Clinical Peer Review: Excerpts from the Literature

This document contains excerpts from a handful of useful articles on peer observation of clinical teaching. This is intended to provide additional depth on the subject and supplement the "Tips for TOP Observers: Clinical Settings" document. Much of this is taken verbatim from the references.

Background

Student and resident evaluations are the dominant method of assessing clinical teaching effectiveness, but they are unidimensional and have biases and weaknesses. Peer review is seldom used to assess clinical teaching but is highly regarded and utilized in other settings, including academic promotions, audits of clinical work, and journal articles. Teaching is a form of scholarship and as such should be subjected to and can benefit from the same high standards as written scholarship. Peer review is very time-consuming and requires overcoming of considerable resistance, but it has substantial benefits for both teachers and observers. If done properly, it can foster a culture of personal questioning, reflection, and improvement and can enrich the local community of teachers.

Five Insights (From Beckman Academic Medicine 2004)

Dr. Beckman, along with two colleagues at the Mayo Clinic, conducted 100 person-hours of directly observed bedside teaching in 2002 and shares his major insights.

Peer Review Benefits the Observer (When You Stay Focused on Teaching)

"A senior peer reviewer warned me that separating oneself from the clinical context while observing teaching interactions is challenging. Inexperienced peer reviewers soon realized that they gave *less* attention to the teaching environment than to the existing patient care issues….Once observers learn to perceive the learning environment, a universe of teaching behaviors appears….Educators who willfully participate in a peer-review program involving the direct observation of bedside teaching may find that this activity ranks amongst the most influential education experiences of their careers."

The Number of Effective Teaching Strategies is Infinite

"Each of the observed clinicians demonstrated a unique teaching style that seemed adapted to his or her personality and that was effective. This finding was unexpected because it was assumed that each teacher would either conform to or deviate from the reviewer's understandings of well-known educational frameworks….It was interesting that teachers who performed imperfectly often seemed to compensate for this by developing a particular strength, which resulted in an overall effective teaching strategy."

Feedback is Rarely Given

"Although I am aware that feedback is generally given too infrequently, the severity and impact of this problem was not evidenced until I spent a considerable amount of time observing bedside teaching."

There is an Art to Asking Skillful Questions

(Paraphrased) Four problems commonly arise among observed questioning styles: (1) asking too many questions, which can induce learner fatigue or even masquerade as a means of teachers displaying knowledge and initiating monologues; (2) asking questions related to a trivial fact that attending recently learned; (3) directing questions to senior members of the team only; (4) asking restrictive questions with a particular goal (single answer).

Teachers Improve with Age

"It was impressive how experienced clinicians would sometimes ask questions that exposed their own uncertainty or knowledge deficits….In this way, attending physicians are able to model humility."

Twelve Tips for Peer Observation of Teaching (From Siddiqui et al, Medical Teacher 5 Sept 2007)

"The essence of the peer-review model is that teachers observe each other…They are not being judged by an externally set criteria; instead the assessment is based around a set of mutually agreed issues."

1. The observation process should be a collaborative effort among colleagues who trust and respect each other.

2. Set aside time for the peer-observation, which occurs in three stages: pre-observation (understanding the session and goals to be observed), observation, post-observation (reflection and debriefing).

3. Clarify expectations: "It is helpful to meet before the observation and clarify the roles of the observer and the observed teacher and to agree on the process and evaluation criteria. This will help alleviate concerns about the observation program…If peers are not comfortable observing or being observed, they will not learn from the experience."

4. Familiarize yourself with the course.

5. Familiarize yourself with the instrument.

6. Inform students. The presence of an observer can cause anxiety for students. Inform students that there will be an observer and that they are participating in professional development of the staff, not evaluating the students.

7. Be objective. Focus on specific teaching techniques and methods that were agreed upon beforehand and/or are outlined in the instrument. You should communicate your observations, not your judgments.

8. Resist the urge to compare with your own teaching style. Being peers does not necessarily mean that the two of you will have the same teaching style. Concentrate on the teaching style of the person and the interactions that you observe.

9. Do not intervene in the teaching. Your role is just to observe. You never know what the teacher has planned. Intervention can reduce the credibility of the observed teacher. "It is harder to observe than be observed."

10. Follow the general principles for feedback. "Observation itself does not lead to improved teaching; rather it is the process of debriefing and feedback that is so helpful. Encourage the observed teacher to articulate their experience of the session."

11. Respect confidentiality. "It is likely that your observations will lead you to make judgments about the person's teaching abilities, but these thoughts should not be shared or discussed with colleagues."

12. Make it a learning experience. "Giving supportive feedback and constructive advice is an extremely challenging skill. The observational experience is a great learning experience for the observer, who can build or enhance skills such as teaching techniques, managing students, and asking questions."

From Regan-Smith M et al. Teaching and Learning in Medicine 2007

Samples of comments from one observation made by a PhD non MD re: ward rounds:

Strengths:

Dr. W was exceptionally good at letting housestaff and student know when they did a good job…Dr. W got commitments from the residents asking for differential diagnoses and made them give evidence for each of the diagnoses they entertained (e.g., hypoxemia). If the team did not include an important diagnosis, he corrected their omission and explained his reasoning…

Dr. W modeled setting expectations with his team…telling them what sequence he wanted to see the patients…

Dr. W used learner-centered teaching skills including being genuine (e.g., he shared his frustration over the heroin addict patient)…he created a safe learning environment to ask questions…he demonstrated his love of careful, systematic practice of quality medicine (e.g., "let's carefully review the neurologic exam")…

Dr. W modeled patient-centered communication…modeled good listening, asking open-ended questions, and speaking in plain language, which all the residents could observe.

Areas for Consideration:

Dr. W asked questions frequently but was usually satisfied with correct facts or yes/no rather than asking “Why” thereby assuming that a correct answer reflected proper reasoning and not a lucky guess or the correct answer given for the wrong reason. This may be a missed opportunity to probe the learners’ understanding and correct it or move them forward…

Dr. W had a tendency to preferentially engage the senior residents when asking questions, thereby excluding the more junior trainees. On a few occasions when the senior resident was unable to answer his questions, he turned to the junior trainees, which undermined the authority and confidence of the senior resident, especially when they were able to answer correctly. Perhaps he could begin with questioning the students and interns, and leave more challenging inquiries for the senior resident. If questioning the senior resident reveals a deficit in his knowledge or reasoning, Dr. W could end the line of inquiry with his intended teaching point.

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