Conflicts of Interest
• None

Talk Overview
• Visual Intelligence Quiz
• Teaching at the bedside-then and now
• Observation and Feedback
• Dossier Preparation-Clinician Educators
• Hidden, Null and Silent Curricula
• Strategies for Success
• Round Table Discussion, Questions and Comments

Amy Herman
• http://www.visualintelligencebook.com/blog/test-your-visual-literacy

• Help professionals whose judgment relies on assumptions, biases, and inferences operate to the maximum of their ability.

“Teaching is discovering to reflect on the number of students we have flanked in chemistry for not knowing what we have found to be utmost.” - Robert Wiser
Current Clinical Teaching

• Dramatic improvements in research and clinical care over the past 100 years
• Very few structural changes in bed-side teaching practices
• Little emphasis has been placed on teaching methods during your training
• Modestly reimbursed
• Contributes to promotion in clinician educator series
• Happening by default rather than design
**History of Time-Motion Studies of Residents in GIM**

<table>
<thead>
<tr>
<th>Year</th>
<th>Time Spent at Bedside in Direct Patient Contact</th>
<th>Time Spent Away from Bedside</th>
<th>Study Setting</th>
<th>Authors</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>12% (10-24 mins on admit then 7.7 mins per day in follow up)</td>
<td>40% with EMR reviewing the chart and writing orders</td>
<td>Residents on Medicine Wards at Johns Hopkins</td>
<td>Block et al/ J Gen Intern Med. 2013</td>
</tr>
<tr>
<td>1988</td>
<td>20% (17-28 mins on admit and 3.5 mins daily in follow up)</td>
<td>42-45% time charting in written MR, finding labs and writing orders</td>
<td>Residents on Medicine wards at a Minnesota VA</td>
<td>Parenti et al Am J Med 1993</td>
</tr>
<tr>
<td>1959</td>
<td>13-16% (Most time spent in first 24hrs then 10 mins daily)</td>
<td>Considerable time spent on chart and messenger work and writing orders</td>
<td>Residents at Grace-New Haven Hospital CT</td>
<td>Payson et al NEJM 1961</td>
</tr>
</tbody>
</table>

**Bedside Rounds Valued But Not Preferred:** Perceptions of Internal Medicine Residents and Attending Physicians in a Diverse Academic Training Program

Nursema B. Merchant, sec, and Daniel G. Federman, so:
- Despite participants finding few barriers and endorsing many values and adequate attending skills, our study reported that the frequency and preference for BDR were low and trainees were unsure of the educational value of BDR.
- Only 34% of residents agreed that BDR allowed them to learn more about patient care compared with other modes of rounding.

**Atrophy of Physical Exam Skills**

- **Hospitalists:** 18% of their time spent in direct patient contact
- **Interns:** 11% of time with patient 40% with EMR
- Poor percussion and tendon reflex elicitation techniques
- Failure to disrobe patients adequately

**The findings overlooked more than 5 times included:**
- Abdominal mass/organomegaly (n = 21, including 3 pregnancies and 2 distended bladders)
- Diagnostic skin finding (n = 15, such as café au lait spots, neurofibroma, erythema migrans, syphilitic lesions, and meningococcal lesions but not including herpes zoster)
- Neurologic findings (n = 18)
-Murderousness (n = 12, including 4 missed meningoencephalitis, 3 missed pericardial rubs)
- Cerebral aneurysm (n = 10)
- Skin lesions (n = 10) or cerebral/aneurysmal pathology (n = 6)
- Signs of pertussis (n = 10)
- Breast masses (n = 9)
- Fracture or orthopedic finding (n = 9)
- Congestive heart failure (n = 8)
- Absent or abnormal pulses (n = 6)
- Wound or ulcer (n = 6)
Practical tips to resurrect the clinical skills

- Engage students and residents in developing their visual intelligence
  - Formal Art Appreciation
  - Birding
- High Value Care
  - The value of sound clinical skills as a way to reduce cost and unnecessary testing
- Invest in junior faculty development
  - Improve our attending physicians confidence in teaching/demonstrating examination techniques at the bedside

Art Observation Improves Diagnostic Skills


The Learning Environment

- Setting will rarely be perfect
- Hallways/bedside/post call/ICU/OR/ED/PACS
- Interruptions a constant
- Absent team members
- Sleep deprivation

Create a Learning Environment

- Give them your undivided attention
- Engage all members of the team
- Acknowledge their work stressors
- Mix things up
  - Sit down
  - Walk round
- Merge teaching pearls and business rounds where possible
- Involve patient whenever possible

What is the Goal?

