Teaching at the Bedside: Practical Strategies to Overcome Real-World Challenges

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Objectives

By the end of this session, you will:

- **Recognize and articulate** the unique value of bedside teaching
- **Address barriers** to effective and efficient bedside teaching/rounding
- **Be ready to implement** several tips for better bedside teaching

Why teach at the bedside?

Educational Benefits

- Better feedback: assess reasoning, communication, examination
- Confirm/adjust history/physical early, efficiency
- Model clinical reasoning
- Model behavior (compassion, communication, professionalism)
- Teach physical examination

Nursing Benefits

- Many nurses like it

Patient Benefits

- Many patients like it
- Perception of more time in care
- Involve patient in discussions
- Show patient how smart their team is and how hard they're working

- Fun

Potential barriers to effective bedside teaching/rounding

1. Time (yours, theirs)
2. Learner concerns: intimidating, corrections, autonomy
3. Structure: roles/position, computers
4. Patients: talk too much, sensitive issues, intrusive, confusing
5. Teacher concerns: knowledge, communication deficiencies
6. Not thought worthwhile

1. Time

Bedside rounding does not take longer

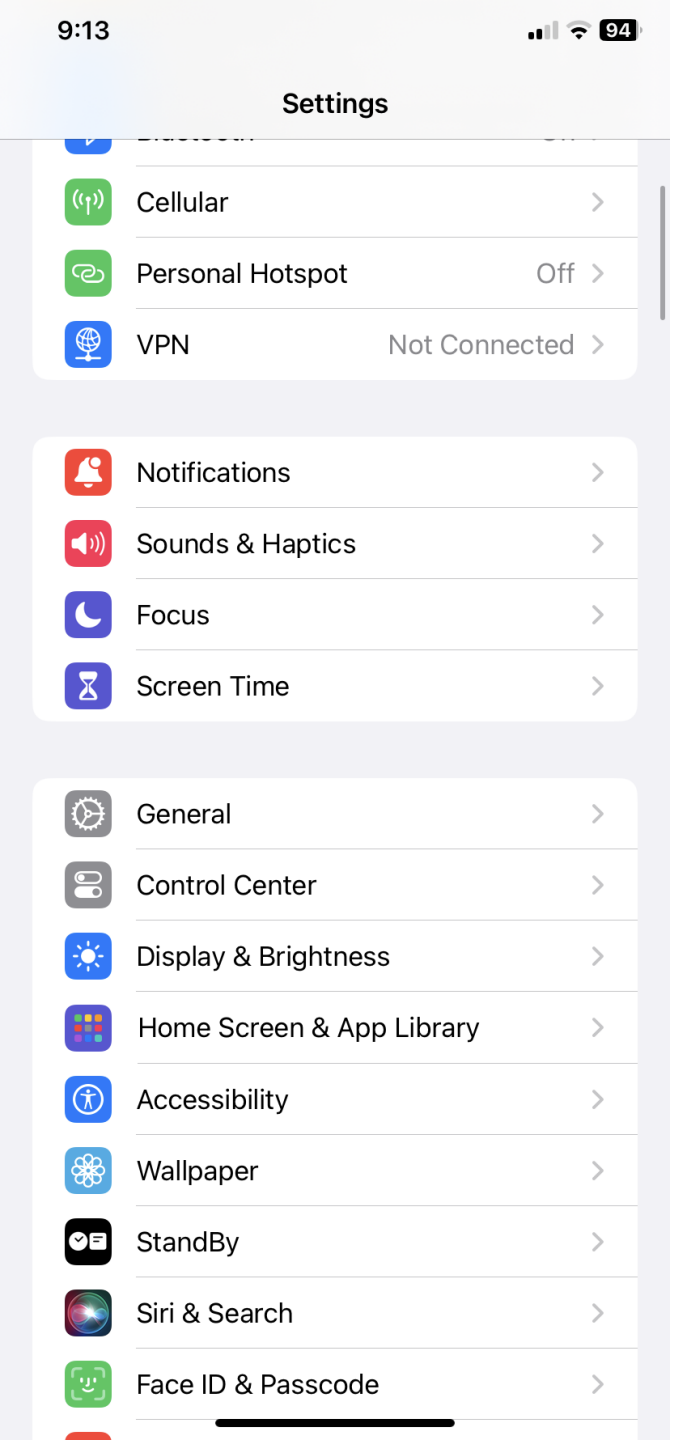
Bedside rounding takes no more time at BIDMC (Gonzalo JGIM 2010):

- Mean duration new patient encounters: 16 vs. 15 min (p=0.42)
- Mean duration team rounding per day: 95 min vs. 98 min (p=0.52)

- But it must be done right.

