionalism Systems Based Practice

4. Giving a resident feedback that they missed a few important things on a physical exam

Patient Care Medical Knowledge Practice Based Learning and Improvement Interpersonal/Communication Skills
Professionalism Systems Based Practice

For each scenario, circle the Core Competencies in which problems exist.

5. A resident is late for rounds repeatedly, despite feedback by you that they should be on time.

Patient Care Medical Knowledge Practice Based Learning and Improvement Interpersonal/Communication Skills
Professionalism Systems Based Practice

6. A resident calls for a consult and is not able to summarize the case or clearly formulate a question.

Patient Care Medical Knowledge Practice Based Learning and Improvement Interpersonal/Communication Skills
Professionalism Systems Based Practice

7. Resident punctures brachial artery when drawing blood, but doesn't mention this in the procedure note.

Patient Care Medical Knowledge Practice Based Learning and Improvement Interpersonal/Communication Skills
Professionalism Systems Based Practice

8. A resident does not time their progress note.

Patient Care Medical Knowledge Practice Based Learning and Improvement Interpersonal/Communication Skills
Professionalism Systems Based Practice

CME Course: Faculty Teaching Rounds
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Recognizing Sleep Deprivation and Fatigue in Trainees

The ACGME requires that the faculty be educated on recognizing the signs and symptoms of sleep deprivation and fatigue.
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1. What are the signs and symptoms of sleep deprivation and fatigue?

American Academy of Sleep Medicine Signs and Symptoms of Sleep Deprivation and Fatigue

--Falling asleep in conferences or teaching rounds (environment can unmask sleepiness but does not cause sleepiness)
--Feeling restless or irritable with people
--Having to check your work repeatedly
--Difficulty focusing on the care of your patients
--Feeling like you just don't care

There is a power presentation from the American Academy of Sleep Medicine on the www.bimcmedicine.org website for your review.

2. What is the Internal Medicine Training Program's process for handling trainee sleep deprivation and fatigue?

If they are too tired to continue work or to get home safely, house staff should report this to either their immediate supervisor (resident or fellow), the chief medical resident on call, their faculty supervisor, or one of the program directors.

Arrangements will be made to remove the house officer from duty and provide them time to sleep.

We have a "**NO FAULT, NO BLAME, NO QUESTIONS ASKED"** policy regarding those house officers who self report that they are too fatigued to continue work or get home safely.

If you suspect a trainee is too fatigued to work or return home safely, please discuss it with them. Alternatively, you can notify the chief medical residents or the any of the program directors.

Improving Bedside Teaching: Findings from a Focus Group Study of Learners

Keith N. Williams, MD, MSME, EdM, Subha Ramani, MBBS, MMEd, MPH, Bruce Fraser, PhD, and Jay D. Orlander, MD, MPH

Abstract

Purpose
Literature reviews indicate that the proportion of clinical educational time devoted to bedside teaching ranges from 8% to 19%. Previous studies regarding this paucity have not adequately examined the perspectives of learners. The authors explored learners' attitudes toward bedside teaching, perceptions of barriers, and strategies to increase its frequency and effectiveness, as well as whether learners' stages of training influenced their perspectives.

Method
Six focus group discussions with fourth-year medical students and first- or second-year internal medicine residents recruited from the Boston University School of Medicine and Residency Program in Internal Medicine were conducted between June 2004 and February 2005. Each 60- to 90-minute discussion was audiotaped, transcribed, and analyzed using qualitative methods.

Results
Learners believed that bedside teaching is valuable for learning essential clinical skills. They believed it is underutilized and described many barriers to its use: lack of respect for the patient; time constraints; learner autonomy; faculty attitude, knowledge, and skill; and overreliance on technology. Learners suggested a variety of strategies to mitigate barriers: orienting and including the patient; addressing time constraints through flexibility, selectivity, and integration with work; providing learners with reassurance, reinforcing their autonomy, and incorporating them into the teaching process; faculty development; and advocating evidence-based physical diagnosis. Students focused on the physical diagnosis aspects of bedside teaching, whereas views of residents reflected their multifaceted roles as learners, teachers, and managers.

Conclusions
Bedside teaching is valuable but underutilized. Including the patient, collaborating with learners, faculty development, and promoting a supportive institutional culture can redress several barriers to bedside teaching.

Acad Med. 2008; 83:257–264.

> There is a general uneasiness both in the minds of the public and also in the practicing physician, that future specialists in internal medicine will become mostly reliant on laboratory, computerized, nonpersonal techniques of management, and the patient as a human being with emotional and psychological aspects will be forgotten. If such physicians are to come into being, it must be due to the kind of training and environment to which they are exposed in their years in medical school.
>
> —L.H. Nahum

Bedside teaching, clinical teaching done in the presence of a patient, has been a fundamental component of medical training in the United States since the institution of modern methods of instruction in the late 19th century. Although few data exist regarding the effectiveness of bedside teaching, many medical educators espouse its value in training physicians.[1–17] It seems logical to assume that clinical skills related to physician–patient communication, physical examination, clinical reasoning, and professionalism are better learned at the bedside than in a classroom. Nevertheless, the proportion of clinical educational time devoted to bedside teaching has ranged from 8% to 19% since the 1960s.[18–23] Although medical educators have speculated on the reasons for this paucity, few studies have examined the issue systematically. Existing studies have had a limited scope or have explored bedside teaching only from the perspective of teachers.[24–28] Although numerous guidelines advocating specific bedside teaching strategies have been published, it is unclear whether the perspectives of learners influenced their development.[29–42]

Learners are likely to have unique and valuable perspectives on bedside teaching; any effort to increase or improve bedside teaching should consider their views. Our objectives were to explore learners' attitudes toward bedside teaching, perceptions of barriers, and strategies to increase its frequency and effectiveness. We included learners at different stages of training to assess whether experience influenced perspective.

Method

With the exception of the principal investigator (K.W.), all coinvestigators had qualitative research experience before the conduct of this study, and one (B.F.) taught a graduate course on qualitative research. We conducted six focus group discussions between June 2004 and February 2005 with students from the Boston University School of Medicine and residents from the Boston University Residency Program in Internal Medicine. All prospective participants received an e-mail letter of invitation. Participation was voluntary and confidential, and verbal consent was obtained from all participants. We audiotaped discussions and transcribed them verbatim. The institutional review board of the Boston University Medical Center approved the research protocol.

Please see the end of this article for information about the authors.

Correspondence should be addressed to Dr. Williams, c/o Dr. Ramani, Boston University School of Medicine, 715 Albany St., Vose 320, Boston, MA 02118; telephone: (617) 638-7985; fax: (617) 638-7905; e-mail: (Keith.Williams@bmc.org).

We sought varied perspectives by recruiting participants at different stages of training. Groups one and two consisted of fourth-year students. Groups three and five consisted of "first-year" internal medicine (IM) residents, and groups four and six of consisted of "second-year" IM residents; by definition, the former had completed one year of postgraduate study, and the latter had completed two.

We defined bedside teaching as clinical teaching in the presence of a patient. We constructed open-ended questions to explore learners' experiences and opinions regarding bedside teaching. We asked whether they learned from bedside teaching and, if so, what they had learned. We asked about the quality and quantity of bedside teaching they received. Finally, we solicited their views on barriers to bedside teaching and suggestions on strategies to increase its frequency and effectiveness. The interviewer (K.W.) pursued relevant themes and sought clarification or elaboration as required. Participants had ample opportunity to express unsolicited opinions.

Focus group discussions were 60 to 90 minutes in duration. The principal investigator (K.W.) conducted all interviews and, using standard qualitative methods, coded the transcripts.[43] We grouped coded passages into major categories and identified prominent themes that emerged. We also identified contrasting responses across the experience levels of participants.

Results

Thirty-three students and residents participated in one of six focus group discussions (Table 1). All residents had attended medical school in the United States or Canada. Coded passages generated several categories: value of bedside teaching, quantity and quality of bedside teaching, barriers to bedside teaching, and strategies to increase and improve bedside teaching. Differences between students' and residents' views were apparent and reflected differences in their roles. When applicable, we have noted the level of learner. Statements represent the views of learners and not the authors.

Value of bedside teaching

Learners believed bedside teaching is valuable, if not essential, for learning skills relating to physician–patient communication, physical examination, clinical reasoning, and professionalism (List 1). They reported that observing the resident or attending physician interact with patients is often instructive. Learners indicated that patients also benefit from bedside teaching encounters, and they emphasized that discussions of topics not directly related to patient care are more appropriately taught elsewhere.

> It's very powerful if you see the example on an actual person, and especially if you know more about their story, their background, you're more likely to take something away from that experience, whether it be some kernel of knowledge about a disease or a certain way of interacting with patients. (*Fourth-year medical student*)

List 1

Knowledge and skills learned with bedside teaching

- Obtaining a medical history
- Performing a physical examination
- Generating a differential diagnosis
- Formulating a management plan
- Applying clinical reasoning
- Communicating effectively
- Exhibiting professional bedside demeanor
- Demonstrating empathy
- Performing diagnostic and therapeutic procedures
- Acquiring knowledge about medical instrumentation

Quantity and quality of bedside teaching

Learners stated that bedside teaching is underutilized and that there are missed opportunities for bedside teaching. They reported that the quantity and quality of bedside teaching vary greatly among faculty and, for students, between clerkships. Students noted the most bedside teaching during their IM clerkships, but even there, quantity and quality vary.

> We do [bedside teaching] rarely because I feel like when it happens it stands out so much. (*Second-year IM resident*)

Barriers to bedside teaching

Viewing bedside teaching as the interplay of patient, teacher, and learner in the context of the learning environment, barriers were classified as personal, interpersonal, or environmental (Table 2).

Table 1

Characteristics of 33 Volunteer Participants in Six Focus Groups on Bedside Teaching, Boston University (BU) School of Medicine and BU Residency Program in Internal Medicine, 2004–2005

				Age of participants			Students' specialty plans			Residents' specialty plans		
Group	Type	Men	Women	20–25	26–30	31–35	Medicine	Surgery	Other	Yes	No	Maybe
1	Fourth-year student	3	3	5	1	0	1	2	3	NA	NA	NA
2	Fourth-year student	4	1	3	2	0	2	1	2	NA	NA	NA
3	First-year resident	5	2	0	5	2	NA	NA	NA	5	0	2
4	Second-year resident	3	2	0	2	3	NA	NA	NA	5	0	0
5	First-year resident	3	3	1	4	1	NA	NA	NA	5	0	1
6	Second-year resident	3	1	0	3	1	NA	NA	NA	2	2	0

Table 2

Barriers to Bedside Teaching, and Strategies to Increase and Improve Bedside Teaching, Compiled from Six Focus Groups on Bedside Teaching, Boston University (BU) School of Medicine and BU Residency Program in Internal Medicine, 2004–2005

Category	Barrier	Strategy
Personal	Low initiative for teaching	Increase teaching initiative with institutional incentives
	Low teacher/learner expectations for teaching	Increase teacher/learner expectations with: • Explicit teaching expectations for teachers • Explicit learning objectives for students and residents
	Inadequate bedside teaching skills	Develop teaching skills through faculty development and resident training initiatives • Create a supportive learning environment (e.g., admission by teachers of own limitations/errors) • Acknowledge learners' needs • Plan teaching in a flexible manner to accommodate work schedules • Selectively and efficiently integrate teaching with work • Set time limits when teaching
	Inadequate clinical knowledge and/or skills (faculty)	Improve clinical knowledge and/or skills through faculty development initiatives (e.g., advanced training in evidence-based physical diagnosis)
Interpersonal	Lack of patient cooperation	• Request permission from the patient • Orient the patient to the dual purpose of the bedside session (i.e., patient care and teaching) • Include the patient in discussions and answer questions • Inform the patient about his/her care (i.e., patient education)
	Learners' desire for autonomy in patient care/fear of a compromised relationship with the patient	• Respect the learner–patient relationship • Negotiate an appropriate level of autonomy with learners • Create a supportive learning environment • Share teaching responsibility with team members
	Learner/patient fear of embarrassment/humiliation	Learner • Create a supportive learning environment Patient • Request permission from and orient the patient • Include and inform the patient
Environmental	Lack of time attributable to high patient volume and turnover	• Reduce service caps on the number of patients admitted and/or managed • Create nonteaching services for patient overflow
	Competing responsibilities of faculty	Reduce or eliminate competing demands on faculty such as outpatient clinical duties and research responsibilities
	Deficient institutional expectations/incentives for teaching	Increase institutional expectations/incentives for teaching with: • Explicit teaching expectations/incentives for faculty/residents • Explicit learning objectives for residents/students
	Inadequate institutional recognition of teaching	Enhance institutional recognition of teaching with legitimate rewards for excellence in teaching
	Devaluation of clinical skills by technology	Emphasize evidence-based clinical diagnosis through faculty development and resident training initiatives
	Interruptions during rounds	No strategy offered
	Lack of privacy in multipatient room	No strategy offered
	Lack of space within patient room	No strategy offered
	Excessive noise	No strategy offered

Personal barriers are factors attributable to individuals, whereas interpersonal barriers represent aspects of the relationship between at least two individuals. Environmental barriers denote contextual factors that influence bedside teaching. The learning environment includes cultural aspects of the learning institution as well as structural and functional aspects of the patient-care environment. Several overarching themes emerged from the data: lack of respect for the patient; time constraints; learner autonomy; faculty attitude, knowledge, and skill; and overreliance on technology.

