hard copies to [redacted]

4/4/97

Dear [redacted] -

I've reviewed the video narratives a few times, and am providing you with my own (filtered) summary. I think this makes it a little easier to see what's there. I would draw the following (tentative) conclusions, based only on the written comments:

In terms of what students value, I identify three Interpersonal categories: 1a) Rapport: Faculty have to be "approachable," nonthreatening, have good listening skills 1b) Interaction: Faculty must challenge and stimulate thinking in students and involve student in dialogue 1c) Feedback: Faculty must give feedback, a lot of positive reinforcement, but also constructive criticism. Then there are "basic" and "advanced" content requirements: 1) Basic fund of knowledge and skills: Faculty have to know more than students, share information they don't have, or demonstrate new skills. Students are looking for specifics and detail in teaching. accuracy and relevance 2) Advanced diagnostic/clinical reasoning: Faculty have to be able to show students how to get from a to z, how to synthesize isolated facts and observations, how to analyse, organize and prioritize information/problems, etc. What is particularly valued in this area is organization and a systematic approach.

Regarding what is important to faculty, there is less articulated, (and I think more implicit expectations), but this is what is emphasized in the written narrative: 1) Interpersonal - good listening skills, not interrupting 2) Helping student identify and set priorities 3) Covering key issues. Less often faculty mentioned the importance of giving positive feedback, being organized, systematic, and thorough in their interaction with the student.

In the interpersonal sphere, student criticism of faculty, predictably, focused primarily on interpersonal skills (or lack thereof!), such as poor rapport, being intimidating, harsh, and rigid, behaving in a condescending or sexist manner, interrupting, seeming hurried. Students also complained when faculty were insufficiently helpful in developing a differential diagnosis, or gave them inadequate guidance about how to prioritize/conduct the H & P, or the PE.

Faculty criticism focused on interruptions, missed teaching opportunities, being too intrusive and not sufficiently interactive (ie., simply lecturing the student, taking over the exam, not eliciting/stimulating student ideas/thinking), and not providing positive feedback. Faculty observers occasionally criticised preceptors for omitting important questions or apparently not seeing the big picture of the differential (ie., focusing excessively on the symptom).

Comments were clearly as much a function of student/faculty observer and station as they were of the individual preceptor. For example, certain observers persistently commented on interruptions, and certain stations elicited negative comments about the H & P instruction regardless of preceptor. On the other hand, individual preceptor characteristics were also implicated, and clearly certain preceptors were regarded as superior to others. In terms of faculty styles, I would identify three: 1) Superstars, who were triple threats: Great interpersonal style, impressive fund of knowledge, and outstanding clinical reasoning skills 2) Drones, not very interpersonally gifted, but hardworking, knowledgeable doctors who concentrated on the "medicine" and knew their stuff 3) Taskmasters, who were somewhat harsh, cold, or abrupt, but nevertheless were recognized as having something to teach students.

Well, that summarizes my initial reactions. Please review these comments and let me know where you think we should go from here. Hope all is going well. Johanna