1. Time

- Read beforehand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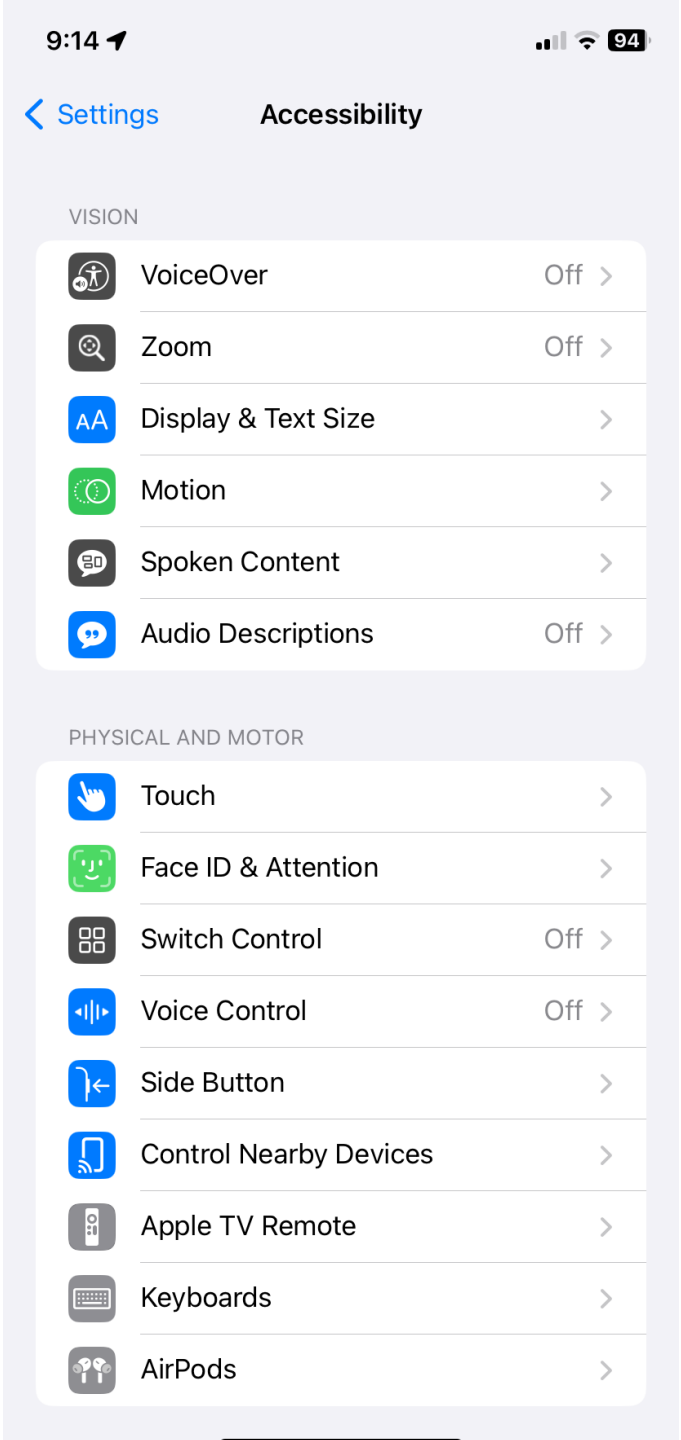
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Accessibility
Spoken Content
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A Speak button will appear when you select text.
Speak Screen
Swipe down with two fingers from the top of the screen to hear the content of the screen.
Speech Controller
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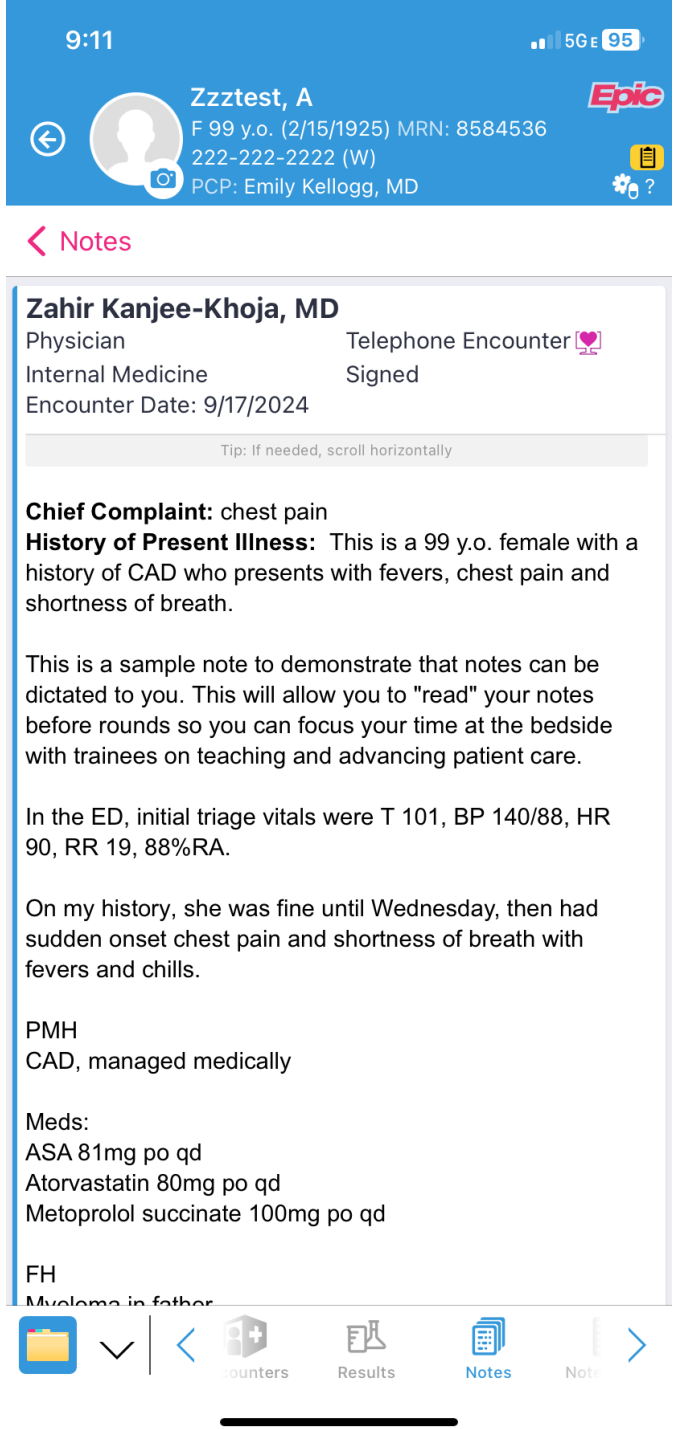
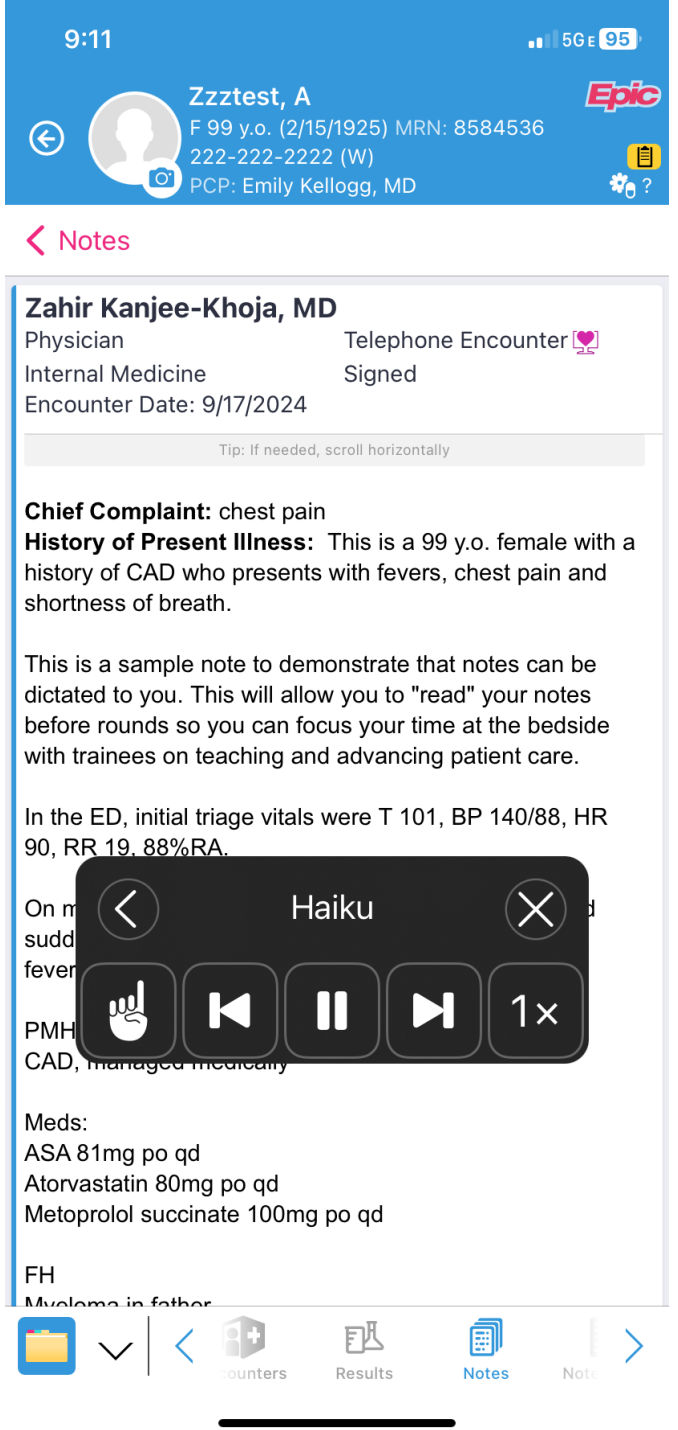
Typing Feedback
Voices
Default Language
Detect Languages
SPEAKING RATE
Pronunciations





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1. Time

- Read beforehand
- Pre-set limits on time, teaching points
- Limit teaching points, check in regularly on time
- Be intentional about what gets read out loud
- Be intentional about what is discussed/decided on rounds versus later
- Separate by intern?
- Defer longer patient conversations to later in the day

2. Learner Concerns

Preparing a team for bedside rounding

- What are your concerns about bedside rounding?
- What can be learned best at the bedside?
- How can we conduct rounds so that we and patients benefit from the time we invest at their bedside?

Lichstein and Atkinson. Patient-centered bedside rounds and the clinical examination. *Med Clin N America* 2018.

Effective Socratic Teaching at Bedside

- Supportive atmosphere, know/use learner names
- Enthusiasm
- The *right* approach to the “wrong” answer
  - Avoid grilling
  - Reword problem/question to help “discover” the correct answer
  - Acknowledge effort, difficulty
  - Say “wrong” in a non-demeaning way
- Pause before asking another person
- Show own knowledge gaps and model good learning

Slide based on one provided by Chris Smith

Ask the right type of question

1. Factual – How long has the patient had symptoms?
2. Broadening – What are other potential causes of this patient's lower abdominal pain?
3. Justifying – What supports your diagnosis?
4. Hypothetical – If the patient were immunocompromised, how would this change your diagnosis?
5. Alternative – What would be the advantage or disadvantage of surgery vs conservative treatment?

From Whitman and Schwenk, in Alguire et al. *Teaching in Your Office*
Slide based on one by Chris Smith

“Don’t just **stand there, do something**.”

“Don’t just **do something, stand there.**”

Other ways to address learner concerns

- Explicit acceptance that story may change
- Positive feedback, save negative feedback for later, correct with grace
- Phased approach to bedside rounding, demonstrate once?

3. Structure

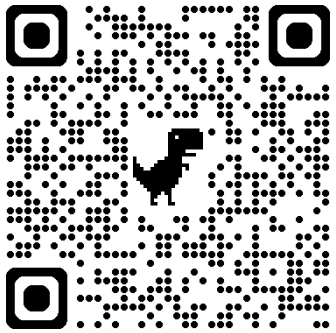
Positioning

BEDSIDE2-R framework

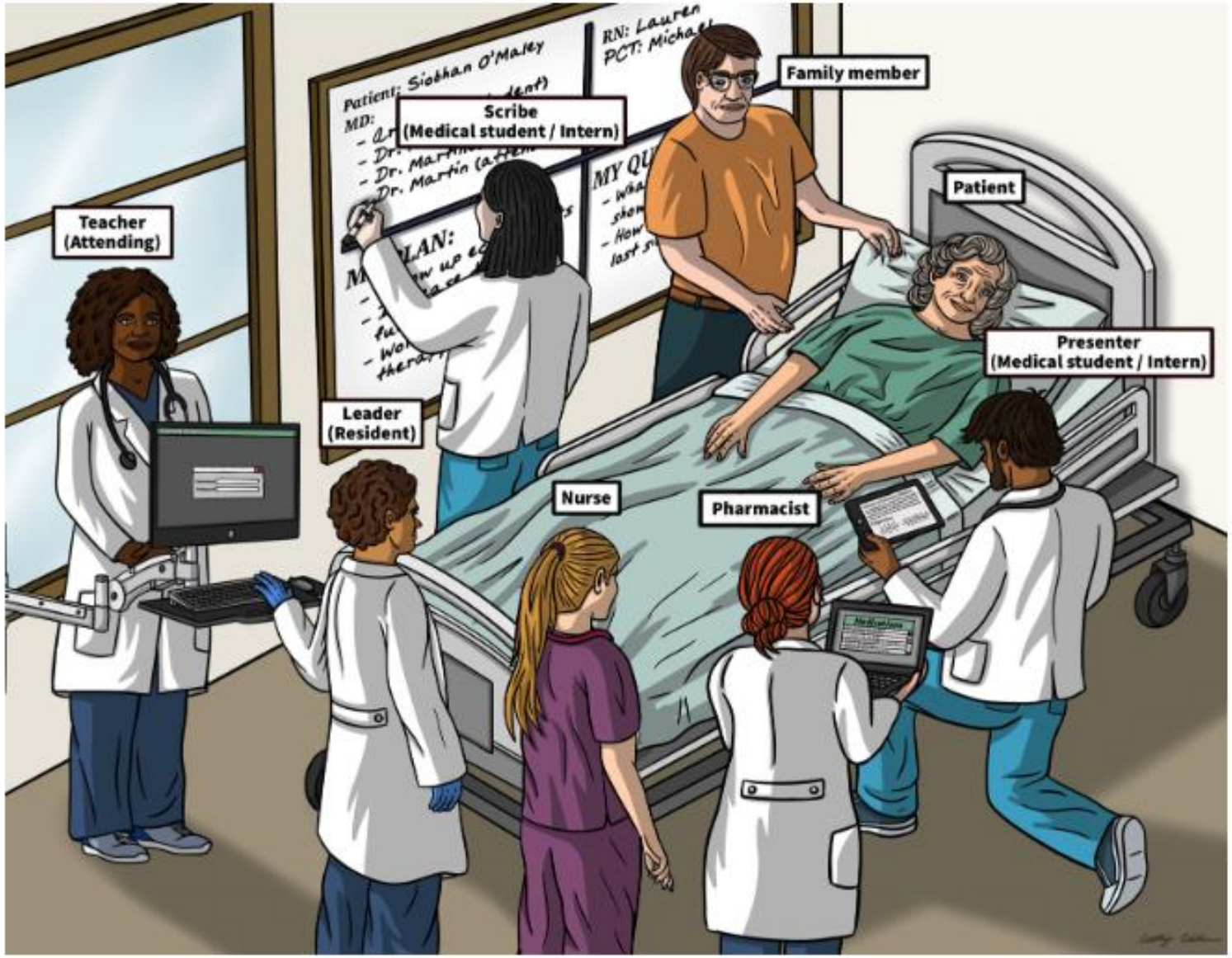
Before
- **BED**
  - **B**rief team
  - **E**ngage patient
  - **D**elineate roles