Lack of respect for the patient. Learners expressed concern for patients' welfare and recognized that their own education is secondary to patient care. Bedside discussion of sensitive issues, such as substance abuse, mental health, and sexuality-related topics, could embarrass the patient and result in the elicitation of

inaccurate information. Discussion of diagnostic possibilities could cause undue alarm, particularly conversations about fatal diseases such as cancer. Bedside deliberation of management plans could lead patients to lose confidence in the medical team if they witnessed disagreements. Learners attested that patients are rarely asked permission or oriented to bedside teaching. Most concerning to learners are situations in which the patient is marginalized during a bedside discussion, as manifested by a clinician's failure to seek patient input, explain medical terminology, or answer questions.

> I've seen attendings or residents exclude the patient when they're bedside teaching, and patients find that really offensive because it's their body, it's their story, and they're marginalized while they're being used for teaching, whereas if the patient's included then it's great for everybody and it's a really effective learning tool. (*First-year IM resident*)

Time constraints. Most learners believed that time constraints significantly limit bedside teaching. Contributing to this perception are a high resident workload and the observation that attendings often maintain significant ambulatory, administrative, or research responsibilities during their ward service, thus reducing time for learner interaction and bedside teaching. Learners preferred to avoid extended teaching encounters when overwhelmed by workload or fatigue.

> You duck out and you're not involved in the actual teaching at the bedside because you need the computer and the phone in the hallway to get things done so that things are happening earlier in the day and you're not discharging someone at six in the afternoon. (*First-year IM resident*)

Interestingly, some learners questioned why bedside teaching should take more time than that required for teaching in other settings. Such speculation led them to conclude that there is not so much a lack of time for bedside teaching, but for all teaching.

> Theoretically, bedside teaching shouldn't take any longer. What we're actually saying is there's not enough time for teaching in general, rather than for bedside teaching. (*First-year IM resident*)

Learner autonomy. Advanced residents expressed concern that bedside teaching compromises the relationship between learner and patient. They feared that bedside demonstration of deficiencies causes patients to lose confidence in the learner as clinician, or in the advanced resident as team leader. They also feared that their attendings would usurp their authority to manage the team. Although many learners voiced discomfort at admitting "I don't know" to their patients, some accepted the necessity, if not inevitability, of making such an admission. Some believed that lack of harmonious team dynamics contributes to these difficulties.

> It is uncomfortable when you're the resident and the patient knows that you're the one that's there all the time and somebody's going through this lengthy teaching episode with you, because I feel they want to be comforted by the fact that you know something, which you do, but there's that line where it can be uncomfortable. (*First-year IM resident*)

Ironically, some residents believed that attendings sometimes allow excessive autonomy. In such circumstances, all teaching suffers, not just that performed at the bedside.

> We crave autonomy, but it's a balance. I'm at the point now where I don't want as much autonomy, I actually want to interact more with my attendings. I had an attending this past month who gave me too much autonomy. It was fun, it was easier, but I didn't learn much. (*Second-year IM resident*)

Faculty attitudes, knowledge, and skill. Learners believed that all attendings have something to teach at the bedside. There was speculation that the reluctance of attendings to engage in bedside teaching derives more from lack of teaching skill than lack of clinical competence.

> I definitely ran into some people where I'd ask them questions and I could tell that I was making them uncomfortable, even though they had lots to offer me. That was what was really strange; they didn't realize that I'm asking at such a basic level that they have lots to teach me. (*Fourth-year medical student*)

Overreliance on technology. Given the ever-increasing technological options for diagnosis and treatment, some learners questioned the role and importance of proficiency in bedside diagnostic skills if further testing is done regardless of clinical impression. This loss of faith in traditional skills led to speculation about whether efforts to learn them are futile.

> So much of medicine now with radiology studies and blood tests is so algorithm driven that a lot of this other stuff doesn't matter anymore. I know what the plan's going to be before I see the patient. A lot of bedside teaching is gone away because of that. (*First-year IM resident*)

> One intern used to call the CT scanner the "doughnut of truth." It's kind of revealing. It's like saying that you don't need to lay your hands on the patient, just plop them down on the thing. (*Second-year IM resident*)

However, many learners believed that, in spite of technology, patients still expect dialogue with and examination by their physicians and are disappointed and indignant when clinical interactions are inadequate. Some learners desired international medical experiences where they could obtain traditional clinical teaching in the absence of the influence of technology.

> I don't think we'll ever get away from the physical exam. Even if you don't have to listen to their lungs and learn anything, the patients feel so much more of a connection to you when you do. It's more than just learning the physical exam. It's learning patient interaction, too. (*First-year IM resident*)

Strategies to increase and improve bedside teaching

Learners provided many insightful recommendations to increase and improve bedside teaching (Table 2). Strategies addressing the barrier themes noted previously are discussed below.

Orient and include the patient. Although patients were rarely described as uncooperative, learners emphasized the need to orient patients and request permission before teaching. Explaining the purpose of a bedside teaching encounter and requesting permission to observe or examine were identified as important signs of respect that foster trust and cooperation.

> The most important thing is being able to develop a rapport with your patients, and making them feel like you're not forcing something on them, where it's a comfortable environment. If an attending or resident has the ability to establish a relationship with the patient that's reasonable, you can get a lot more out of that situation because the patient is more willing to participate and the students will feel more comfortable in that setting, too. (*Fourth-year medical student*)

Learners believed that inclusion of patients permits clarification of historical facts and validation of exam findings. It allows the medical team to educate patients about their conditions and options for care. They felt that establishing rapport with patients could alleviate concerns regarding discussion of sensitive topics and prevent misunderstandings or alarm with regard to discussion of diagnostic possibilities or management plans. Patients might also have the satisfaction of contributing to the education of future physicians.

> The attending did a good job of making the patient feel we cared about her. He set a good example of making her feel like a whole person and not a specimen, in the end reassuring her about her findings: "This isn't new, this is something that we've already known you have, and what I'm talking about here isn't anything for you to worry about, and it's consistent with the diagnosis you have and nothing's changed." I thought that was a good closure to the teaching. (*Fourth-year medical student*)

Address time constraints through flexibility, selectivity, and integration. Although many time-related factors are beyond their control, learners provided several suggestions to address the effect of time constraints. Faculty accommodation of the call schedule and resident workload was considered paramount. Learners stated that it is senseless to engage in prolonged postcall teaching rounds when the team is too fatigued and distracted to engage in a meaningful learning experience. Faculty teaching at the bedside should be selective and limited in duration. Paradoxically, some residents suggested that faculty participate regularly in work rounds; they recognized the efficiency of combining work and learning, especially when it obviates the need to round later with the attending. Residents advocated a decrease in the number of patients they manage on the teaching ward. Considering the amount of clerical work associated with each patient, even slight reductions in census numbers would increase the time available for teaching.

> [It] is very important to prioritize, to pick one or two pearls on the patients that you're interested in and emphasize that, because we're not going to remember more than that, and we usually don't have time for more than that. (*First-year IM resident*)

Learners emphasized the value of having attendings available on the ward on a consistent basis. Attending time on the ward should be "protected" from competing responsibilities.

> It really helps when the focus of that person's day is to take care of patients and to do teaching . . . it makes a big difference . . . rather than someone who's got their hands in so many things, their mind might be in as many places. (*Fourth-year medical student*)

Provide learners with reassurance, reinforce their autonomy, and incorporate them into the teaching process. To alleviate their anxiety at the bedside, learners believed that simple reassurance by the attending physician is often sufficient. They advocated the establishment of a positive learning environment in which acknowledgement of deficiencies and errors is accepted as an inevitable, if not essential, aspect of the learning process. In this context, bedside questioning is seen as a Socratic exercise in learning, not as "pimping" with an intent to demoralize or cause embarrassment. Some believed that harmonious team dynamics facilitate acceptance of one's own limitations.

> If teachers can set the tone and what the expectations are and say that "it is okay to make mistakes, we all make mistakes, but the great doctors are the ones who take those mistakes and use them to improve themselves," that's the best way to learn in that stressful environment. (*Second-year IM resident*)

Some residents suggested that autonomy, although important for professional growth, could sometimes be counterproductive in its effect on opportunities for learning, because autonomy often correlates inversely with attending participation. They recognized the need to balance their roles as managers and learners, although it is often difficult to negotiate the appropriate level of autonomy with attendings. They believed that distributing teaching responsibility to all team members and creating a collaborative learning environment could minimize compromise of the professional relationship between learner and patient.

> One solution is to equalize the teaching on the team. Just because you're ahead of someone else, like the attending's above you or you're above the intern, doesn't mean you're going to know more about every topic than the medical student. (*First-year IM resident*)

Develop faculty attitudes, knowledge, and skill for bedside teaching. Learners suggested faculty and resident training to develop effective bedside teaching skills. Such training could alleviate the anxiety related to bedside teaching content, such as physical examination skills. They advocated a variety of bedside teaching strategies, including assessment of learners' needs, role modeling, selective and explicit instruction, learner evaluation and feedback, and distribution of teaching responsibility. Legitimate institutional incentives for proficient teaching should be available.

> Everything counts the minute you walk into the patient's room. Everything you do is being watched, whether it's something you say, or it's the way you approach the patient, the way you sit by the bed, or just the way you're ignoring what the patient's saying. Teachers should be very sensitive to that issue alone. It's not just the verbal aspect of teaching. (*Second-year IM resident*)

Advocate evidence-based physical diagnosis. Learners believed that the indifference of the medical establishment towards physical diagnosis skills derives from lack of emphasis in training, and they suggested that faculty and resident training initiatives could improve these skills. They encouraged participation in international medical experiences in which technology does not play a central role in the diagnosis and treatment of illness.

> Some things in physical exam are actually useful. There's some literature on the prognosis implied in a certain physical exam finding. Us[e] that to say, "these things are important and it can actually guide the management." (*Second-year IM resident*)

Table 2 lists these and additional strategies to increase and improve bedside teaching.

Contrasting student and resident perspectives

Residents' beliefs, such as the desire for autonomy in patient care and for a collaborative learning environment, were more pragmatic than those of students. This pragmatism stemmed from two major differences between students and residents. First, residents viewed bedside teaching, and teaching in general, from

the vantage points of both learner and teacher. Second, their views were influenced by work responsibilities and a desire to have a reasonable quality of life, even during training. Teaching initiatives that fail to recognize these differences are often unsuccessful.