- For Teacher
  - Evaluations
  - Promotion
  - A captive audience
- For Learner
  - How will this help me care for or advocate for my patients when you are not here?
  - Passing the course/shelf test, graduating etc.
  - Why am I here?

Who is Your Audience

- MS I-II:
  - Memorize facts
  - Concrete thinking
- MS III-IV:
  - Problem Solving/Analytical Skills
  - Many different approaches to clinical problems
  - Using evidence in the right context
- Residents:
  - Taking responsibility for decisions
- Fellows:
  - Learn by teaching and modeling
  - Guarding against too narrow a focus
**In a Clinical Setting - Tips**

- Base all discussion on the patient alone
- Respect the patients comfort, confidentiality and dignity
- Model professionalism and bedside manner
- Teach/observe clinical skills
- Step out of earshot and debrief immediately.
  - “What just happened?”
- Choose your patients/cases wisely

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**The Work Habits of Effective Clinical Teachers**

- Preparation
- Interactive process
  - Direct observation
  - Questioning and giving examples
- Interplay between existing and new knowledge
  - Activate and mold what they already know
- Experiential learning

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**A Word on Preparation**

- Can’t always anticipate
- Have a series of canned topics ready to go
  - Common scenario’s in your area of expertise
- An image bank
- Show the junior learners how you problem solve using electronic data systems at your disposal.
  - Discuss your anxieties and intuition with them.
- The electronic pre-round-Epic:
  - Review at least one patient in depth and have an article and several teaching points ready

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**Facilitation of Small Groups**

- Set ground rules/ice breakers
- Clear tasks
- Don’t answer your own questions
- Try not to talk TOO much, take a back seat
- Look around the group, eye contact, take time to learn names

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**Appendix 2. “Diagnosing Parkinson Disease”: A Teaching Script**

1. The diagnosis of Parkinson disease is based on bedside findings.
2. The 5 cardinal features of Parkinson disease are resting tremor, bradykinesia, postural instability, and dysautonomia.
3. Resting tremor: “pill rolling” or “pill rolling.”
4. Bradykinesia: “Parkinsonian” or “pill rolling” rigidity.
5. Postural instability: 
   - Common to Parkinson disease.
   - Can be assessed with the patient “walking a straight line” or “standing on one foot.”
6. Dysautonomia: 
   - Common to Parkinson disease.
   - Can be assessed with the patient “standing on one foot.”
7. The “pill rolling” or “pill rolling” rigidity.
8. Postural instability: 
   - Common to Parkinson disease.
   - Can be assessed with the patient “walking a straight line” or “standing on one foot.”
9. Dysautonomia: 
   - Common to Parkinson disease.
   - Can be assessed with the patient “standing on one foot.”
Learning Problem Solving

- Team Based Learning (TBL)
  - Works in most specialties
  - Students in Y1 and 2 will be familiar with this method
  - In the clinical setting
- Evidence Based Medicine (EBM) has its limits
- Recognize all resources at their disposal, iPad’s/Google/Medline/Colleagues/Patient/Nurse/Social Worker etc.
- Generating the differential diagnosis based on pathophysiology and anatomy

Evaluation

- Verbal and visual cues
- Ask them to apply a new principle they just learned to another diagnosis
  - Anemia: Reduced production/Loss/Increased Destruction
  - Thrombocytopenia: reduced production/loss/destruction
- Listen to them calling a consult or signing out to their colleagues/conveying recommendations to the consulting team.
- Reading their Notes/Dictations

Feedback

- Practical
  - Observation is the currency of feedback
- Timely
  - Mid-block for students
  - Mid-rotation for residents
- Concrete
  - ‘Unpack’ clinical reasoning
  - Review motivations
  - With sensitivity
  - In private

UC Promotion Criteria

- Clinical Excellence
- Teaching
- Creativity
- University and Community Service

- UCLA Health Mission:
  - Teaching
  - Research
  - Clinical Care
  - Community Engagement

Bottom Line—Making it Count

- Start preparing your dossier/CV early
- Update frequently and after any teaching encounter
- Mix it up—Volunteer/Career Day/Local High Schools/talks/PBL/Shadowing/Mentoring
- Case report → vignette → noon conference (internal) → review article → Institution expert → Invited conference (external) → Regional expert → Grant → Peer reviewed publication.
Hidden, Null and Silent Curricula,
Ethics and Professionalism