During
- **SIDE2**
  - **S**ummarize events
  - **I**nvestigate data
  - **D**emonstrate exam
  - **E**xplain plan
  - **E**nsure understanding

After
- **R**
  - **R**eflect in transit



Nelson, Kanjee, Freed, Cichon, Ricotta. J Hosp Med 2024



BOX 1. Sample script for introducing BEDSIDE$_2$-R to patients

Ms. O'Maley, we'd like to discuss your plan of care today using a style of rounding called bedside rounds. We'll start by summarizing the overnight events and any pertinent physical exam findings. Then, we will investigate data by reading aloud your vital signs, lab results, and any new reports since yesterday. Next, we will demonstrate a cardiac examination as a team to listen to your heart murmur. Finally, we will explain the problem-based plan of care for today. Throughout our discussion, you may hear some medical terminology, so we will make sure to ensure understanding and answer any questions you have at the end. How does that sound to you?

Nelson, Kanjee, Freed, Cichon, Ricotta. J Hosp Med 2024

4. Teacher Concerns

Actually teaching

- Hidden curriculum: “You can’t not teach.”
- Communication skills: “Could I add something?”
- Physical exam: multiple approaches

Image: htxt.co.za

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“You can’t not teach.”

Charlie Hatem MD

Actually teaching

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Teaching Communication Skills

"Could I Add Something?": Teaching Communication by Intervening in Real Time During a Clinical Encounter

Anthony L. Back, MD, Robert M. Arnold, MD, James A. Tulsky, MD, Walter F. Baile, MD, and Kelly Edwards, PhD

Back et al. Acad Med 2010

“Could I add something?”

1. Prepare learner before going in the room.
2. Introduce yourself and your role to the patient.
3. Observe the learner’s communication skills.

Back et al. Acad Med 2010

“Could I add something?”

1. Prepare learner before going in the room.
2. Introduce yourself and your role to the patient.
3. Observe the learner’s communication skills.
4. Decide if intervention needed.
   - Not recognizing patient’s emotions and continuing would cause harm.
   - Emotions overwhelming learner.
   - (Egregiously incorrect information.)

Back et al. Acad Med 2010

“Could I add something?”

1. Prepare learner before going in the room.
2. Introduce yourself and your role to the patient.
3. Observe the learner’s communication skills.
4. Decide if intervention needed.
5. Frame the intervention as adding value.
   - **Step in.** “Could I add something here?”
   - Question is polite, role as supporter.
   - **Step out.** Give control back with “Dr. R, could I ask you to continue?” or “Dr. R, could I ask you to finish this up by talking about….?”

Back et al. Acad Med 2010

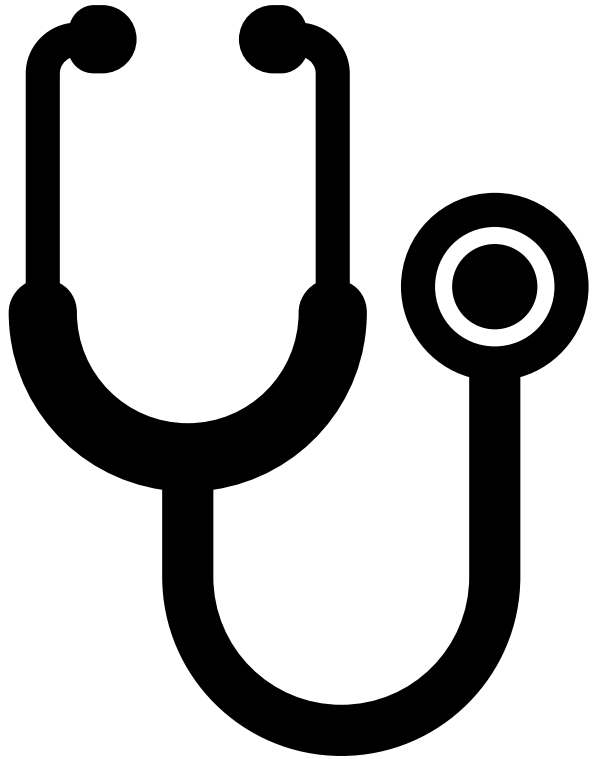
“Could I add something?”

1. Prepare learner before going in the room.
2. Introduce yourself and your role to the patient.
3. Observe the learner’s communication skills.
4. Decide if intervention needed.
5. Frame the intervention as adding value.
6. Include the reason for intervening in learner debrief.

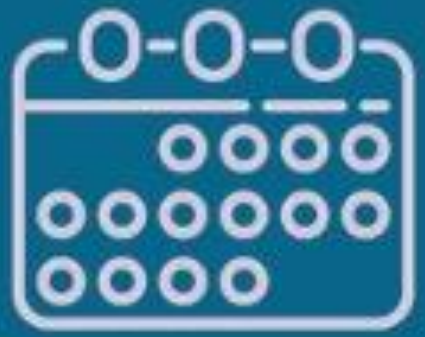
Back et al. Acad Med 2010

Actually teaching

- Hidden curriculum: “You can’t not teach.”
- Communication skills: “Could I add something?”
- Physical exam: multiple approaches



Incorporating Physical Exam Teaching at the Bedside on Rounds



Skill of the Day

Diagnostically Relevant

Clinical Trend

Imaging Correlation

SOCIETY OF BEDSIDE MEDICINE

Ankle Reflexes[1,2]

Narrative Section

Historical Vignette - Did you know that the reflex hammer's history is rooted in wine? The story of the reflex hammer dates back to 1761 when Josef Leopold Auenbrugger first described the art of percussion adapted from his father's method of tapping wine casks to measure the level of remaining wine. Percussion was initially performed with a hammer, but it fell out of use when the fingers were used as pleximeter and hammer. The hammer would later be adapted by physicians for the deep tendon reflexes when Erb and Westhal described the diagnostic utility of the knee-jerk reflex, about 1875.

Clinical Vignette and Usefulness - Mr. Jones presented with progressive weakness in both legs and arms. The examination showed bilateral weakness in all 4 extremities. There was normal sensation below the clavicle, normal cranial nerves, and normal mentation. Deep tendon reflexes were very brisk, and there was ankle and patellar clonus. The Babinski and Hoffman reflexes were present with 3+ reflexes in all 4 extremities. The distinct constellation of findings suggested a transverse cord lesion. The differential would have been different had the reflexes been normal or absent.

[1] Chi J *et. al.* "The Five Minute Moment." *Am J Med.* **2016 Aug;** 129 (8): 792-795.

[2] Lanska, DJ. "The History of Reflex Hammers." *Neurology.* **1989 Nov;** 39: 1542-1549.

Physical Manuever

Model Proper Technique - two techniques can help elicit the ankle reflex in a bed bound patient. The first involves both legs fully extended and the examiner placing two fingers across the plantar surface of the metatarsal heads. With the foot cocked up, strike the hammer against the two fingers, looking for the brisk ankle contraction. Alternatively, the patient can outwardly rotate the hip, flex the knee. The examiner positions two fingers on the metatarsal heads. This time, though, strike the Achilles tendon directly to observe the contraction. Finally, in a patient who is unable to relax their lower extremities, cross the foot being examined over the lower part of the other leg and strike the Achilles tendon as before.

In a seated patient, have the patient relax the ankle while the examiner applies slight tension to the Achilles tendon by lifting the under the foot. Strike over the Achilles tendon to see the tendon contraction (S1 level) and the resulting plantar flexion of the foot.

Interpretation - An explanation of reflex grading: 0 absent, 1+ slight but clear response, 2+ brisk and normal response, 3+ very brisk exaggerated response, 4+ clonus.