Students focused on the physical diagnosis aspects of bedside teaching to a greater degree than did residents. First-year residents were overwhelmed with the responsibilities of daily work, and thus found bedside teaching, and perhaps all teaching, to be another demand on their limited time, and they reported that they often felt too distracted to learn. In the second year of residency and beyond, residents recognized that their role as a team leader allowed them opportunities to influence the frequency and form of bedside teaching rounds.

> There were definitely times where somebody said the word[s] "attending rounds" and I was ready to shoot myself. I was completely disinterested and in fact angry that that was what somebody wanted to do when I had a million other things, and it was only going to keep me in the hospital really late. Some people just don't have any understanding of what's going on around them. (*First-year IM resident*)

> The resident's attitude permeates the team, so you can create a local environment of eagerness and motivation to learn. (*Second-year IM resident*)

Discussion

Our learners confirmed faculty beliefs that bedside teaching is valuable for learning essential clinical skills, such as those related to physician–patient communication, physical examination, clinical reasoning, and professionalism.[27,28] In the absence of studies validating the effectiveness of bedside teaching, this affirmation by learners is important. Their recognition that they learn by observing more experienced clinicians interact with patients supports the use of role modeling, an implicit form of teaching, at the bedside. Although they had concerns for the patient and their own psychological well-being during the bedside teaching encounter, they identified strategies to avoid potential harm. We are encouraged, given the learners' beliefs that patient inclusion and faculty development could rapidly enhance the frequency and effectiveness of bedside teaching for the benefit of all.

One of our most striking findings is the recognition by learners that, for the patients and themselves, sensitivity in the interpersonal aspects of bedside teaching is paramount. A poorly executed bedside teaching encounter disrespects patients and compromises learners in their roles as clinicians and managers, thus diminishing their perceived autonomy. Fear of the consequences of poor interpersonal communication during bedside teaching is prevalent. Simple strategies to avoid these pitfalls, such as orienting patients to the process, and explicit acknowledgment of human limitations, can be easily incorporated by faculty.

Although lack of time is frequently described as a major barrier to bedside teaching, some learners believed that this is more perception than reality. In fact, the data suggest that when time is limited, all teaching is compromised, not just bedside teaching. More importantly, learners suggested that properly executed bedside teaching could be integrated within typical clinical activities, such as work rounds, allowing efficient time use.

Autonomy was a major concern for residents. They avoid teaching situations that might jeopardize their role as manager and the students' or first-year residents' role as caregiver. A collaborative approach to teaching helps to preserve the integrity of their semiautonomous roles. Learners found it difficult to admit "I don't know" during a bedside teaching encounter. Reassurance by attendings and the establishment of a positive learning environment and harmonious team dynamics can alleviate these concerns.

Learners speculated that faculty might be reluctant to teach at the bedside because of a lack of teaching skills rather than a lack of clinical competence. In their opinion, the belief that technology has supplanted the medical history and physical examination undermines bedside teaching. Faculty development could address both of these issues.

The differences in the perspectives of students and residents regarding bedside teaching are provocative. One could predict both the tremendous appeal of bedside teaching to students as they learn the skills of clinical medicine and the pragmatism of first-year residents inundated with work. However, second-year residents' expectation for a more collaborative approach to teaching is somewhat unexpected and compelling. This expectation stemmed from a need for autonomy as they embraced their newfound leadership role. Their desire for a collaborative approach has profound implications: if given the opportunity to influence the timing, content, and process of bedside teaching, residents could have a key role in promoting the regular occurrence of such teaching.

Our findings complement previous literature reports regarding learners' perspectives on bedside teaching. In a study by Nair et al,[26] learners were found to believe that bedside teaching is a "valuable way to develop professional skills." More than 90% of the learners believed that bedside teaching is effective for learning communication, history-taking, and physical examination skills. Between 41% and 65% stated that they do not receive sufficient bedside teaching. Our findings also complement the views of teachers. In another study by Nair et al,[27] 95% of teachers agreed that bedside teaching is an effective way to develop professional skills, and more than 80% believed that it is effective for learning communication, history-taking, and physical examination skills. Comparison with a study by Ramani et al[28] reveals a striking similarity between the perspectives of teachers and the views of our learners; teachers concurred with the five overarching themes we describe in this paper, including learner autonomy, as suggested by a "fear of undermining housestaff." They also suggested strategies to increase and improve bedside teaching that are remarkably consistent with those of our learners, such as orienting the patient, establishing a positive learning environment, and treating the learner as primary caregiver for the patient. The suggestions of our learners are compatible with the bedside teaching recommendations of various educators.[29–42] The "model of best bedside teaching practices" by Janicik and Fletcher,[42] which describes three domains of effective bedside teaching skills (attending to patient comfort, focused teaching, and group dynamics), addresses several of the important findings in our study.

Bedside teaching, rather than being an antiquated mode of clinical instruction

from a pretechnological era, is consistent with modern education theory. Specifically, it is consistent with the experiential learning principles of the progressive movement that began in medical education during the late 19th century, as well as with the principles of adult learning as defined by Malcolm Knowles.[44,45] Most striking, however, is the compatibility of bedside teaching with the modern theory of situated cognition, or contextual learning, which states that the learning of knowledge is inherently dependent on the context in which it is learned; that is, "knowledge is situated, being in part a product of the activity, context, and culture in which it is developed and used."[46] William Osler[4] was aware of the advantages of contextual learning: "In what may be called the natural method of teaching, the student begins with the patient, continues with the patient, and ends his studies with the patient, using books and lectures as tools, as means to an end." Our learners were aware of this "contextual" advantage, as demonstrated by their views regarding the value of bedside teaching. One may logically ask, how else is a student of medicine to become a professional, let alone learn the appropriate manner of speaking with, touching, and comforting a patient, if not in the context of the bedside teaching encounter?

This study has several limitations. We recruited students from only one school of medicine, and residents from only one specialty at a single academic medical center. Our study explored learners' opinions about bedside teaching but did not address whether increasing or improving bedside teaching would lead to better learning outcomes or enhanced patient care. Although there is always the potential for interviewer bias to influence the views of participants during focus group discussions, we attempted to reduce this possibility by limiting the interviewer's dialogue to questions and clarifications and by avoiding expression of opinion. We also avoided asking whether learners "liked" bedside teaching; we focused instead on questions concerning value, barriers, and strategies.

Future research should determine whether faculty development directed at improving bedside clinical and teaching skills could enhance bedside teaching and should focus on a variety of learner outcomes, including knowledge retention, skill proficiency, and professionalism. Meanwhile, the results of this study support ongoing efforts to promote faculty development in teaching and to facilitate an institutional culture and environment conducive to the regular occurrence of bedside teaching.

We believe clinical education that incorporates substantial bedside teaching is an effective approach to fulfilling the public interest of training intelligent, skilled, and compassionate clinicians. Including the patient, collaborating with learners, developing faculty skills, and promoting a supportive institutional culture can redress a variety of barriers to bedside teaching. In the end, "no books, no tapes, no audio-visual aids, no seminars, no avant-garde philosophy will ever be substitutes for the discipline of the bedside medicine—the one-to-one situation where tradition, humanity, art and science are blended."[6]

Dr. Williams is clinical instructor of medicine, Boston University School of Medicine, Boston, Massachusetts. When this research was conducted, he was a general internal medicine clinician–educator fellow, Boston University School of Medicine MET Program, Boston, Massachusetts.

Dr. Ramani is associate professor of medicine and director of clinical skills development, Internal Medicine Residency Program, Boston University School of Medicine, Boston, Massachusetts.

Dr. Fraser is professor of linguistics and education, Boston University Applied Linguistics Program and School of Education, Boston, Massachusetts.

Dr. Orlander is associate professor of medicine, Boston University School of Medicine, and associate chief medical service, VA Boston Health Care System, Boston, Massachusetts.

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Disclaimer

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Correction

In the article "Beyond the Dual Degree: Development of a Five-Year Program in Leadership for Medical Undergraduates," in the January 2008 issue of *Academic Medicine*, an author's name was misspelled. The correct authors are: Gerald E. Crites, MD, MEd, James R. Ebert, MD, MBA, and Richard J. Schuster, MD, MMM.

Inconvenient truths about effective clinical teaching

Brendan M Reilly

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Department of Medicine, Cook County (Stroger) Hospital, Rush Medical College, Chicago IL 60612, USA (B M Reilly MD)
Correspondence to:
breilly@cchil.org

I've been teaching clinical medicine for more than 30 years but it seems to be getting harder, not easier. Conventional wisdom in the USA holds that the problem is time and money (or, more precisely: time is money). Hospitalised patients, discharged before doctors can get to know them, are sicker and quicker today. Outpatient teaching is no less awkward, 10-minute office visits and outdated Medicare reimbursement rules gumming up the works. Long overdue restrictions on resident work hours won't solve these problems.[1]

Too little time and money for clinical teaching betokens lack of respect too. Most academic centres in the USA don't provide adequate support for clinician-educators' salaries despite substantial government subsidies for postgraduate education. This shortfall is not an oversight; it is a calculated budgetary decision. Insult compounds injury when physician-researchers openly disparage the academic gravitas of physician-educators on the same faculty.

This situation raises the obvious question: is clinical teaching today not only more difficult but also less effective? One might assume that our research-proud profession would know the answer.[2] In fact, despite shocking indictments of the quality, safety, and equity of US medical care,[3–6] we know little about the effect of clinical teaching on learners or patients, nor even how to measure it.[7,8] Worse, we don't seem very concerned about this situation. In 2006, four major medical journals (*BMJ*, *JAMA*, *Lancet*, and *New England Journal of Medicine*) and four medical education journals (*Academic Medicine*, *BMC Medical Education*, *Medical Education*, and *Medical Teacher*) published a total of one original outcomes study of this kind (which found no correlation between measures of teaching effectiveness and patients' clinical outcomes).[9]

Lacking evidence, I do what clinicians do when we don't have the data we need: I go with my gut instinct. My gut tells me that clinical teaching today—my own and others'—is less effective than it used to be and needs to be. Among those who will disagree are many academic leaders and quality gurus who don't even acknowledge the question. They maintain plausible deniability by looking elsewhere: we need better systems, they say, not better doctors. No doubt they are right about the systems.

I propose that the decline of clinical teaching in our training programmes is, like global warming, an inconvenient truth. Even if we saw evidence as eerily convincing as Al Gore's pictures of melting polar ice-caps,[10,11] many in academic medicine would look the other way. Rather than take remedial action, we will be tempted to do the greenhouse-gas-shuffle: blame it on random variation or transient aberration (anything but ourselves) and hope the hurricanes and heat waves just go away.

Doubly inconvenient would be to learn that fixes from the past might not work in the present. For example, due to digital information systems, clinical trainees inevitably review patients' laboratory data and diagnostic images before they do a history or physical examination. This change portends more than the devaluation of bedside skills;[12] it is nothing less than complete inversion of the conventional diagnostic process. The good news is that innovation in medical education eventually catches up with advances in science and technology.[13] The bad news is that the pace of change is glacial.[14,15] Worse, we know so little about medicine's informal curriculum (clinical training) that it's hard to know where to start.[16–19] In this spirit, I describe eight habits of exemplary clinical teachers I have known and try to emulate still.

Think out loud

Making transparent to learners the teacher's own clinical reasoning is the most powerful predictor of learners' satisfaction.[20] This method is not the same as talking off the top of one's head, a habit common among ineffective teachers. Instead, thinking out loud is highly disciplined and strategic,[21,22] with three primary purposes. First, it communicates a general framework for solving the clinical problem at hand. In the past, this was the main challenge for clinical teachers: to extrapolate from the particular patient to the general (all presentations like it) and back again. But now even novice learners, armed with expert guidelines and algorithms, can lend logic and authority to their problem-solving strategy. Thus, teachers today can afford to spend less time thinking out loud about these things. This efficiency assumes that learners read about their patients and apply well what they read, not always a safe assumption.