Optimizing Clinical Learning Environments in
Becoming and Being a Physician

- **Formal Curriculum**
  - Intended, official curriculum sanctioned by the institution
  - Examples:
    - Course objectives
    - Course content
    - Competencies

- **Informal Curriculum**
  - Idiosyncratic, sporadic learning that occurs outside the classroom
  - Examples:
    - Ward rounds
    - Bedside rounds

- **Hidden Curriculum**
  - Embedded in organizational structure/culture. Not explicitly intended
  - Examples:
    - Empathetic role models
    - Respect for all patients and colleagues
    - Negative attitudes towards patients with substance abuse or obesity
    - Conflating a patient’s disease with who they are as a patient

- **Null Curriculum**
  - Definition: What is not taught
  - Examples:
    - Social justice
    - Patient advocacy

ACP Positions and Recommendations

1. The hidden curriculum must become a positive curriculum that aligns with the formal curriculum. Faculty and senior clinicians should model empathy, encourage reflection and discussion of positive and negative behaviors in the training environment, and promote clinician wellness.

2. The learning environment should foster respect, inquiry, and honesty and empower every individual, including learners, to raise concerns about ethic, professionalism, and care delivery. Teamwork and respect for colleagues must be both taught and demonstrated.
ACP Positions and Recommendations

3. Leaders should create and sustain a strong ethical culture by encouraging discussion of ethical concerns, making values in everyday decision making explicit, and embodying expectations of professionalism in which patient well-being is a core value.

Hidden Curricula, Ethics and Professionalism

A resident admits a patient with decompensated liver failure, stays with the family all night, and bonds with the patient. Despite resuscitation, the patient declines, developing multiorgan failure. The family meets with the team to discuss goals of care, but the resident has left the hospital because her duty hours have been completed. The ICU attending physician subsequently asks why the resident was not at the meeting, because it was a unique learning opportunity and she was that patient’s physician. The resident feels caught between conflicting messages, worrying that some attending physicians may unfairly judge her as not eager to learn when she is simply trying to follow duty hour rules.

What’s In A Name?

It is your first day as a PBL instructor, and your co-instructor is a senior professor in another department. The two of you ask for introductions. When one student says his name, your co-instructor asks him to repeat it a couple of times. Finally, the co-instructor says, “Well, I have never heard of that name before, I can't really pronounce it, so I am just going to call you ‘Joe’.” The student is surprised, and clearly not sure how to respond. He looks around the group, but everyone is quiet as they move to the next student.

How might this make the student feel?

How do you feel?

What do you say? Would this be difficult?
“My Name is Not ‘Interpreter’”

“As a medical student, I have often felt marginalized from my medical community. I have been told that my name is not American,” fallen prey to being confused for support staff such as a janitor (even while wearing my white coat), and have been asked questions like “Where are you really from?” or “When you’re done with training, are you going back to your country?” The greatest barb, however, was being summoned as “interpreter” by an attending physician during my surgery rounds...

...“Interpreter!” he would bark out. I instantly appeared before the group and would begin to interpret. I dreaded the days I had to work with this attending... I was stuck trying to decide if and how I would respond to these comments, especially in such a disproportionate power dynamic. Is he trying to help me by showcasing my language skills? Is he just trying to be funny? Am I overreacting? Will I be perceived as the angry minority if I speak up? At these instances, I felt helpless and powerless—there were no open conversations about racism, and I was left alone to deal with these difficult situations.”

Statement on Diversity

We, the David Geffen School of Medicine at UCLA, aim for excellence in all tenets of healthcare, including education, research, community engagement, and clinical care. We believe that the core values of diversity and inclusion are inseparable from our institutional goal.
Tips for Success As an Academic Clinical Investigator

• Choosing and Completing Projects
• Interacting With People
• Giving Talks
• Writing Papers
• Securing Funding
• Clinical Work
• Time Management
• Self-Awareness
• Keep Evolving

Time Management
• Set priorities
• Meet deadlines
• Work many hours
• Work efficiently
• Do not confuse being busy with being productive
• Keep a realistic and prioritized to-do list
Tips for Success As an Academic Clinical Investigator

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• Securing Funding
• Clinical Work
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Welcome!

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Round Table Discussion
Questions & Comments