Caveat and Common Errors - When first using the reflex hammer, many learners tend to hold the hammer too high. This lowers the torque and can lead to a reflex that is falsely absent because adequate pressure is not applied quickly. Holding the hammer in too tight a fashion impairs the stroke.

Virchow's Node[1]

Narrative Section

Historical Vignette / Case Study - A 72 year old man presented to the clinic with a 10 pound weight loss over the past year and swelling of the area of his left clavicle. He denied fever, chills, or night sweats. His examination was notable for being afebrile, a BP = 127/81, a pulse = 72, and respirations = 18. He had no cervical or axially adenopathy. His left supraclavicular fossa had a large, 2 cm, soft,

Physical Manuever

Model Proper (And Improper) Technique - Virchow's node lie junction of the thoracic duct and the left subclavian vein, where from most of the body drains into the systemic circulation. Tumc gastrointestinal cancers via the thoracic duct usually leads to th enlargement of the left supraclavicular node. Virchow's node (al as Troisier's node or **Troisier's sign**) can be the first clue to a C malignancy.[2] For this reason, they are also called sentinel or sig

A method for examination of the supraclavicular lymph nodes:

1) **Have patient seated upright** and facing forward as you pal supraclavicular fossa
2) **Ask patient to perform the Valsalva** during the examinatic can help bring out an otherwise unapparent lymph node
3) **Instruct the patient to tilt their head** to the side being exa which can help in feeling deeper into the supraclavicular fos

Clubbing[1,2]

Narrative Section

Historical Vignette - While convalescing from emergency aortic and mitral valve surgery due to endocarditis, South African cardiologist Leo Schamroth noticed a change in his swollen digits. A painless, lilac hue at the nail beds began to recede after surgery. "The 'window' [seen by holding his nail beds together] reappeared 2 months after the infection had been controlled," he wrote in his landmark reflection on his own illness. However, it took many more months before the bulbous slope of the distal nail returned to its baseline shape. For decades since, "Schamroth Sign" of digital clubbing has been a marker for underlying disease, but a careful reading of the literature suggests that other bedside tests can indicate digital clubbing with both better inter-observer agreement and higher disease-specific reliability.

Context and Usefulness - The presence of digital clubbing can help the aware clinician focus further work up. The "gold standard" diagnostic test to confirm clubbing, though, is an objective bedside measurement, not a lab test or radiograph. Clinicians should also recognized that clubbing has many causes (cardiac, hepatic, oncologic, pulmonary) and is not a part of the natural history of chronic lung disease. In these pulmonary patients, its presence predicts—but does not confirm—pathology. Most patients will not readily notice the change of their nails as the process of nail matrix hypertrophy is slow and painless.

Physical Manuever

Model Proper Technique - observation of the nail beds suggests clubbing with a "drumstick" or bulbous swelling of the distal phalanx. The nail bed often takes an erythematous hue. Nail angles can help bring objectivity to the assessment of the misshapen nail. Observe the "**profile angle**" [ABC] at which the nail emerges from the nail bed (always more acute than a straight-line 180°) and the "**hyponychial angle**" [ABD] at which the nail bed and clipped-edge appear.

The most objective measure of clubbing, however, comes in assessing finger-tip depth (**phalangeal depth ratio**). The depth of the DIP joint [IPD] should always be greater than the depth of the DPD. Slide a tight ring on the finger and it should glide past the nail and stop at the knuckle. If it gets hung up on the nail first (if the ratio is reversed, or DPD:IPD >1:05), clubbing is present.

Interpretation - Fingernails can present with many shapes and sizes. Careful examination of the nails of disease-free patients can often reassure them that clubbing is *not* present (i.e., if the depth ratio is <1.0). However, measures in patients with chronic lung disease confirming clubbing (>1.05 ratio) should also continue the quest for more sinister sources.

Caveat and Common Errors - Remember: clubbing can rarely be hereditary (benign) or unilateral (indicative of a vascular source).

Cirrhosis[1,2]

Narrative Section

Historical Vignette - Hearts hold a place of prominence in the world of love, but it wasn't always so. When Shakespeare wrote in his sixteenth century *Romeo and Juliet* that "young men's love lies not truly in their hearts, but in their eyes," his readers doubtlessly understood. But had that play been performed for an ancient Greco-Roman audience, or at a Babylonian theater, the listeners might have been perplexed. The seat of the soul, of love, and of human emotions in cultures before the modern era was thought to be the

ay sculptures from 2000 BCE (Figure 1) guided priests and ists in understanding this vital organ. The names they gave to its es survive into modern anatomical terms. Indeed, even peare might have understood: reports indicate that Queen Elizabeth ixteenth century was not referred to as England's *head* of state—but This vital three-pound organ, holding over 10% of the body's blood from two separate sources, sends out distress signals when it is

Aortic Regurgitation[1,2]

e Section

. **Vignette** - Why is this photo of Abraham Lincoln

SIAL?

e look at his left foot. It uggested since the Lincoln had Marfan and associated Aortic y / Aortic Regurgitation diagnosis of AR stems in blurred left foot in this ght to be due to ılsation from a hyper- ılse, as found in aortic y; hence, Lincoln's Sign. odern understanding of ysiology of AR and the anifestations of this allow incoln's Sign in clinical not, what physical exam ovide diagnostic value in assessment of AR?

nd Usefulness - A 2006 review cite 31 eponyms in the medical escribing the physical findings of aortic regurgitation. Many milar pathophysiologic signs and pulse characteristic in vascular ghout the body. Remembering the underlying cause of these ins their usefulness: aortic insufficiency causes a regurgitant lood in the aorta. Pathologic conditions resulting in incompetent ts can cause it (*ie.* bicuspid valve, aortopathy, calcific disease, eart disease, syphilis, and endocarditis).

Physical Maneuver

Model Proper (And Improper) Technique[3] - To properly assess the liver, place the patient in a recumbent position with the skin of the abdomen exposed. Note the presence or absence of **dilated abdominal veins** (*caput medusa*). In males, is *body hair reduced*? Is *gynecomastia* present? What about the presence of *spider angiomas* (Figure 2) across the abdomen and chest? Each of these findings suggest estrogen excess as the byproduct of poor hepatic function. Next, search for the **presence of ascites**. When the abdomen is distended, the probability of ascites is increased most by discovering the presence of a fluid wave (LR = 5.0) and the presence of edema (LR = 3.8). Palpating a firm liver edge suggests cirrhosis in chronic liver disease (LR = 3.3). Finally, sit the patient up and evaluate for hepatic encephalopathy. In the studies of physical exam signs and cirrhosis, **encephalopathy** was defined as *disordered consciousness* plus *asterixis*. The conscious patient, with arms outstretched and fingers spread, can be assessed for asterixis by observing for the sudden "flap" of the hands. This occurs when the patient is unable to hold the fixed position. (If necessary, an elevated leg and flexed foot can achieve the same result). EMG studies have demonstrated a "negative myoclonus" occurring during asterixis—a transient interruption of electrical signal to the muscle.

Interpretation - The dilated abdominal wall veins increase the likelihood of cirrhosis most (LR = 9.5), followed by equal measures of

Physical Manuever

Model Proper (And Improper) Technique - The first step in recognizing abnormal signs of AR is to practice normal technique. When listening for diastolic murmurs—the absence of silence—sit the patient forward, listen in end-expiration, and time diastole by palpating a central pulse (*ie.* a carotid). Train your ears on the normal to prepare them for the abnormal. Also, examining for collapsing pulses of AR is best done through the brachial artery, feeling for rapid drop-off. If listening for femoral arteries, position the patient supine, compress the artery with two fingers, and keep the stethoscope's diaphragm flat on the skin.

A 2003 review[1] found these four signs have the most diagnostic value:

1) **Corrigan's pulse** —the "water hammer" or "collapsing" is characterized by a rapidly swelling an falling arterial pulse.
2) **Duroziez's sign** —a systolic *and* diastolic bruit heard when the femoral artery is partially compressed.
3) **Hill's sign** —lower extremity (foot) systolic pressure exceeding upper extremity (brachial) by more than 20 mmHg in the recumbent position. This test has a **LR=17.3** if the foot-arm systolic gradient >60 mmHg.[3]
4) **Austin Flint murmur** —a low-pitched, mid-to-late diastolic rumble heard at the apex. This murmur has been attributed to the effects of competing antegrade turbulent diastolic flow from the left atrium and the retrograde regurgitant flow from the aorta.

Interpretation - Hill's sign has the strongest specificity (71-100%) and is more frequent with more severe AR. Of course, it must be taken in the context of other coexisting co-morbidities such as atherosclerosis. Rather than commit each eponym to memory, remember the principle that a column of blood is reversing. Some signs that directly reflect this (Duroziez's) are more reliable and accurate than indirect measures.

Caveat and Common Errors - Know that these signs apply to *chronic* aortic regurgitation. Acute aortic regurgitation signs are less well described.

Special thanks to ***Dr. Junaid Zaman*** *for submitting this 5M2.*

[1] Chi J *et. al.* "The Five Minute Moment." *Am J Med.* **2016 Aug;** 129 (8): 792-795.

"Does This Patient Have Clubbing." *JAMA.* **2001 July;** 286 (3): 341-347.

The Five Minute Moment." *Am J Med.* **2016 Aug;** 129 (8): 792-795.

Eponyms and the Diagnosis of Aortic Regurgitation: What Says the Evidence?" *d.* **2003;** 138: 736-742.