Second, all clinicians struggle to translate the results of published research into the care of each unique patient. This population-to-person problem, the generic dilemma of practising evidence-based medicine, needs not only the skill to search and understand the published medical literature but also the judgment to use it or not in individual cases.[23,24] This translational process, though imperfectly understood, is the essence of what clinicians do.[25] For this reason, effective teachers do this translation out loud, articulating it in detail for learners as well as patients.

Third, effective teachers purposefully expose for learners the ambiguity and ambivalence inherent to clinical medicine by thinking out loud in the moment (on the fly) as patients' problems arise in real time. Such spontaneity requires teachers to share extemporaneously their own inchoate thoughts about what to ask, what to

look for, what to do. Inevitably, some of these outspoken ideas will seem, in retrospect, irrelevant or mistaken. But learners need to see the teacher's own problem-solving journey—including fits and starts, blind alleys, and missteps. Clinical medicine is messy, with many working diagnoses disproved and therapeutic trials abandoned. Effective teachers give learners a bird's-eye view as they struggle themselves to tidy up the mess.

The inconvenient truth is that thinking out loud needs more than expertise and confidence; it also needs humility, a virtue not encouraged widely enough in the medical education hierarchy. If our profession is serious about lifelong learning, we must recognise that learning can't happen without humility. Teachers who humbly think out loud help to show the way.

Activate the learner

Experts agree that adult education is a tango: it takes two. The dance will fail, no matter how expert the teacher, if the learner is not actively, even passionately, engaged. But clinical teachers typically lead teams of learners—in the USA, groups of residents, interns, and students—whose different skill levels need different moves by the teacher. (By contrast, consider the one-on-one mentoring deemed essential for all researchers-in-training.) The group tango is made doubly difficult by conditions on the dance floor: in today's hurly-burly hospital wards and clinics, getting the work done—taking care of patients—must take priority over teaching. Under such conditions, how do clinical teachers activate learners?

Two steps are fundamental. First, effective teachers insist on learners' motivation as a precondition for their activation. Unmotivated learners waste teachers' time. They don't belong in a profession where lifelong learning (indeed, love of learning) is an absolute requirement. They should be encouraged to change careers (once disability and fatigue have been excluded as the underlying problem). Second, effective teachers synergise learners' needs with their patients' needs. How? They repeatedly pose two questions to their team of learners: what do we know about this patient? What more must we learn to provide them the best care? This agenda exploits the fact that learners on different levels learn and help patients in complementary ways. Whether it is the student who elicits crucial new history or the senior resident who develops the ultimate treatment plan, each member of the team contributes by pulling their own weight on their own level.

Beyond this basic two-step, the key to activating clinical learners is the teacher's style. The Socratic style would seem ideal for medicine, guiding adult learners toward self-discovery in dialogues orchestrated by the teacher. But its tortuous process and delayed effect make the Socratic style impractical in most clinical settings. Alternatively, the autocratic style has many practical advantages, especially when the patient's clinical condition is dire and the right moves must be made right away. However, this (shut-up-and-do-what-the-teacher-says) approach fosters a culture where learners learn by following orders, activated by fear of ridicule in the present[26] and reprisals (poor evaluations) in the future. One needs look no further to appreciate why so many practising clinicians rely on expert opinion, whether evidence-based or not, and why they dread making errors.

Most effective clinical teachers use the democratic style. They assume that clinical learners mature most when encouraged to think and act autonomously under pressure. Here, the challenge for the teacher is knowing when to stand back and when to jump in, giving learners enough freedom to grow without hurting themselves (and their patients). This balancing act is not for the faint of heart: given too much autonomy, clinical learners endanger patients in the present; given too little, they might endanger them in the future. Thus, the democratic style needs leadership as well as teaching skills. The need for both explains why some teachers who perform brilliantly in the classroom don't do as well at the bedside.

The inconvenient truth is that the success of the democratic style is somewhat mysterious. William Penn captured some of its nuance when he said: "Let the people think they govern, and they will be governed."[27] Teaching democratically is all about activating learners' initiative while protecting them from themselves. This effort will succeed in medicine only if wise, watchful teachers lead learners to "think they govern".[27]

Listen smart

Effective clinicians listen carefully to their patients. Effective teachers, who diagnose and treat learners in parallel with diagnosing and treating their patients, also listen carefully to learners.[28] They tune in to learners' acquisition, synthesis, and presentation of clinical data, logic in clinical reasoning, patient-centredness when making decisions, and grasp of the high standards of medical professionalism. Listening to learners requires insight and understanding beyond that needed to listen to patients;[29] for example, it needs a meta-analytical understanding of what makes any clinician effective. Such requirements explain why many effective clinicians are not effective teachers: they don't know how they do what they do so well.[22] Even master clinicians, when listening to learners, might not know what to listen for.

Effective clinical teachers diagnose and treat two general types of learning disorders: pathological conditions and developmental delays. Pathological conditions need urgent attention because pathology in one domain (eg, defective data synthesis) might metastasise to other domains (eg, clinical reasoning); equally dangerous, one learner's pathology could infect other (typically, more junior) learners on the same team. By contrast, developmental delays are less urgent because all clinical

learners attain some competencies more slowly than they attain others. But these delays are important and should not be ignored. So-called watchful waiting, often the best option in clinical care, is rarely the best strategy in clinical teaching. All clinical learners have room to grow, and the teacher's job is to help them grow. In the clinical vernacular, effective teachers are interventionists. But active intervention first requires active listening.

When listening to learners, teachers who lack independent knowledge of learners' patients will be less effective. Why? Because teachers cannot listen smart when they encounter a patient for the first time during a learner's presentation. Under these conditions, the teacher can assess the internal validity of the presentation (does it make sense?) but not its external validity (is it true?). Such teachers, at best, will be inefficient; at worst, they will be complicit in serious error.[30] By contrast, hospitalists in the USA tend to get high marks for inpatient teaching, because their job is to assess patients independently.[31] Similarly, tertiary referral centres might be less conducive to effective teaching than some community hospitals (where the clinicians already know their patients well).

No doubt it is hard work for teachers to assess independently all of their learners' patients in a timely manner. Teachers who do this well complain of being perpetual interns. The inconvenient truth is that personal attention to detail is what is needed to teach clinical medicine effectively. As Alfred North Whitehead noted in The Aims of Education:

> All practical teachers know that education is a patient process of the mastery of details…There is no royal road to learning…There is a proverb about the difficulty of seeing the wood for the trees…The problem of education is to make the pupil see the wood by means of the trees.[32]

Keep it simple

Recommending simplicity will seem disingenuous; certainly medicine is not simple. But teaching medicine as simple does not intend that teachers dumb it down, make it simplistic; rather, simplicity exhorts them to reduce their presentation, as chefs will do, boiling it down to its hearty essence. Many clinical teachers don't do this, sometimes in deference to medicine's complexity (and sometimes to show off their own), but often because they don't appreciate its pedagogic power.

First, one must understand complexity well to express it simply. Clinicians who can't reduce to simple terms what they think probably don't understand what they think well enough to apply to patients' care. Effective teachers keep the teaching simple because they know that concise and clear expression improves communication with patients, too. In boiling complexity down for learners, they show learners how to boil it down for patients.

Second, effective teachers address a specific scenario by conveying general principles relevant to all situations like it. For example, the principle of not letting the sun set on a hot appendix is useful whether the particular patient has appendicitis or not. Whitehead favoured this approach to education:

> The really useful training yields a comprehension of a few general principles with a thorough grounding in the way they apply to a variety of concrete details.[32]

To diagnose the cause of oedema, for example, only two facts are pivotal: the patient's jugular (central) venous pressure and serum albumin level. This principle is always useful, not because the two facts always make the diagnosis but because, even when they don't (eg, in cases of vena cava obstruction), they always point the way. Many such principles have been validated in empirical studies to "help physicians…know what clinical data are important to obtain."[33] Effective teachers promulgate such rules because they give learners what William Osler called "good methods and a proper point of view."[34]

Third, effective teachers recognise the difference between scientific knowledge (which has intrinsic value) and clinical knowledge (which has value only if applicable to patient care). Ultimately, all clinicians must translate complex clinical knowledge about their patient into one simple decision: do this, or do that. Effective teachers show them how.

The inconvenient truth is that keeping it simple is complicated. Even the most effective teachers find it hard to do consistently and well. Additionally, its reductive technique sometimes annoys advanced learners who are more interested in the exceptions than the rules. But this point is where Osler's "good methods" begin to pay handsomely, where learning curves rise, for teachers as well as learners. Getting there is a good thing, even if it isn't simple.

These first four habits comprise the acronym TALK (table 1). But, just as clinical effectiveness is measured more by what clinicians do than what they know, teaching effectiveness is measured more by what teachers do than what they say. Thus, the final four habits pertain to how effective teachers "WALK the walk" (table 2), not how they "TALK the talk".

Wear gloves

Infection control has never been more important than it is today, but wearing gloves addresses a broader issue here: effective clinical teachers are hands-on role models. This practice involves frequent physical interaction with patients—demonstrating the clinical utility of physical examination, the therapeutic value of touching, the diverse benefits of bedside care.[35–37] It also needs a conscious effort to make real to learners the physical experience of sick patients and the glorious relief good doctoring can bring them. Most physicians-in-training are young and healthy, unfamiliar with the travails of being a patient; many have never felt excruciating pain, profound weakness, or desperate dyspnoea. Thus, even

	Strategic goals	Educational challenges	Clinical challenges	Inconvenient truths
Think out loud	Show learner the process, not merely the outcome, of expert reasoning	Articulate, in real time, pivotal steps when making clinical decisions	Missteps inevitable	Requires humility
Activate the learner	Promote learner's initiative and autonomy	Know when to stand back versus when to assert clinical authority	Patient safety always the top priority	Needs democratic leadership skills
Listen smart	Efficiently assess validity of learner's presentation	Know what to listen for	Assess patient before assessing learner	Requires mastery of patient's clinical details (teachers as perpetual interns)
Keep it simple	Exemplify concise communication and rule-based decisionmaking	Use reductive general principles to illuminate clinical complexity	Each patient is unique; some don't follow the rules	Easier said than done

Table 1: **Teaching habits of effective clinical teachers—TALK the talk**

the little things done by hands-on teachers can have great effect on learners: feel the febrile patient's sweat-soaked back on early morning rounds; find her a fresh dry gown; flip her pillow over to the cool side; see her close her eyes in respite. These and other bedside ministrations have been relegated to others today. But effective teachers know, and show, that there is no better way for doctors to connect with patients.

The importance of hands-on teaching has another implication: the most effective clinical teachers are practising clinicians. This point doesn't mean that researchers and administrators can't teach; however, they must do enough direct patient care to grow their own clinical skills, not merely maintain them.[38–40] In many US centres today, academics practice only when on-service (a few weeks per year); not infrequently, this practice amounts to continuing medical education for the attending physician, who unabashedly learns more from the house staff and students than they do from him. The notion that those who teach clinical medicine need not practise it is absurd, a convenient delusion that demeans the discipline and those training to learn it.

The inconvenient truth is that hands-on clinical teaching is largely unappreciated today, despite the effort and expertise required. Well-intentioned reforms in many US medical schools have created separate tracks for academic promotion of clinician-educators but these tracks are widely considered second-class. (Externally funded researchers go first class, as they should.) Private insurers and payers don't reward teaching either, a remarkable oversight in view of their alleged interest in more effective clinical practice. In a very real sense, hands-on clinical teaching has become its own reward, a vestige of professional altruism that will survive only if today's teachers can pass the torch on to a new generation—not a forgone conclusion.

