

The Case of the Pimping Physician

Case by Dr. Heather Murray

Case

Dr. Heather Murray

Objectives / Questions:

Dr. Teresa Chan

Expert Commentaries

Dr. Jeff Riddell

Dr. John Eicken

Curated Community

Commentary

Dr. John Eicken

Dr. S. Lockett-Gatopoulos

MEiC Project Lead

Dr. Teresa Chan

Dr. Brent Thoma

ALiEM Editor-in-Chief

Dr. Michelle Lin

Rahim, a resident, finished his presentation of the case: "So, in summary, this 27 year old female presented with a one week history of pleuritic left sided chest pain but she had become increasingly SOB. She was hypotensive and tachycardic in the ED with a pericardial rub on exam. A bedside echo confirmed a large pericardial effusion. She had a pericardiocentesis with 300 cc drained and she has stabilized overnight."

The team stood outside the room. Dr. Lafleur, the attending on service, nodded. "Thank you, Rahim. Nice summary. Jeanette - tell us the top 5 causes of pericarditis?"

Jeanette was one of two medical students on the team. It was her first week on cardiology and she was definitely not fitting in. She had been up almost all night, admitting a series of chest pain patients that she could hardly keep apart in her head. The night resident hadn't involved her in this case but she remembered him talking about the tap towards the end of the night. "Um..." She paused and looked around. "I think... one is you have an infection and... other things that cause inflammation?"

The team shuffled uncomfortably. There was a long silence. Dr. Lafleur furrowed his brow. "What do you mean, "Other things that cause inflammation"?"

"I'm not sure." Her voice trailed off. "Can't you get...uh.... inflammation sometimes from things like... lupus?"

There was another pause. Dr. Lafleur turned to Yumi, the other medical student on the team. "Yumi, help your colleague out here?"

Yumi smiled. She loved cardiology and came in early most days to review the diagnoses of the newly admitted patients so that she could be ready for the questions on ward rounds. "Well, viral infection, bacterial infection, malignancy, uremia and connective tissue diseases are all causes. Of course, in the context of this patient, we would have to consider her risk factors and past medical history to accurately tier this differential."

Jeanette stared at the floor. She had known that - she remembered listing off those causes on her last exam of pre-clerkship. Why had she blanked? She could feel her face getting hot. She wished she could go back to pediatrics where she at least knew how to be a decent med student. "Very good Yumi." Dr. Lafleur turned to Rahim. "Let's go and see this patient now."

After rounds Yumi and Jeanette were sitting at the desk charting. Sarah, the team's senior resident arrived. "Jeanette - what kind of performance was that? You know Dr. LaFleur likes to pimp everyone about the cases. Try to be more prepared tomorrow. You're making us all look bad." "Yumi - nice job." Sarah smiled over at Yumi. "Keep up the great work."

Usage

This document is licensed for use under the creative commons selected license: Attribution-NonCommercial-NoDerivs 3.0 Unported.



Questions for Discussion

1. "Pimping" is a term used for the structured public questioning of medical trainees, usually during ward rounds or clinical care. There is some debate about the effectiveness of its use as a teaching tool. Do you think there is a role for it in medical education?
2. A significant proportion of graduating medical trainees report feeling humiliated during their training. Should we, as medical educators, try to ensure that our trainees are protected from humiliation? What coping strategies can learners employ to protect themselves from feeling humiliated? Is this ever an effective method for learning, or for motivation?
3. What strategies can medical educators use to conduct ward rounds in an effective manner? How could Dr. LaFleur have conducted this differently? How could the Sarah (the resident) or Yumi (the other student) have responded differently?

Competencies

| ACGME | CanMEDS |
|---|-------------------------|
| Team Management (ICS2) Professional values (PROF1) | Scholar Communicator |

Intended Objectives of Case

1. Discuss and identify learner- and teacher-specific factors that lead to an antagonistic learning environment.
2. Describe approaches that one might use as an educator to decrease the stress of a question-and-answer session.
3. List specific things that can create a more positive learning environment.