[3] McGee, Steven. *Evidence-Based Physical Diagnosis, 4th ed.* Philadelphia, PA: Elsevier; 2018.

State

Ask

Identify

Demonstrate

Look

Reinforce

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Teaching Evidence-Based Physical Diagnosis: A Workshop for Hospitalists

Zahir Kanjee, MD, MPH, Anjala V. Tess, MD

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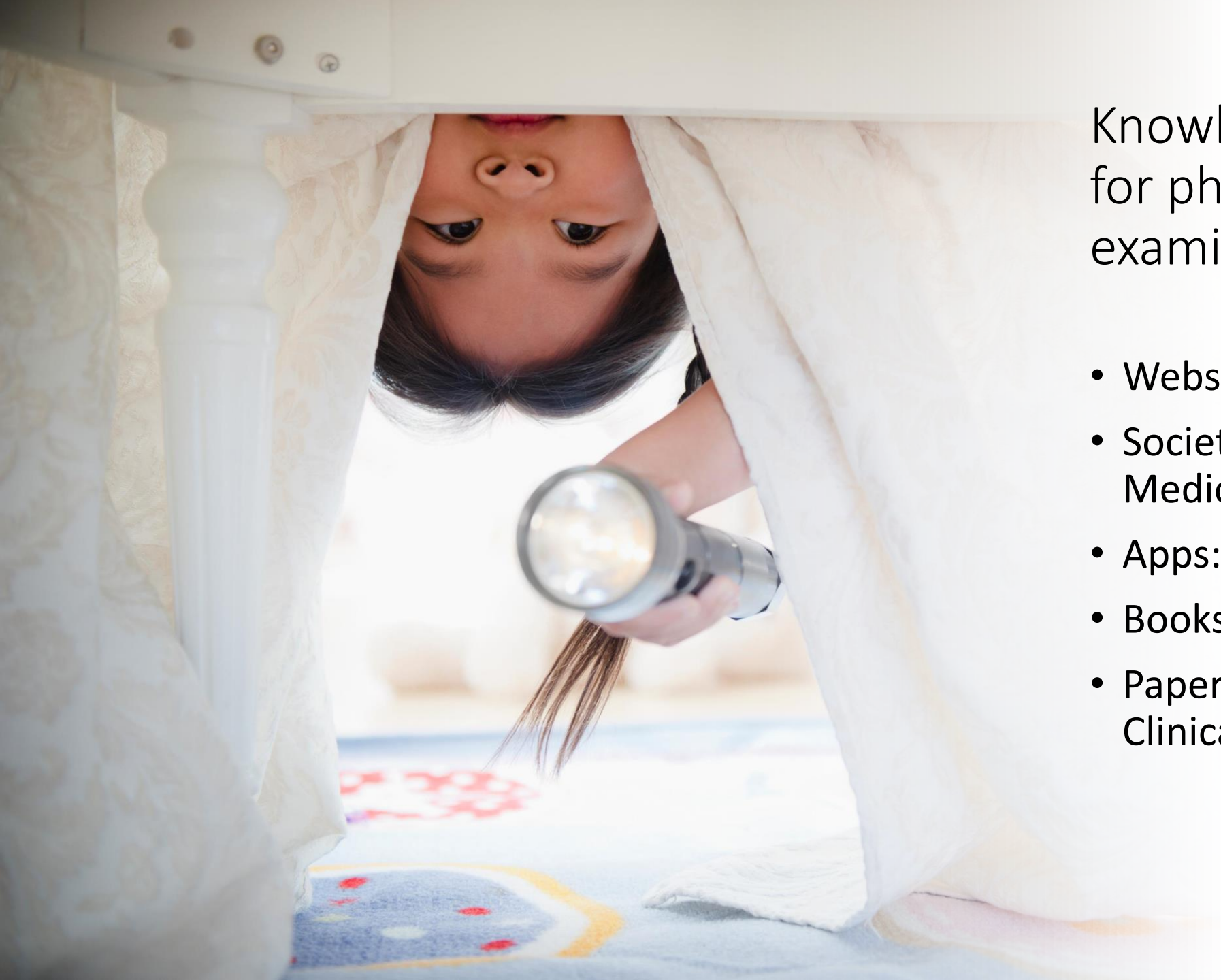

Knowledge resources for physical examination teaching

- Websites: Stanford 25
- Societies: Society of Bedside Medicine
- Apps: DocLogica, SDx, CORE
- Books: McGee
- Papers: JAMA Rational Clinical Examination

Stanford MEDICINE | Stanford Medicine 25
Promoting the Culture of Bedside Medicine

An Initiative of the Program for Bedside Medicine

The Stanford Medicine 25

This site is a map to a territory that must be explored in person.
We created this website to complement live, hands-on Stanford Medicine 25 sessions — the site isn't meant to be a substitute for personal experience. This site is a place to remind ourselves of what we learned or are about to learn in a hands-on session.

Gait Abnormalities

Abnormal gaits are commonly seen in the hospital and elsewhere. Many of them should be recognizable on sight and it would be a shame to subject a person to a CAT or MRI for lack of recognition. We review a number of abnormal gaits and their disease associations.

Learn about gait abnormalities ›

Fundoscopic Exam

When it comes to an ophthalmoscopic exam there's more to it than meets the eye! Here we take a look at the various

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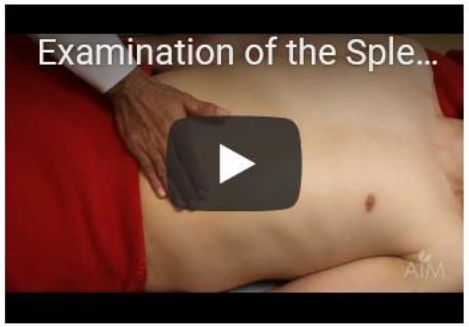
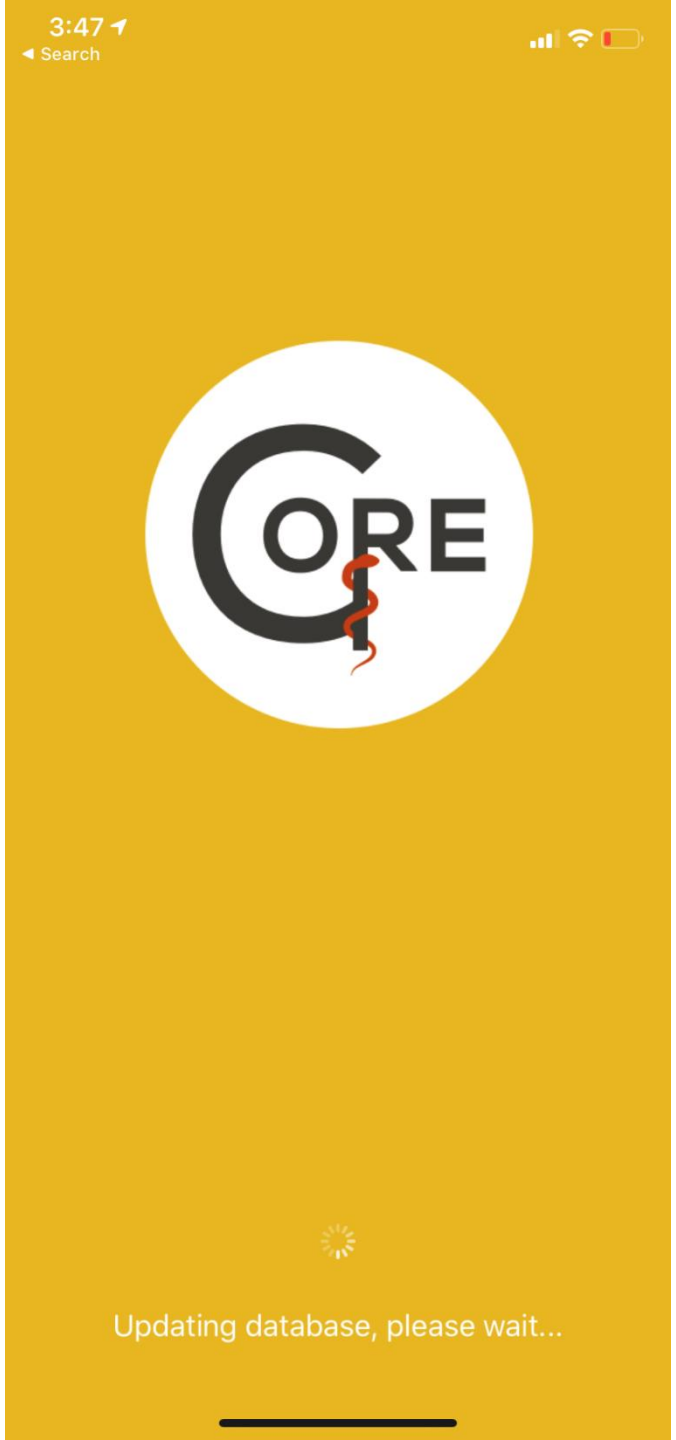
Abdominal Examination