Adapt, enthusiastically

As Osler said, "Medicine is a science of uncertainty and an art of probability."[41] What the science predicts, however confidently, might not happen; what clinicians do for patients, however artfully, might not succeed. Thus, despite the best laid plans, all clinicians must adapt to the unexpected. Effective teachers seek these situations because they present the greatest opportunities to learn (and to help patients). Exploiting these opportunities is not an easy thing to do, for several reasons.

Two demons haunt all clinicians: chance and fallibility. Assessing the agency of chance is difficult[42] but clinical teachers should try, because clinical error is a different kind of learning opportunity than bad luck. Both are instructive but only error provides the opportunity to learn the most difficult of all cognitive skills (when, and why, to change one's mind) and the most wrenching of all clinical responsibilities (how, and to whom, to admit

	Strategic goals	Educational challenges	Clinical challenges	Inconvenient truths
Wear gloves	Promote hands-on doctoring	Role-model unfashionable skills (physical exam) and countercultural behaviour (nurses' work)	Continuing refinement of clinical acumen to complement advances in science and technology	Bedside care undervalued and inadequately rewarded
Adapt, enthusiastically	Embrace clinical uncertainty as a valuable learning opportunity	Role-model aplomb and savoir faire when unexpected clinical events occur	Changing one's mind; admitting error; lack of evidence for many clinical dilemmas	Managing clinical uncertainty highly stressful yet poorly taught; burn-out an occupational hazard
Link learning to caring	Show, and expect of learners, empathy and responsibility for each patient	Role-model professionalism and patient-centredness	Understand the patient's illness as well as their disease	Medical consumerism (care as a commodity) undermines medical professionalism
Kindle kindness	Establish generosity (not politeness) as the standard for all clinical interactions	Give encouragement (hope) to learners even when giving critical feedback	Treat the disease as your enemy but the patient as your friend	Unknown whether simple human kindness is teachable

Table 2: **Teaching habits of effective clinical teachers—WALK the walk**

mistakes).[43] Ironically, this learning opportunity could explain why some teachers, always on the lookout for teachable moments, find error when bad luck is equally likely. Such attribution bias is dangerous; clinical errors are frequent enough without inflating their number.[4] All clinicians accumulate guilt over the course of a career—even when we deal with our mistakes constructively, most of us incur a personal loss—and increasing that guilt arbitrarily doesn't help.[44] Teachers walk a tightrope here. Teetering between finding fault and ruing randomness, their missteps have consequences either way.

But adapting to the unexpected needs more than hard-headed honesty about our errors and biases. It also needs creativity, an ability to improvise when making uncertain clinical judgments. Evidence-based medicine zealots might disagree, but randomised trials and expert guidelines will never address more than a fraction of all conceivable eventualities in clinical medicine. In other words, judicious improvisation will always be an integral part of what clinicians do. But when (and how) do clinicians learn this skill? Not in US medical schools, according to Melvin Konner, the anthropologist who wrote trenchantly about his experience as a medical student:

> Medical school [and] graduate school…have diametrically opposite purposes. The graduate school must produce a unique product: the student must…go as soon as possible beyond what has been taught…The medical student must on the contrary end by being as similar as possible to every other medical student…according to a process that leaves no room for originality. At the end of study, all…medical students…should perform the same examination, write the same assessment, and formulate the same options for treatment.[45]

One might conclude that postgraduate medical education also should produce carbon-copy exemplars of some curricular ideal (although Konner doesn't say as much; he wrote only about medical school). But this notion, seductive to many who want to standardise clinical care, fundamentally misunderstands what clinicians do and what effective teachers must teach. The formal medical school curriculum, albeit bloated and intimidating, is the easy part of medical education; the hard part is learning how to decide what to do when no one knows what to do, creatively using clinical judgment to help the patient as best one can.[46]

The inconvenient truth is that clinicians learn to manage uncertainty haphazardly, without formal instruction, despite its manifest importance to patient care. As a result, most clinicians don't like surprise. Enthusiasm for surprise—a sort of swashbuckling eagerness to handle whatever happens next—allows effective teachers to confront the unexpected head-on, the only way to address it. Such brio is a lot to ask of any teacher lifelong; many of us burn out, a problem we must learn more about.[47]

Link learning to caring

Patient-centred teaching refers to teaching that is directly and immediately relevant to each patient's main clinical problem. Whether sepsis or somatisation or a surgical abdomen, this main problem determines what must be taught and learned about a particular patient today. Patient-centred teaching contrasts sharply with teacher-centred teaching, an all too common practice where clinical teachers teach what they know whether it addresses the patient's problem or not. Although patient-centred teaching requires explicit prioritisation of the patient's problems, effective teachers take pains not to prioritise disease (what the patient has) more highly than illness (what the patient feels). This fundamental tenet of clinical medicine has become countercultural in many academic centres today.

But, whether the caring agenda is strictly technical (disease-oriented) or more holistic (illness-oriented), its defining characteristic is notable. Here, patient care refers to what doctors do for patients, the services we provide, whether brief counselling or major surgery. Such things, of course, clinical teachers must teach. But there's the rub: thus defined, care is a thing—a product provided by clinicians, received by patients, measured by quality analysts, quantified by payers. This banal definition, especially when combined with the mistaken notion that well-trained physicians are interchangeable, contributes to the increasingly popular idea that clinical care is a commodity.

Francis Peabody took a different view when he observed famously that "the secret of the care of the patient is in caring for the patient."[48] In words that still resonate today, he noted:

> The physician who attempts to take care of a patient while he neglects [the patient's emotional life] is as unscientific as the investigator who neglects to control all the conditions that may affect his experiment. The good physician knows his patient through and through, and his knowledge is bought dearly. Time, sympathy and understanding must be lavishly dispensed but the reward is to be found in that personal bond which forms the greatest satisfaction of the practice of medicine.[48]

For Peabody, dying of cancer at age 47 when he wrote, caring meant not only the things clinicians do for patients but also the personal bond that gives them meaning.

Of course, to link learning to such depth of caring assumes that learners (and teachers) care so deeply. This assumption is not true for all clinicians today; some of us don't care, not in the way Peabody meant. Worse, the medical profession as a group has not tried to discover who these careless clinicians are or how they got that way. Ask patients what makes a good doctor and many will give some variation on the same answer: a doctor who cares about me. But the truth is that our profession has not taken the trouble to study systematically what

such caring means. Our negligence in this matter is not merely inconvenient, it is deeply troubling, calling into question how much our profession really cares about patient care.

To their credit, august professional organisations have defined competencies requisite for all clinicians, including the 800-pound gorilla called professionalism.[49–52] Its components no doubt make up much of what patients look for in a doctor who cares. But defining professionalism won't make it happen; only the professionals can do that. Fortunately, thousands do, magnificently, every day. The unanswered question is who will join their ranks, take their place? Who will convince future generations that Peabody's way of caring is normative, not nostalgic? The inconvenient truth is that no one knows the answers to these questions, and not all of us care.

Kindle kindness

Ultimately, teaching is all about the learner, not the teacher. Thus, effective clinical teachers aspire to a sort of selflessness whose tangible expression is kindness to learners, especially when assessing them (giving feedback). Kindness makes even the toughest criticism hopeful, empowering the learner by making learning less oppressive. Not incidentally, patients appreciate kindness too.

If, then, kindness makes patients more satisfied, teachers more effective, and learners more receptive, we should kindle it. But, what is it, exactly? It is not merely politeness, as the philosopher André Comte-Sponville has argued.[53] He does not demean politeness, surely an important thing:

> All the world's a stage, and living means acting…Not being virtuous, we make a pretense of virtue; this is called politeness. Not knowing how to love, we act as though we did; this is called morality.[53]

But, in medicine today, this apparent pretence of virtue is often confused with the real thing. The new provider-customer model of the doctor-patient relationship abets this confusion, making little distinction between the solicitude of a salesman and the benevolence of a physician. Some learners today don't know the difference. Unfailingly polite, they pretend kindness, a smarmy sham of the real thing.

The real thing, in the philosopher's view, has more to do with gentleness than politeness. On a mundane level, physicians' gentleness is tactical. Privileged to enter the intimate lives of strangers, they use gentleness to enable empathy and communication. But its deeper relevance—to Peabody's secret of caring, to the ideals of medicine—shows itself when gentleness combines with generosity.

> Generosity invites us to give in the absence of love to the very people we do not love, and to give them more the more they need it, or the better equipped we are to help them. Indeed when love cannot guide us because we do not feel it, let us be guided by urgency and proximity. This…is…generosity. Joined by justice, [generosity] becomes equity. Coupled with compassion, it becomes benevolence…But its most beautiful name is its secret, an open secret that everyone knows: accompanied by gentleness, it is called kindness.[53]

How, then, can teachers kindle kindness in medicine? It can't be done in a classroom. No doubt medical learners are "good at reading what the environment expects of them—and then meeting these expectations".[54] But courses in medical ethics and medical humanities, however valuable, can't kindle kindness. The inconvenient truth is that there is only one way: someone has to do it, walk the walk for all to see. "Example is not the main thing in influencing others," Albert Schweitzer said, "it is the only thing."[55]

Demonstrating kindness doesn't mean that clinical teachers must be heroes or saints. In fact, what matters are the little things, what Comte-Sponville calls "kindness of manner".[53] Such simple human kindness is natural to most physicians-in-training (in whom it must be nurtured); unfortunately, it is not natural to all. Whether kindness is teachable is a crucial question because, without its spark, kindness in its nobler forms—altruism, benevolence, equity—cannot be kindled. The ideals of medicine, both in practice and in teaching, "begin…and end…with the patient".[56]

Some might think these habits set the bar too high. Certainly they exceed my own reach more often than I like. But there is much to recommend lofty goals, especially today when the science of medicine is soaring. Clinicians must catch up, not to compete with the scientists but to become their equal partners again.[2,57] To do so, we can tap new sources of energy—computer-simulated training, decision-support systems, faculty development programmes—but we must also prove their power and cost-effectiveness. Better educational research is essential.[58–60] Above all, we must acknowledge a final inconvenient truth: "Our will to take action is a renewable resource."[11] Temperatures are rising. We best take heed before the tides rise too.[61,62]

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Beth Israel Medical Center
University Hospital and Manhattan Campus
for the Albert Einstein College of Medicine

Department of Medicine
Residency Training Program
First Avenue at 16th Street
New York, NY 10003
Tel: 212-420-3992
Fax: 212-420-4615

COMPETENCY BASED CLINICAL EVALUATION EXERCISE (CEX)

Evaluator: _____ **Subject**: _____ **Rotation**: _____

Setting: In-patient **Focus**: History and Physical **Approx time**: 5-20 minutes *(*HCAHPS Physician Questions)*

PROFESSIONALISM

1) *Treats patient with courtesy and respect during the encounter
☐ Always ☐ Usually ☐ Sometimes ☐ Never

2) Hand Washing
☐ Washes hands ☐ Should wash hands ☐ Not observed

3) Performs introductions
☐ Introduces individuals present ☐ Needs to complete introductions ☐ Not observed

4) Explains Process to patient
☐ Explains process to patient ☐ Needs to explain more fully ☐ Not observed

5) Considerate of Patient
☐ Considers patient comfort/privacy ☐ Should better address patient comfort/privacy ☐ Not observed

INTERPERSONAL AND COMMUNICATION SKILLS (Interview)

6) Uses open ended questions
☐ Open ended ☐ Should be more open ended ☐ Not open ended ☐ Not observed

7) *Listens carefully
☐ Elicits concerns and responses ☐ Usually elicits ☐ Sometimes elicits ☐ Overlooks concerns ☐ Not observed

8) Completeness
☐ Is complete ☐ Largely complete ☐ Incomplete ☐ Not observed

9) Focus
☐ Is properly focused ☐ Mainly focused ☐ Needs to focus ☐ Not observed

PATIENT CARE (Physical examination)

10) Organization
☐ Very organized ☐ Reasonably organized ☐ Requires organization ☐ Not observed

11) Positions self correctly
☐ Examines from the right ☐ Should examine from the right ☐ Not observed

12) Technique
☐ Technique good ☐ Needs some work ☐ Needs lots of work ☐ Not observed

13) Elicits findings
☐ Thorough and accurate ☐ Largely elicited ☐ Inaccurate exam ☐ Not observed

MEDICAL KNOWLEDGE

14) Ability to construct Differential Dx:
☐ Complete and appropriate ☐ Needs to be expanded ☐ Needs more focus ☐ Not discussed

OVER →

Beth Israel Medical Center
University Hospital and Manhattan Campus
for the Albert Einstein College of Medicine

Department of Medicine
Residency Training Program
First Avenue at 16th Street
New York, NY 10003
Tel: 212-420-3992
Fax: 212-420-4615

MEDICAL KNOWLEDGE (cont'd)

15) Completeness of Diagnostic Plan:
☐ Plan complete ☐ Largely complete ☐ Incomplete ☐ Not observed

16) Is logical and cost-effective:
☐ Logical and cost effective ☐ Requires more logic and less cost ☐ Not discussed

17) Knowledge:
☐ Solid ☐ Exceptional ☐ Outstanding ☐ Satisfactory-area of work
☐ Needs significant work ☐ Major concerns ☐ Not able to comment from interaction

18) Judgment:
☐ Knows what is important ☐ Needs to be more relevant ☐ Not observed

19) Recognizes patient acuity:
☐ Recognizes patient acuity ☐ Misreads or overlooks acuity ☐ Not observed

SYSTEMS-BASED PRACTICE (Counseling)

20) Completeness:
☐ Covers important areas ☐ Needs to be more complete ☐ Not observed

21) *Explains things in ways that the patient understands
☐ Always ☐ Usually ☐ Sometimes ☐ Never ☐ Not observed

22) *Explains meds/side effects
☐ Always ☐ Usually ☐ Sometimes ☐ Never ☐ Not observed

23) Gets commitment & closure:
☐ Gets a commitment ☐ Needs to get commitment ☐ Not observed

24) Overall by observer
☐ No proficiency ☐ Minimal skills ☐ Major concerns ☐ Needs significant work
☐ Needs work in several areas ☐ Solid performance ☐ Excellent ☐ Outstanding ☐ Exceptional

PRACTICE BASED LEARNING & IMPROVEMENT

25) Trainee constructs self assessment/action plan:

Comments

PRACTICE BASED LEARNING & IMPROVEMENT

26) Observer provides feedback/recommendation/direction:

Comments

Confidential Evaluation of Attending and Rotation by Trainee

Evaluator: **Subject:**

Rotation:

Employer:

This is a CONFIDENTIAL EVALUATION.

Please evaluate the Attending and the Rotation you just completed. Please rate the attending or rotation for each listed question or criteria. Be as specific and factual as possible. Global adjectives or remarks, such as "good attending" do not provide meaningful feedback.

PATIENT CARE

1) How often did faculty member bring team to the bedside for history or physical exam demonstration or observation?

Never 1 | Hardly ever 2 | Some days 3 | Most days 4 | Almost everyday 5 | Everyday 6

2) How often did faculty member directly observe my history or physical examination skills?

Never 1 | Hardly ever 2 | Some days 3 | Most days 4 | Almost everyday 5 | Everyday 6

3) How often did the faculty member discuss cases?

Never 1 | Hardly ever 2 | Some days 3 | Most days 4 | Almost everyday 5 | Everyday 6

4) How often did the faculty member address patient management?

Never 1 | Hardly ever 2 | Some days 3 | Most days 4 | Almost everyday 5 | Everyday 6

MEDICAL KNOWLEDGE

5) Practical clinical knowledge

Unsatisfactory 1 2 3 | Satisfactory 4 5 6 | Excellent 7 8 9

6) Knowledge of pathophysiology

Unsatisfactory 1 2 3 | Satisfactory 4 5 6 | Excellent 7 8 9

7) Review & coverage of the written curriculum

Unsatisfactory 1 2 3 | Satisfactory 4 5 6 | Excellent 7 8 9

PRACTICE-BASED LEARNING AND IMPROVEMENT

8) How often did faculty member cite useful references?

Never 1 | Hardly ever 2 | Some days 3 | Most days 4 | Almost everyday 5 | Everyday 6

9) How often did faculty member **bring in** handouts, articles or materials for the team?

Never 1 | Hardly ever 2 | Some days 3 | Most days 4 | Almost everyday 5 | Everyday 6

10) Did faculty member provide me

Yes No

with verbal feedback about my performance both during (at least once mid-way) **and** at the end of the rotation?

○ ○

INTERPERSONAL AND COMMUNICATION SKILLS

11) Models compassionate patient interaction

Unsatisfactory 1 2 3 — Satisfactory 4 5 6 — Excellent 7 8 9

○ ○ ○ ○ ○ ○ ○ ○ ○

12) Addresses patient values

Unsatisfactory 1 2 3 — Satisfactory 4 5 6 — Excellent 7 8 9

○ ○ ○ ○ ○ ○ ○ ○ ○

PROFESSIONALISM

13) On average how often were the required teaching attending rounds held for your rotation (expectations are 5 days/week for floors/elective, 7 days/week for MICU/CCU, RSDU)?

Never 1 — Hardly ever 2 — Some days 3 — Most days 4 — Almost everyday 5 — Everyday 6

○ ○ ○ ○ ○ ○

14) Attendance, availability and punctuality

Unsatisfactory 1 2 3 — Satisfactory 4 5 6 — Excellent 7 8 9

○ ○ ○ ○ ○ ○ ○ ○ ○

15) Treats others with respect

Unsatisfactory 1 2 3 — Satisfactory 4 5 6 — Excellent 7 8 9

○ ○ ○ ○ ○ ○ ○ ○ ○

16) Commitment to teaching

Unsatisfactory 1 2 3 — Satisfactory 4 5 6 — Excellent 7 8 9

○ ○ ○ ○ ○ ○ ○ ○ ○

17) Did the Faculty member encourage and assist me in complying with ACGME Duty Hour regulations?

Yes No

○ ○

SYSTEMS-BASED PRACTICE

18) Critical review of my H&P, assessment, plan

Unsatisfactory 1 2 3 — Satisfactory 4 5 6 — Excellent 7 8 9

○ ○ ○ ○ ○ ○ ○ ○ ○

19) When I presented a case, how often did the faculty member provide me feedback on my oral presentation?

Never 1 — Rarely 2 — Sometimes 3 — Most times 4 — Every time 5

○ ○ ○ ○ ○

20) Feedback on my chart documentation

Unsatisfactory 1 2 3 — Satisfactory 4 5 6 — Excellent 7 8 9

○ ○ ○ ○ ○ ○ ○ ○ ○

21) Discusses efficient use of medical resources

Unsatisfactory			Satisfactory			Excellent		
1	2	3	4	5	6	7	8	9

CLINICAL JUDGMENT AND DECISION-MAKING

22) Clinical judgment

Unsatisfactory			Satisfactory			Excellent		
1	2	3	4	5	6	7	8	9

OVERALL

23) OVERALL

Unsatisfactory			Satisfactory			Excellent		
1	2	3	4	5	6	7	8	9

24) Would you recommend that this faculty member continue to serve as a teaching attending for the training program?

Yes No

In your comments, please focus on specifics. Cite examples of both positive behaviors and those in need of improvement, and where applicable, give clear suggestions for how to improve. Describe interactions with patients, families, or colleagues, and comment on the quality of presentations/participation in rounds.

25) **COMMENTS ON ATTENDING (150 characters - about 35 words - mandatory minimum):**

Comment

Remaining Characters: 5000

COMMENT

26) **COMMENTS ON ROTATION (150 Characters - about 35 words - mandatory minimum):**

Comment

Remaining Characters: 5000

WELL BEING

27) Please rate your stress level during this rotation

No Stress								Severe Stress
1	2	3	4	5	6	7	8	9

28) Please rate your fatigue level during this rotation

No Fatigue							Severe Fatigue
2	3	4	5	6	7	8	

1 9

Return to Questionnaire

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Beth Israel

University Hospital and
Manhattan Campus for
the Albert Einstein College
of Medicine

Department of Internal Medicine
Beth Israel Medical Center
Milton and Carroll Petrie Division
First Avenue at 16th Street
New York, NY 10003
Tel: 212 420 4016
Fax: 212 420 4615
E-mail: dsteinbe@chpnet.org

WeHealNewYork.org

Daniel I. Steinberg, MD, FHM
Vice Chair for Education
Program Director
Residency Training Program
Department of Medicine

Dear Faculty Colleagues,

The Albert Einstein College of Medicine requires that every third and fourth year medical student rotating on either their clerkship or sub-internship complete an Observed Clinical Encounter (OCE).

The OCE is a "traditional" observed history and physical exam that takes about one hour, including feedback given to the student.

Previously these had been done by our subspecialty fellows, but AECOM is now clear that only Faculty may conduct the OCEs.

Faculty will be asked to complete an OCE during a month in which a Faculty member is serving as an inpatient ward teaching attending. The rules stipulate that the OCE should be done by a Faculty member who is not the student's teaching attending. So, when you are on your ward teaching month, you will be asked to conduct an OCE on medical student who is not on your ward team.

Students will be assigned to a Faculty member to conduct their OCE. The students are responsible for contacting their assigned Faculty member (we will provide them with your contact information). The Faculty member is responsible for selecting a patient. The OCE may occur in any setting at any time, either inpatient or outpatient, at your convenience (but before the student finishes their rotation.)

The forms attached are samples of the OCE for the MS4 (Sub interns) and MS3 (Clerks) students that you can use at the bedside to make notes on during the OCE. However, the original and required form which you must then complete is on "New Innovations."

Ms. Marvia Alston, our Medical Student Manager, can help you with New Innovations username and password issues and general OCE instructions/questions. Her contact information is (212) 420-2058 or malston@chpnet.org.

The Department of Medicine clearly recognizes and appreciates the time and support that you dedicate to the AECOM students.

Respectfully Yours,

Daniel I. Steinberg, MD, FHM

Albert Einstein College of Medicine
FACULTY EVALUATION OF OBSERVED CLINICAL ENCOUNTER (OCE)

Name of Student: _____Date: _____

Name of Faculty Observer:_____

Evaluate the clerk's performance in each section. Comment on areas that need improvement and review form with the student.