Ankle Brachial Index

Bedside Ultrasound



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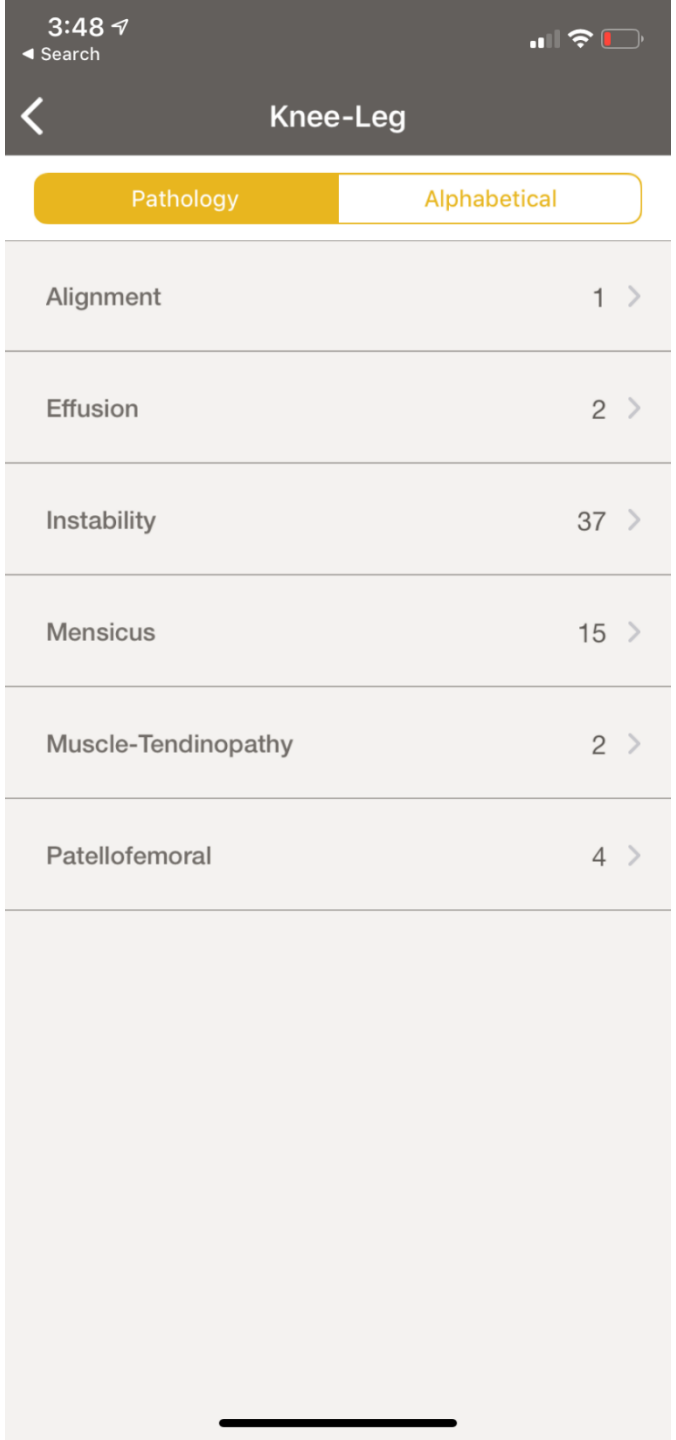

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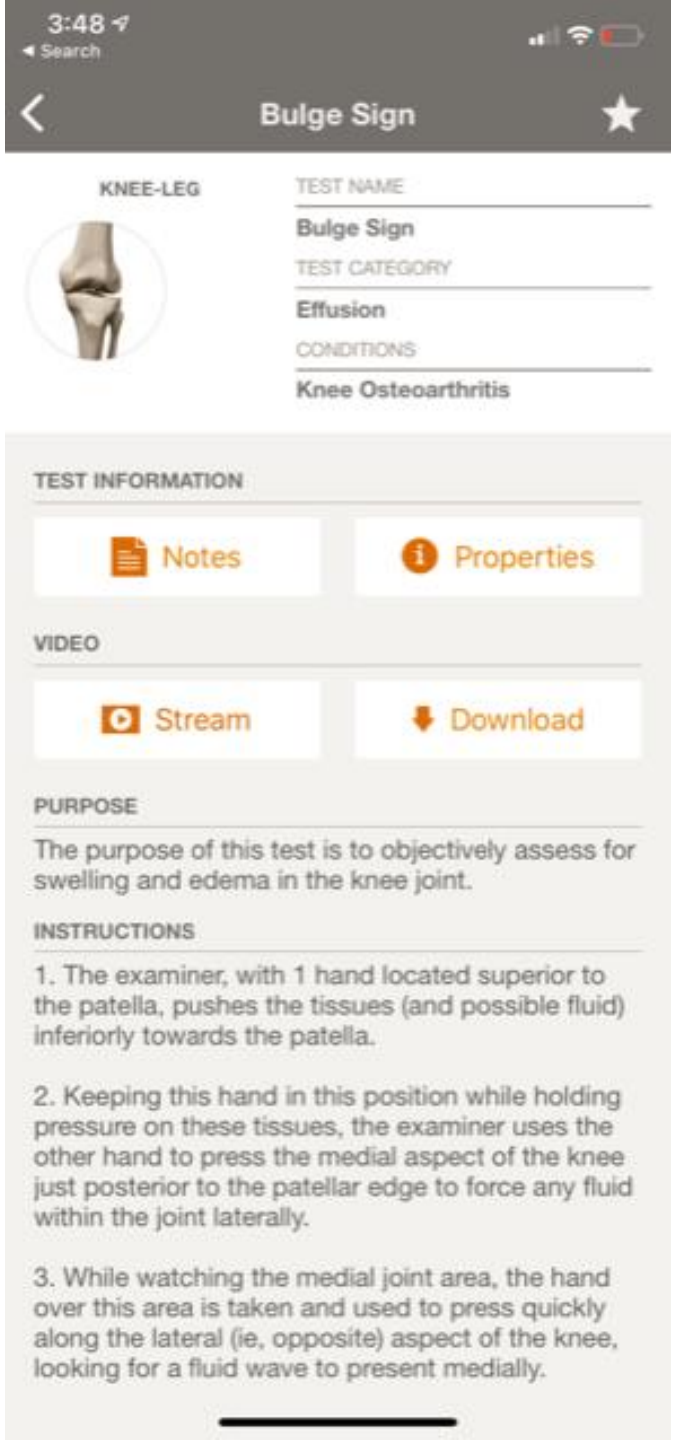

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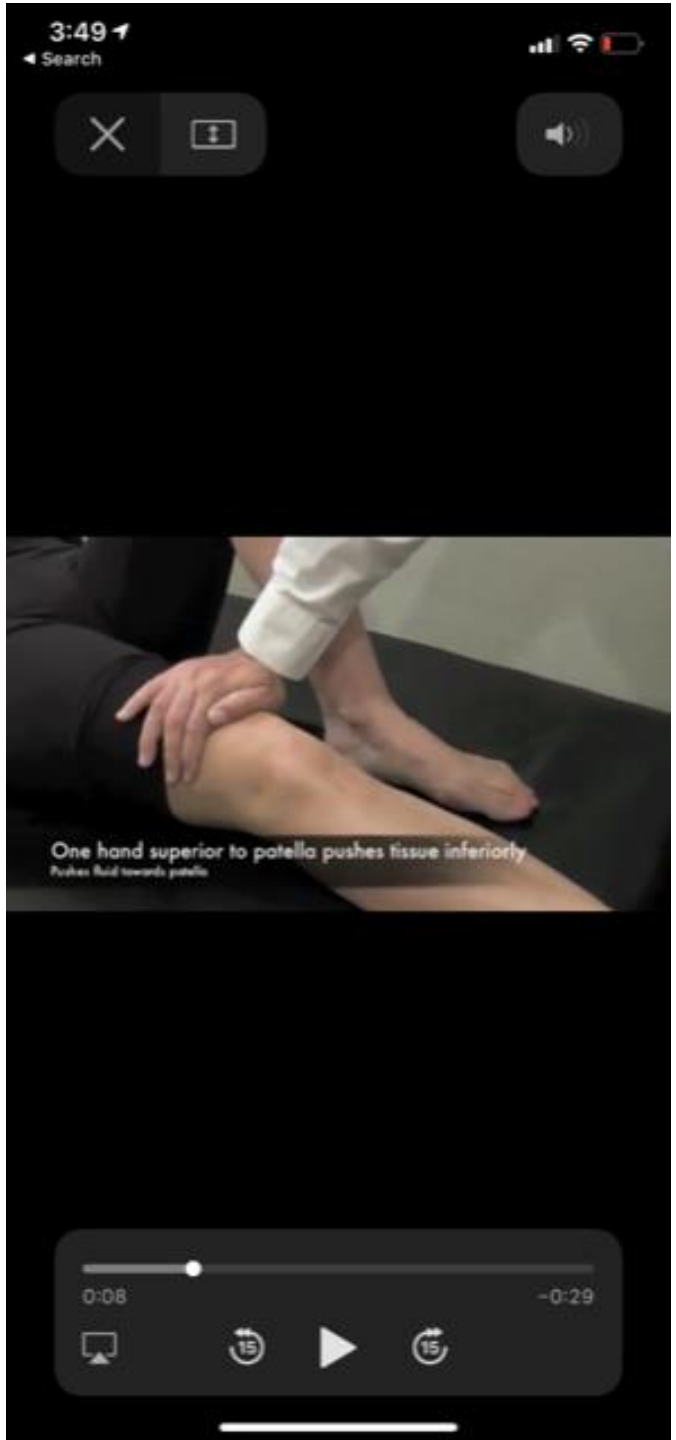

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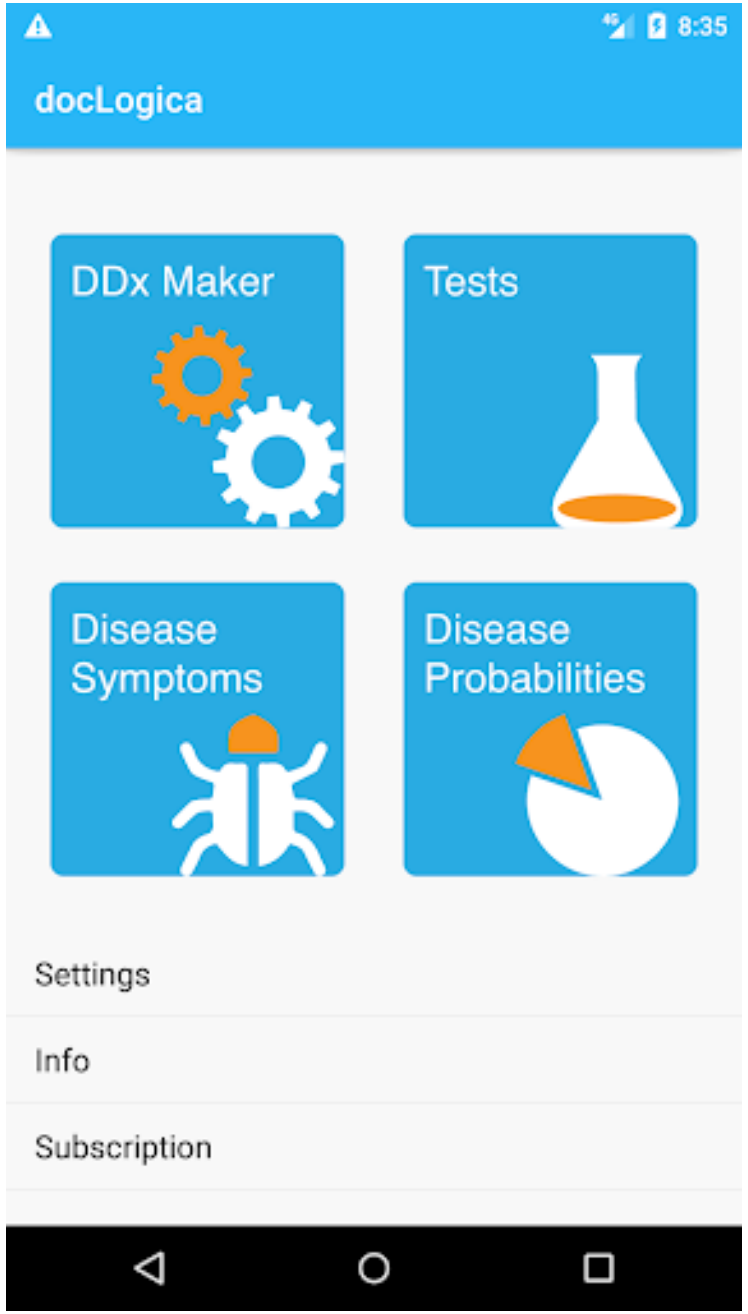

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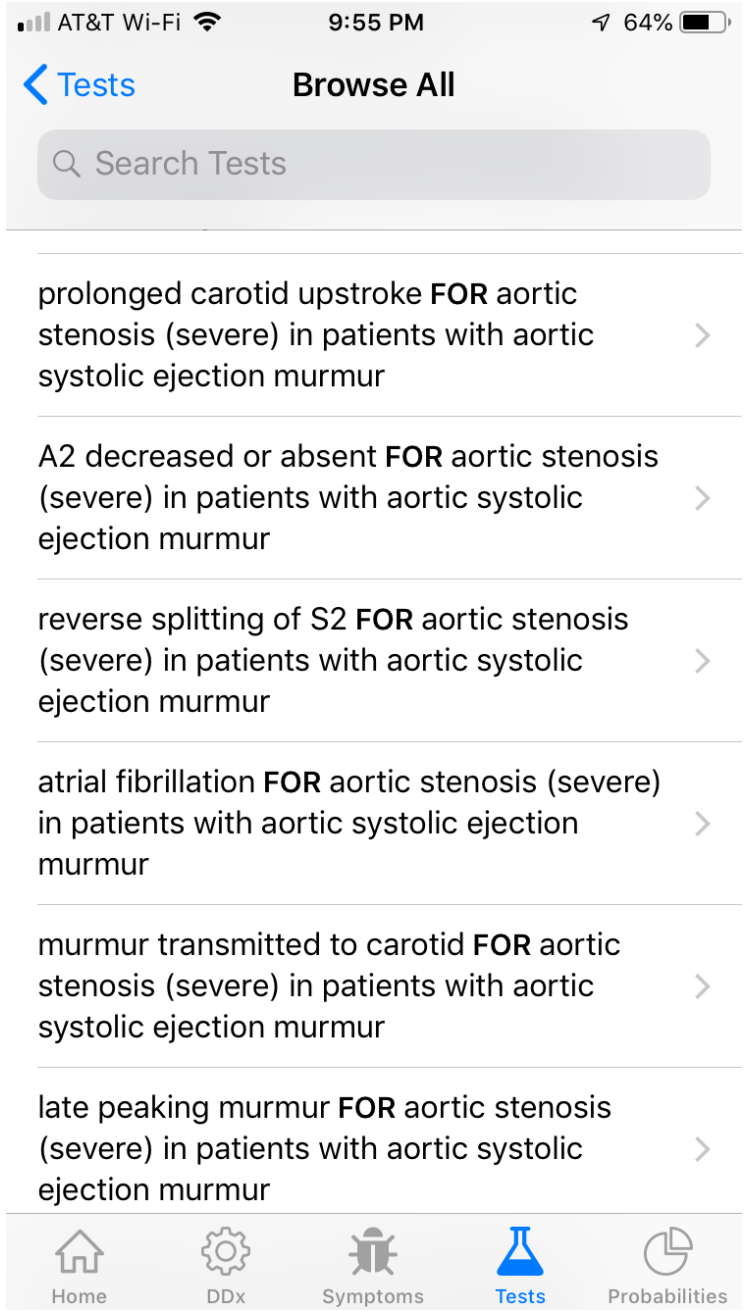

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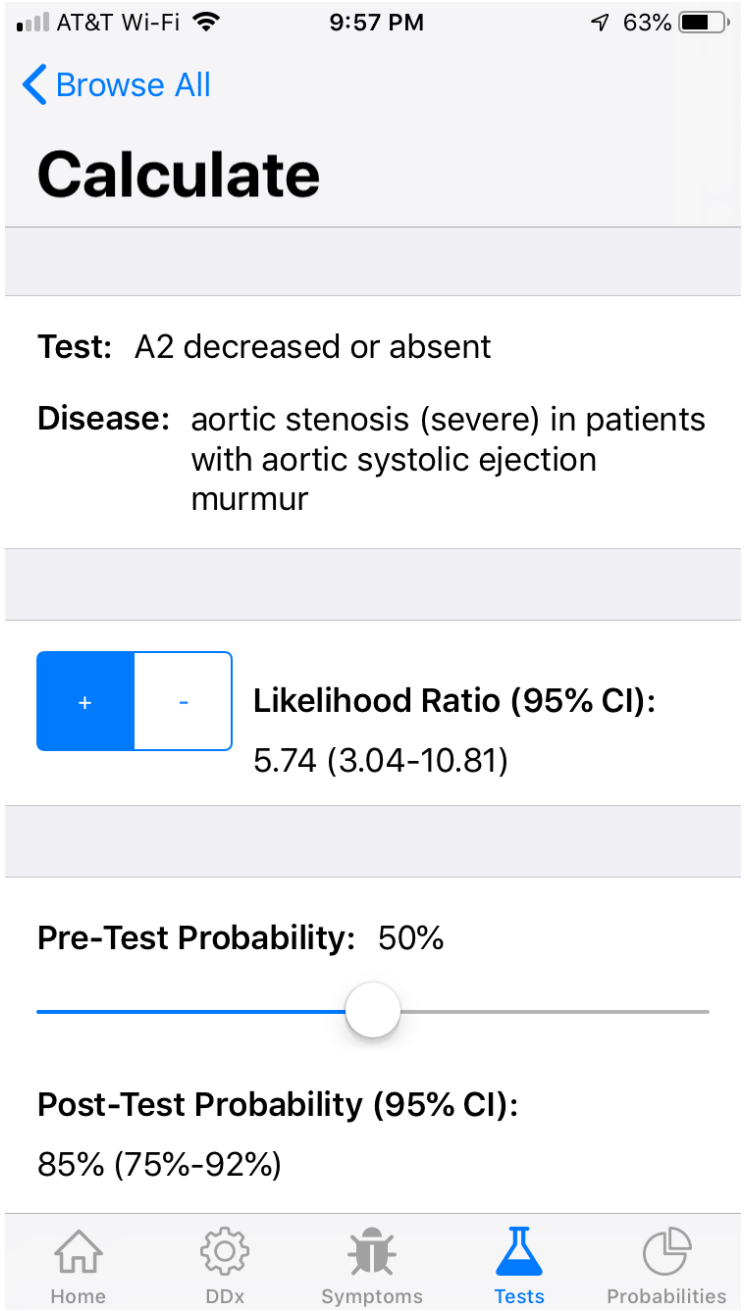

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2. Does this patient with shoulder pain have rotator cuff disease?: The **Rational Clinical Examination** systematic review.