I. Opening Skills	Fully	Partially	Not at all	N/A	Comments:
1. Introduces self and explains role	☐	☐	☐	☐	
2. Establishes names/relationships of patients and families	☐	☐	☐	☐	
3. Attends to patient's comfort	☐	☐	☐	☐	
4. Starts with an open-ended question	☐	☐	☐	☐	

II. Information Gathering Skills	Fully	Partially	Not at all	N/A
1. Elicits patient's agenda	☐	☐	☐	☐
2. Examines each problem/concern using open-to-closed questions	☐	☐	☐	☐
3. Clarifies patient's unclear statements	☐	☐	☐	☐
4. Allows sufficient time (pauses) for patient to answer	☐	☐	☐	☐
5. Summarizes effectively	☐	☐	☐	☐
6. Asks "what else?" to elicit all problems and concerns	☐	☐	☐	☐
7. Develops in chronological sequence an accurate description of the history of present illness	☐	☐	☐	☐

III. Interpersonal Skills	Fully	Partially	Not at all	N/A
1. Uses appropriate eye contact, body language	☐	☐	☐	☐
2. Uses facilitative listening skills (e.g., head nodding, "uh-huh", repeating patient's last statement)	☐	☐	☐	☐
3. Demonstrates empathy (reflection, legitimation, respect)	☐	☐	☐	☐
4. Partnership: elicits patient's perspective and negotiates solutions and treatment plans	☐	☐	☐	☐
5. Involves family member as appropriate	☐	☐	☐	☐

IV. Patient Education Skills (when appropriate)	Fully	Partially	Not at all	N/A
1. Elicits patient's understanding of problems	☐	☐	☐	☐
2. Addresses beliefs, misconceptions	☐	☐	☐	☐
3. Gives explanations in clear language, avoids jargon	☐	☐	☐	☐
4. Invites questions/checks for understanding	☐	☐	☐	☐

V. Direct Observation of Physical Examination

	Yes	No				
1. Washes hands	☐	☐				
	Fully	Partially	Not at all	N/A	Comments:	
2. Demonstrates concern for the patient's comfort and modesty	☐	☐	☐	☐		
3. Explains to patient what is being done	☐	☐	☐	☐		
4. Enlists the patient's cooperation during the exam	☐	☐	☐	☐		
5. Follows a logical sequence of examination from one region to another	☐	☐	☐	☐		
6. Emphasizes areas of importance as suggested by interview	☐	☐	☐	☐		
7. Modifies the exam to adapt to patient limitations (imposed by illness, age or temperament of patient)	☐	☐	☐	☐		

8. Uses proper technique for the following portions of the exam:

	Yes	No	Comments
Eyes	☐	☐	
Ears	☐	☐	
Throat	☐	☐	
Neck	☐	☐	
Lungs	☐	☐	
Heart	☐	☐	
Abdomen	☐	☐	
Extremities	☐	☐	
Neuro	☐	☐	
Other	☐	☐	

Overall Evaluation:

☐	☐	☐	☐	☐	☐	☐	☐
1	**2**	**3**	**4**	**5**	**6**	**7**	**U/A**
Unsatisfactory	**Marginal**		**Satisfactory**		**Outstanding**		

Comments (Please be explicit about strengths and areas that need improvement):

_____

_____

_____

_____

_____

_____

Albert Einstein College of Medicine of Yeshiva University
EVALUATION OF CLINICAL PERFORMANCE AND PROFESSIONAL ATTRIBUTES

Student _____

Clerkship/Rotation _____ _____ _____Required _____ Elective

Location _____ Dates _____

Evaluators _____

For each item, please CIRCLE THE NUMBER that best describes the level of performance that the student demonstrated for each objective. CIRCLE NA for items you are unable to assess or are not applicable.

1	2	3	4	5	6	7	NA
Unacceptable	**Below expectations**		**Meets expectations**	**Exceeds expectations**		**Outstanding**	**Not applicable**

KNOWLEDGE: Demonstrates the breadth and depth of information specific to patient care.

1	2	3	4	5	6	7	NA
Exhibits major deficits in fund of basic science and/or clinical knowledge.			Exhibits appropriate fund of basic science and clinical knowledge needed to provide patient care.			Exhibits broad under-standing of basic science & clinical knowledge. Integrates knowledge from multiple sources at a depth greater than expected for level.	

INTERVIEWING SKILLS: Elicits an accurate and appropriate history**.**

1	2	3	4	5	6	7	NA
Fails to elicit pertinent & major components of history. Is disorganized and/or poorly focused. Insensitive to patient's needs and comfort.			Accurately gathers clinical information from patients. Is organized. Is sensitive to patient's needs and comfort.			Exceptionally accurate & thorough history taking. Routinely organized & logical. Superb interactions with patient during interview.	

PHYSICAL EXAMINATION SKILLS: Performs an accurate and appropriate physical exam.

1	2	3	4	5	6	7	NA
Fails to do parts of the PE pertinent to the case. Demonstrates poor technique. Is insensitive to patient comfort.			Performs an appropriate, systematic & accurate physical examination. Is respectful and sensitive to patient comfort.			Exceptionally accurate & thorough PE. Able to elicit subtle physical findings. Consistently able to tailor PE to specific case.	

MANUAL AND PROCEDURAL SKILLS: Adeptly and safely performs defined procedures.

1	2	3	4	5	6	7	NA
Compromises safety, does not address patient comfort & understanding OR did not attempt defined procedures.			Appropriately & safely performs defined procedures. Addresses indications, risks & alternatives. Attends to patient comfort & understanding.			Adeptly performs all defined procedures with minimal direction. Completely & clearly explains all indications, risks & alternatives. Optimizes patient comfort.	

ORAL PRESENTATION SKILLS**:** Effectively presents all pertinent patient oriented information.

1	2	3	4	5	6	7	NA
Disorganized, difficult to follow; inaccurate or missing key information; assessment & plans inadequately expressed.			Organized & easy to follow. Conveys accurate picture. Assessment & plans adequately delineated.			Succinctly and effectively presents all relevant information; assessments and plans clear and convincingly justified; few questions left unanswered.	

WRITTEN NOTES/WRITE-UPS: Effectively documents patient oriented information.

1	2	3	4	5	6	7	NA
Disorganized, difficult to follow, inaccurate or missing key information. Assessment & plans inadequately documented.			Organized & easy to follow. Conveys accurate picture. Assessment & plans adequately delineated.			All pertinent information present; accurate & well organized. Assessment & plans clear & convincingly justified. Any reader receives clear picture of patient's condition & management.	

COMMUNICATION WITH PATIENTS & FAMILIES: Communicates effectively with patients and families.

1	2	3	4	5	6	7	NA
Heavy use of medical jargon. Does not convey patient action steps. Does not check for under-standing. Does not use language interpreter when appropriate.	.		Minimizes medical jargon and uses plain language. Conveys basic patient action steps. Checks for understanding. Uses a language interpreter when appropriate			Avoids all medical jargon and uses plain language. Emphasizes patient action steps. Assesses for accurate patient under-standing; Effectively uses a language interpreter when appropriate.	

CLINICAL JUDGMENT: Reasons effectively to form comprehensive differential diagnoses.

1	2	3	4	5	6	7	NA
Unable to prioritize patient information and generates inaccurate, inadequate differential diagnoses.			Prioritizes patient information and generates accurate & basic differential diagnoses.			Prioritizes relevant patient information & synthesizes accurate & comprehensive differential diagnoses.	

PATIENT MANAGEMENT: Formulates patient centered management plans.

1	2	3	4	5	6	7	NA
Formulates inappropriate management plans or management plans neglect patient values & preferences.			Formulates appropriate management plans that consider patient values and preferences.			Formulates comprehensive management plans that integrate patient values & preferences.	

HEALTH PROMOTION / DISEASE PREVENTION: Formulates the recommended clinical preventive services in a patient centered manner.

1	2	3	4	5	6	7	NA
Does not formulate health maintenance plans for patients or develops inappropriate plans for the patient's age, gender, and risk factor status.			Identifies evidence-based health maintenance plans appropriate for the patient's age, gender, and risk factor status. Promotes prevention during most patient encounters when appropriate.			Appraises and formulates appropriate evidence-based health maintenance plans. Promotes prevention during all patient encounters when appropriate.	

RELATIONSHIP WITH PATIENTS & FAMILIES: Builds rapport with and advocates for patients and families.

1	2	3	4	5	6	7	NA
Does not connect to patients and families. Shows insensitivity to patient needs and concerns. Is disrespectful towards patients.			Develops rapport and partners with patients and families. Is respectful and caring towards patients and attentive to their needs.			Builds productive, trusting relationships with patients and families. Is exceptionally caring, supportive & empathetic towards patients. Is a strong patient advocate.	

RELATIONSHIP WITH CLINICAL STAFF / TEAMWORK SKILLS: Establishes productive, respectful working relationships with all health team members.

1	2	3	4	5	6	7	NA
Does not integrate into the team. Is disrespectful to any member of the health care team. Does not contribute to the team effort.			Is respectful towards and works well with all members of the health care team. Participates in and contributes to the team effort .			Integrates smoothly and productively with the entire clinical team. Takes exceptional initiative to contribute to the work and education of the team.	

PROFESSIONAL ATTRIBUTES: Exhibits personal integrity.

1	2	3	4	5	6	7	NA
Disrespectful, insensitive, inattentive to patients' needs. Fails to acknowledge errors, disinterested, or not forthright.			Truthful, trustworthy, models ethical behavior, Accepts responsibility for errors, maintains privacy & confidentiality and appropriate attire.			Demonstrates leadership. Always demonstrates respect, integrity & honesty. Willingly acknowledges errors.	

RELIABILITY / ATTENDANCE: Exhibits commitment, dependability, & responsibility.

1	2	3	4	5	6	7	NA
Does not show up or is late to scheduled activities. Fails to complete assignments. Misses deadlines. Lack of preparation.			Prepared. Punctual, meets deadlines, complies with policies, follows through on tasks.			Seeks additional responsibility beyond what is assigned. Functions independently. Self-motivated. Always does what is expected & more. Always available when needed.	

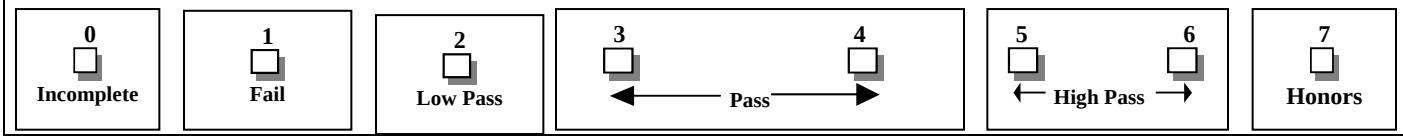
SELF-DIRECTED LEARNING: Identifies and addresses own educational needs.

1	2	3	4	5	6	7	NA
Fails to recognize limits of knowledge. Does not engage in reading			Recognizes limits of knowledge; reads about patient cases daily and uses appropriate resources			Sets learning goals. Reads extensively. Actively asks questions & seeks new knowledge. Communicates findings to colleagues & patients.	

FEEDBACK: Demonstrates willingness to elicit and responds constructively to feedback

1	2	3	4	5	6	7	NA
Fails to ask for, or modify behavior based on feedback			Asks for general feedback. Shows improvement based on feedback given.	.		Asks for specific feedback. Effectively incorporates feedback. Shows consistent improvement.	

NARRATIVE SUMMARY:



Evaluator signature: _____ Date: _____

Rev 5/11

AECOM Faculty Evaluation of Observed Clinical Encounter (OCE)

Evaluator: **Subject:**

Rotation:

Employer:

Evaluate the Clerk's performance in each section. Comment on areas that need improvement and review form with the student.

I. Opening Skills

1) Introduces self and explains role. Fully Partially Not at all N/A

Comments

Remaining Characters: 5000

2) Establishes names/relationships of patients and families. Fully Partially Not at all N/A

Comments

Remaining Characters: 5000

3) Attends to patient's comfort. Fully Partially Not at all N/A

Comments

Remaining Characters: 5000

4) Starts with an open-ended question Fully Partially Not at all N/A

Comments

Remaining Characters: 5000

II. Information Gathering Skills

5) Elicits patients agenda Fully Partially Not at all N/A

Comments

Remaining Characters: 5000

II. Information Gathering Skills

6) Examines each problem/concern using open-to-closed questions Fully Partially Not at all N/A

Comments

Remaining Characters: 5000

II. Information Gathering Skills

7) Clarifies patient's unclear statements Fully Partially Not at all N/A

Comments

Remaining Characters: 5000

II. Information Gathering Skills

8) Allows sufficient time (pauses) for patient to answer — Fully Partially Not at all N/A

Comments

Remaining Characters: 5000

II. Information Gathering Skills

9) Summarizes effectively — Fully Partially Not at all N/A

Comments

Remaining Characters: 5000

II. Information Gathering Skills

10) Asks "what else?" to elicit all problems and concerns — Fully Partially Not at all N/A

Comments

Remaining Characters: 5000

II. Information Gathering Skills

11) Develops in chronological sequence an accurate description of the history of present illness — Fully Partially Not at all N/A

Comments

Remaining Characters: 5000

III. Interpersonal Skills

12) Uses appropriate eye contact, body language — Fully Partially Not at all N/A

Comments

Remaining Characters: 5000

III. Interpersonal Skills

13) Uses facilitative listening skills (e.g., head nodding, "Uh huh", repeating patient's last statement) — Fully Partially Not at all N/A

Comments

Remaining Characters: 5000

III. Interpersonal Skills

14) Demonstrates empathy — Fully Partially Not at all N/A

(reflection, legitimation, respect)

Comments

Remaining Characters: 5000

III. Interpersonal Skills

15) Partnership: elicits patient's perspective and negotiates solutions and treatment plans

Fully Partially Not at all N/A

Comments

Remaining Characters: 5000

III. Interpersonal Skills

16) Involves family member as appropriate

Fully Partially Not at all N/A

Comments

Remaining Characters: 5000

IV. Patient Education Skills (when appropriate)

17) Elicits patient's understanding of problems

Fully Partially Not at all N/A

Comments

Remaining Characters: 5000

IV. Patient Education Skills (when appropriate)

18) Addresses beliefs, misconceptions

Fully Partially Not at all N/A

Comments

Remaining Characters: 5000

IV. Patient Education Skills (when appropriate)

19) Gives explanations in clear language, avoids jargon

Fully Partially Not at all N/A

Comments

Remaining Characters: 5000

IV. Patient Education Skills (when appropriate)

20) Invites questions/checks for understanding

Fully Partially Not at all N/A

Comments

Remaining Characters: 5000

V. Direct Observation of Physical Examination

21) Washes hands — Yes No

V. Direct Observation of Physical Examination

22) Demonstrates concern for the patient's comfort and modesty — Fully Partially Not at all N/A

Comments

Remaining Characters: 5000

V. Direct Observation of Physical Examination

23) Explains to patient what is being done — Fully Partially Not at all N/A

Comments

Remaining Characters: 5000

V. Direct Observation of Physical Examination

24) Enlists the patient's cooperation during the exam — Fully Partially Not at all N/A

Comments

Remaining Characters: 5000

V. Direct Observation of Physical Examination

25) Follows a logical sequence of examination from one region to another — Fully Partially Not at all N/A

Comments

Remaining Characters: 5000

V. Direct Observation of Physical Examination

26) Emphasizes areas of importance as suggested by interview — Fully Partially Not at all N/A

Comments

Remaining Characters: 5000

V. Direct Observation of Physical Examination

27) Modifies the exam to adapt to patient limitations (imposed by illness, age or temperament of patient) — Fully Partially Not at all N/A

Comments

Remaining Characters: 5000

Uses proper technique for the following portions of the exam:

28) Eyes — Yes No

Uses proper technique for the following portions of the exam:

29) Ears Yes No

Uses proper technique for the following portions of the exam:

30) Throat Yes No

Uses proper technique for the following portions of the exam:

31) Neck Yes No

Uses proper technique for the following portions of the exam:

32) Lungs Yes No

Uses proper technique for the following portions of the exam:

33) Heart Yes No

Uses proper technique for the following portions of the exam:

34) Abdomen Yes No

Uses proper technique for the following portions of the exam:

35) Extremities Yes No

Uses proper technique for the following portions of the exam:

36) Neuro Yes No

Uses proper technique for the following portions of the exam:

37) Other Yes No

Comments

Remaining Characters: 5000

38) **OVERALL EVALUATION:**

1 Unsatisfactory 2 Marginal 3 4 Satisfactory 5 6 Outstanding 7 U/A

Comments

39) (Please be explicit about strengths and areas that need improvement):

Comments

Remaining Characters: 5000

Return to Questionnaire

AECOM Student Evaluation Form

Evaluator: **Subject:**

Rotation:

Employer:

Skip this Form

1) To Skip this form, please select the appropriate option below:

I did not work with this Student ○ Not enough time to evaluate ○

For each item, please SELECT THE NUMBER that best describes the level of performance that the student demonstrated for each objective. SELECT NA for items you are unable to assess or are not applicable. **1=Unacceptable, 2-3=Below expectations, 4=Meets expectations, 5-6=Exceeds expectations, 7=Outstanding, NA=Not applicable**

KNOWLEDGE:

2) Demonstrates the breadth and depth of information specific to patient care. **1=**Exhibits major deficits in fund of basic science and/or clinical knowledge.**4=**Exhibits appropriate fund of basic science and clinical knowledge needed to provide patient care. **7=**Exhibits broad understanding of basic science & clinical knowledge. Intergrates knowledge from multiple sources at a depth greater than expected for level.

1 2 3 4 5 6 7 N/A

○ ○ ○ ○ ○ ○ ○ ○

INTERVIEWING SKILLS:

3) Elicits an accurate and appropriate history. **1=**Fails to elicit pertinent & major components of history. Is disorganized and/or poorly focused. Insensitive to patient's needs and comfort. **4=**Accurately gathers clinical knowledge needed to provide patient care. **7=**Expectionally accurate & thorough history taking. Routinely organized & logical. Superb interactions with patient during interview.

1 2 3 4 5 6 7 N/A

○ ○ ○ ○ ○ ○ ○ ○

PHYSICAL EXAMINATION SKILLS:

4) Elicits an accurate and appropriate history. **1**=Fails to elicit pertinent & major components of history. Is disorganized and/or poorly focused. Insensitive to patient's needs and comfort. **4**=Accurately gathers clinical information from patients. Is organized. Is sensitive to patient's needs and comfort. **7**=Exceptionally accurate & thorough history taking. Routinely organized & logical. Superb interactions with patient during interview.

1 2 3 4 5 6 7 N/A

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MANUAL AND PROCEDURAL SKILLS:

5) Adeptly and safely performs defined procedures. **1**=Compromises safety, does not address patient comfort & understanding OR did not attempt defined procedures. **4**=Appropriately & safely performs defined procedures. Addresses indications, risks & alternatives. Attends to patient comfort & understanding. **7**=Adeptly performs all defined procedures with minimal direction. Completely & clearly explains all indications, risks & alternatives. Optimizes patient comfort.

1 2 3 4 5 6 7 N/A

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ORAL PRESENTATION SKILLS:

6) Effectively presents all pertinent patient oriented information. **1**=Disorganized, difficult to follow; inaccurate or missing key information; assessment & plans inadequately expressed. **4**=Organized & easy to follow. Conveys accurate picture. Assessment & plans adequately delineated. **7**=Succinctly and effectively presents all relevant information; assessments and plans clear and convincingly justified; few questions left unanswered.

1 2 3 4 5 6 7 N/A

○ ○ ○ ○ ○ ○ ○ ○

WRITTEN NOTES/WRITE-UPS:

7) Effectively documents patient oriented information. **1**=Disorganized, difficult to follow, inaccurate or missing key information. Assessment & plans inadequately documented. **4**=Organized & easy to follow. Conveys accurate picture. Assessment & plans adequately delineated. **7**=All pertinent information present; accurate & well organized. Assessment & plans clear & convincingly justified. Any reader receives clear picture of patient's condition & management.

1 2 3 4 5 6 7 N/A

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COMMUNICATION WITH PATIENTS & FAMILIES:

8)

Communicates effectively with patients and families. **1**=Heavy use of medical jargon. Does not convey patient action steps. Does not check for understanding. Does not use language interpreter when appropriate. **4**=Minimizes medical jargon and uses plain language. Conveys basic patient action

steps. Checks for understanding. Uses a language interpreter when appropriate. **7**=Avoids all medical jargon and uses plain language. Emphasizes patient action steps. Assesses for accurate pateint understanding; Effectively uses a language interpreter when appropriate.

1 2 3 4 5 6 7 N/A

CLINICAL JUDGMENT:

9) Reasons effectively to form comprehensive differential diagnoses. **1**=Unable to prioritize patient information and generates inaccurate, inadequate differential diagnoses. **4**=Prioritizes patient information and generates accurate & basic differential diagnoses. **7**=Prioritizes relevant patient information & synthesizes accurate & comprehensive differential diagnoses.

1 2 3 4 5 6 7 N/A

PATIENT MANAGEMENT:

10) Formulates patient centered management plans. **1**=Formulates inappropriate management plans or management plans neglect patient values & preferences. **4**=Formulates appropriate management plans that consider patient values and preferences. **7**=Formulates comprehensive management plans that integrate patient values & preferences.

1 2 3 4 5 6 7 N/A

HEALTH PROMOTION / DISEASE PREVENTION:

11) Formulates the recommended clinical preventive services in a patient centered manner. **1**=Does not formulate health maintenance plans for patients or develops inappropriate plans for the patient's age, gender, and risk factor status. **4**=Identifies evidence-based health maintenance plans approprite for the patient's age, gender, and risk factor status. Promotes prevention during most patient encounters when appropriate. **7**=Appraises and formulates appropriate evidence-based heatlh maintenance plans. Promotes prevention during all pateint encounters when appropriate.

1 2 3 4 5 6 7 N/A

RELATIONSHIP WITH PATIENTS & FAMILIES:

12) Builds rapport with and advocates for patients and families. **1**=Does not connect to patients and families. Show insensitivity to patient needs and concerns. Is disrespectful towards patients. **4**=Develops rapport and partners with patients and families. Is respectful and caring towards patients and attentive to their needs. **7**=Builds productive, trusting relationships with patients and families. Is exceptionally caring, supportive & empathetic towards patients. Is a strong patient advocate.

1 2 3 4 5 6 7 N/A

RELATIONSHIP WITH CLINICAL STAFF / TEAMWORK SKILLS:

13) Establishes productive, respectful working relationships with all health team members. **1**=Does not integrate into the team. Is disrespectful to any member of the health care team. Does not contribute to the team effort. **4**=Is respectful towards and works well with all members of the health care team. Participates in and contributes to the team effort. **7**=Integrates smoothly and productively with the entire clinical team. Takes exceptional initiative to contribute to the work and education of the team.

1 2 3 4 5 6 7 N/A

PROFESSIONAL ATTRIBUTES:

14) Exhibits personal integrity. **1**=Disrespectful, insensitive, inattentive to patients' needs. Fails to acknowledge errors, disinterested, or not forthright. **4**=Truthful, trustworthy, models ethical behavior. Accepts responsibility for errors, maintains privacy & confidentiality and appropriate attire. **7**=Demonstrates leadership. Always demonstrates respect, integrity & honesty. Willingly acknowledges errors.

1 2 3 4 5 6 7 N/A

RELIABILITY / ATTENDANCE:

15) EXHIBITS COMMITMENT, DEPENDABILITY, & RESPONSIBILITY. **1**=Does not show up or is late to scheduled activities. Fails to complete assignments. Misses deadlines. Lack of preparation. **4**=Prepared. Punctual, meets deadlines, complies with policies, follows through on tasks. **7**=Seeks additional responsibility beyond what is assigned. Functions independently. Self-motivated. Always does what is expected & more. Always available when needed.

1 2 3 4 5 6 7 N/A

SELF-DIRECTED LEARNING:

16) Identifies and addresses own educational needs. **1**=Fails to recognize limits of knowledge. Does not engage in reading. **4**=Recognizes limits of knowledge; reads about patient cases daily and uses appropriate resources. **7**=Sets learning goals. Reads extensively. Actively asks questions & seeks new knowledge. Communicates findings to colleagues & patients.

1 2 3 4 5 6 7 N/A

FEEDBACK:

17) Demonstrates willingness to elicit and responds constructively to feedback. **1**=Fails to ask for, or modify behavior based on feedback. **4**=Asks for general feedback. Shows improvement based on feedback given. **7**=Asks for specific feedback. Effectively incorporates feedback. Shows consistent improvement.

1 2 3 4 5 6 7 N/A

NARRATIVE SUMMARY:

18) **NARRATIVE SUMMARY:**

1 Fail 2 Low Pass 3 4 Pass 5 6 High Pass 7 Honors Incomplete

Comments

Remaining Characters: 5000

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