Hermans J, Luime JJ, Meuffels DE, Reijman M, Simel DL, Bierma-Zeinstra SM.
JAMA. 2013 Aug 28;310(8):837-47. doi: 10.1001/**jama**.2013.276187. Review.
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3. Does This Patient Have Infectious Mononucleosis?: The **Rational Clinical Examination** Systematic Review.

Ebell MH, Call M, Shinholser J, Gardner J.
JAMA. 2016 Apr 12;315(14):1502-9. doi: 10.1001/**jama**.2016.2111. Review.
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4. Does This Patient With Chest Pain Have Acute Coronary Syndrome?: The **Rational Clinical Examination** Systematic Review.

Fanaroff AC, Rymer JA, Goldstein SA, Simel DL, Newby LK.
JAMA. 2015 Nov 10;314(18):1955-65. doi: 10.1001/**jama**.2015.12735. Review.
PMID: 26547467
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5. Does This Patient Have Acute Mountain Sickness?: The **Rational Clinical Examination** Systematic Review.

Meier D, Collet TH, Locatelli I, Cornuz J, Kayser B, Simel DL, Sartori C.
JAMA. 2017 Nov 14;318(18):1810-1819. doi: 10.1001/**jama**.2017.16192. Review. Erratum in: **JAMA**. 2018 Jun 19;319(23):2443.
PMID: 29136449
Similar articles

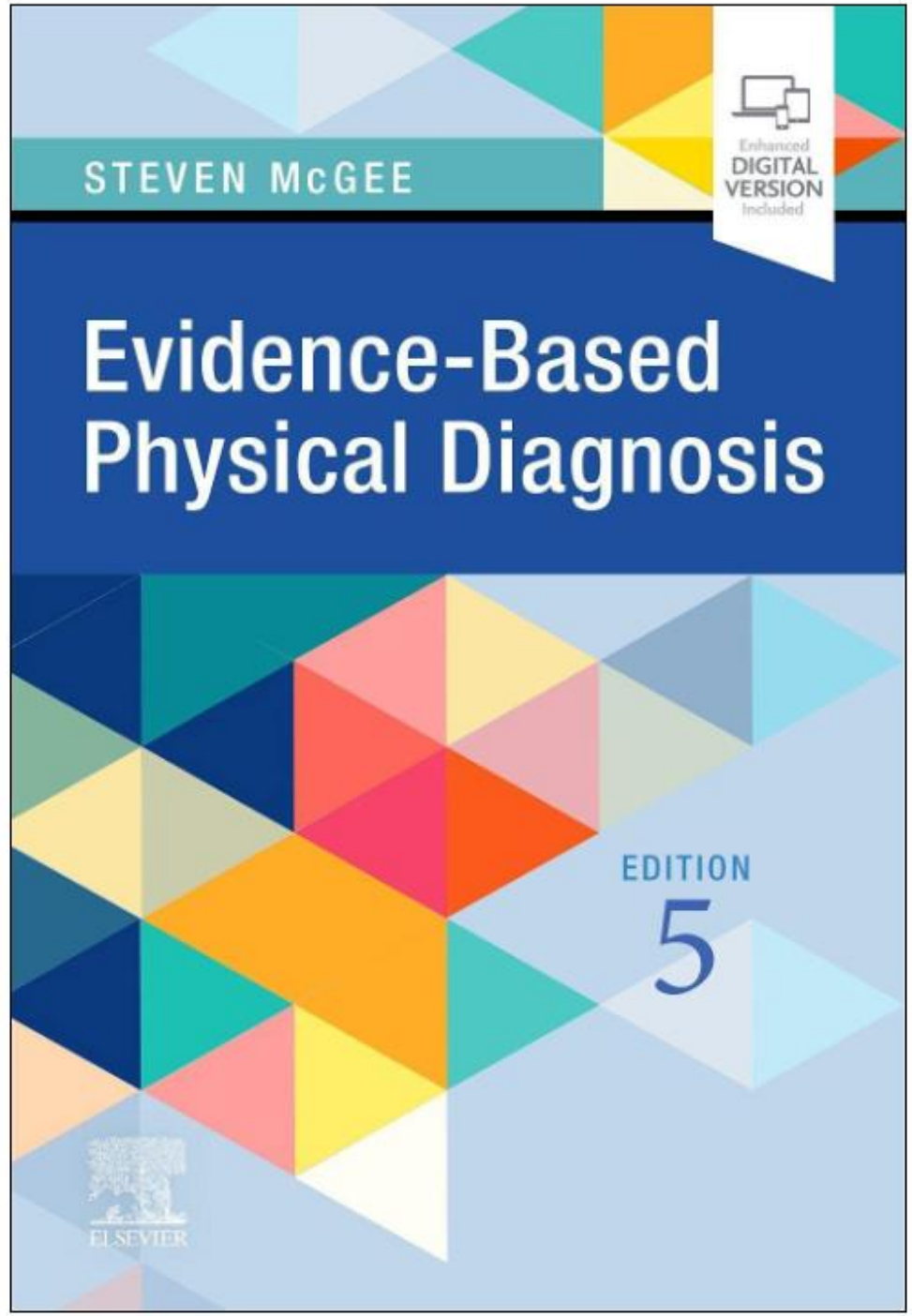
6. The **rational clinical examination**. Does this adult patient have acute meningitis?

Attia J, Hatala R, Cook DJ, Wong JG

JAMAevidence

THE RATIONAL CLINICAL EXAMINATION

EVIDENCE-BASED CLINICAL DIAGNOSIS


STEVEN McGEE
Enhanced
DIGITAL
VERSION
Included
Evidence-Based
Physical Diagnosis
EDITION
5
ELSEVIER

Finding	Positive Likelihood Ratio (95% CI)	Negative Likelihood Ratio (95% CI)	Pre-Test Probability (Range)
EBM BOX 51.4 ASCITES			
Bulging flanks	1.9 (1.4, 2.6)	0.4 (0.2, 0.6)	24-33
Edema	3.8 (2.2, 6.6)	0.2 (0, 0.6)	24
Flank dullness	1.8 (0.9, 3.4)	0.3 (0.1, 0.7)	24-29
Shifting dullness	2.3 (1.5, 3.5)	0.4 (0.2, 0.6)	24-33
Fluid wave	5 (2.5, 9.9)	0.5 (0.3, 0.7)	24-33
CHAPTER 52 ABDOMINAL PAIN AND TENDERNESS			
Sonographic McBurney's point tenderness, detecting appendicitis	8.4 (2.9, 24.6)	0.1 (0.1, 0.3)	67
Sonographic Murphy's sign, detecting cholecystitis	9.9 (5.4, 18.3)	0.4 (0.3, 0.6)	21
Murphy's sign in patients with liver abscess, detecting biliary tract sepsis	2.8 (1.1, 6.9)	0.8 (0.6, 1)	40
Left lower quadrant tenderness, detecting diverticulitis (surgery)	13.8 (6.3, 30)	0.8 (0.7, 0.9)	17
Left lower quadrant tenderness, detecting diverticulitis (CT scan)	2.2 (1.7, 2.7)	0.4 (0.3, 0.5)	43
Loin tenderness, detecting ureterolithiasis	27.7 (10.7, 72)	0.9 (0.8, 0.9)	4
Renal tenderness, detecting ureterolithiasis	3.6 (3.1, 4.1)	0.2 (0.1, 0.3)	4
Microscopic hematuria, detecting ureterolithiasis	73.1 (41.7, 128)	0.3 (0.2, 0.4)	4
Positive abdominal wall tenderness test in chronic abdominal pain, predicting	7 (3.4, 14.3)	0.2 (0.1, 0.5)	35

Source: McGee, *Evidence-Based Physical Diagnosis*, 2018.

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5. Patient concerns

- Defer longer conversations to later in day
- Defer *certain* sensitive issues to before/after
- Separation of “MD” and “patient” discussions, appropriate explanation

6. Not worthwhile?

- Focus on bedside teaching
- Be cognizant of time, situational awareness
- Enthusiasm
- Emphasize benefits in real-time
- “You can’t not teach.”

Barriers to Bedside Rounding	Potential Solutions
Time (yours, theirs)	Done well, shortens time Read beforehand, be intentional of what happens on rounds vs after Expectation setting, returning for longer conversations Pre-set limits on time, teaching points
Learner concerns: intimidation, autonomy	Huddle, debrief Safe learning environment, explicit acceptance that story may change Positive feedback, save negative feedback for later, correct with grace Phased approach, demonstrate once? Ask *how/why* rather than *what* questions, avoid factual questions "Don't just do something, stand there."
Structure	Standardization: positions, roles, BEDSIDE2-R Tablets, computers in room, WOWs
Teacher concerns: knowledge, communication deficiencies	Prepare before: review topics/teaching points, develop/save scripts, return to preferred teaching topics "Can I add something?" PE teaching resources
Patients: too talkative, sensitive issues, confusing	Expectation setting, including patient (time, coming back) ? defer sensitive issues to before/after Separation of "MD" and "patient" discussions, appropriate explanation
Not thought worthwhile	Enthusiasm, emphasize benefits in real time "You can't not teach."

Sources: Gonzalo JGIM 2010, Ricotta JHM 2019, Lichstein&Atkinson Med Clin N America 2018, Gonzalo Acad Med 2014, Ramani Med Teach 2003, Ramani Med Teach 2009, LaCombe Ann