Pimping is Harmful and Ineffective

by Jeff Riddell MD

I feel for Jeanette here.

I shut down when pimping's peculiar cruelty was unleashed on me as a learner and I shudder when I now see it inflicted upon others.

By the time I left my previous job in the private sector to start medical school I had grown accustom to professional etiquette and respect. When I entered the clinical rotations and suddenly had residents my age (or younger) rudely hurling repetitive questions at me in front of my colleagues, I decided it was time to stop feeding the trolls. Eventually, I just stopped responding to pimping.

I recall a time in residency when an attending haughtily asked me repeated questions about ocular anatomy, each time attempting to make the question easier so I would bite and start playing his game (it was clearly a game for him). With a straight face I answered "I don't know" multiple times as the questions got easier. When he finally asked me to name any anatomic structure in or around the eye and I responded with "I don't know", he realized I was not interested in being pimped in front of my colleagues. Before discussing how teachers can ask questions well, it is worth justifying my above actions by explaining how pimping can be harmful and why it is ineffective.

What is pimping?

Though it evades easy definition, it is important to try to define pimping. It remains difficult, however, to distinguish between malignant pimping and asking good questions. These phenomena are quite similar. Both use questions as means to an end, but the key difference may be the end itself: Are the questions used to foster or scaffold the student's thinking? Or is it simply a power play?

Brancati initially suggested that pimping occurred whenever an attending posed a series of very difficult questions to a lower-level learner.[1] Detsky later added that pimping occurs to medical trainees in the presence of their peers.

[2] More recently, Kost highlighted the malignant underlying purpose of pimping is to reinforce the power hierarchy of a team and, more specifically, the attending's place at the top. [2,3]

Perhaps Justice Potter Stewart's famous insight into obscenity, also applies here: "I shall not today attempt further to define the kinds of material I understand to be embraced... [b]ut I know it when I see it..."[4]

Pimping is not harmless

Medical students have described their experiences with pimping with the words "indignity" and "worthless." [5] Of the 13,886 medical students that completed the 2015 Association of American Medical Colleges' Graduation Questionnaire, almost 40% reported at least 1 form of mistreatment.[5,6] When given the opportunity to use cartoons to portray their experiences in medical school, 47% of senior medical students drew horror-genre cartoons with scenes of death and darkness perpetrated by supervising physicians.[7] One student even described how "possessing too little information" factored into a scene of a student's beheading. Although mistreatment is not specific to pimping, pimping is thought to be a primary driver of student humiliation.[8]

Pimping is ineffective

Pimping often asks for fact-based knowledge with dichotomous right or wrong answers. The right answer is usually the one the question asker would choose, despite the fact that there may be several valid approaches to a given clinical scenario.[3] In this "read-my-mind" context, pimping does not support the development of critical thinking skills but stays at the lowest level of Bloom's taxonomy. Pimping suppresses creativity and intellectual curiosity because of fear of embarrassment.[8]

Pimping, with its associated feelings of indignity and worthlessness, creates a hostile learning environment, which is in contention with several learning theories. Social constructivism, in particular, outlines the teacher's role in shaping learning environments and interactions to facilitate the learning process.[9] To be successful, adult learning programs should have mutual respect, a safe and supportive educational environment, and nonthreatening ways to challenge learners.[10,11] A disrespectful environment that decreases self-esteem may decrease learners ability to effectively solve problems.[3] Indeed the learning environment itself may be equally as important as the knowledge and skills shared within it.[12]

Ask questions well

Asking questions can allow teachers to assess their learners' knowledge base, help them learn to think quickly, and handle the pressure of the medical spotlight.[13] The One-Minute-Preceptor and SNAPPS are commonly used clinical teaching techniques that utilize questions to promote higher-order clinical reasoning.[14] Below are a few strategies that

Expert Response

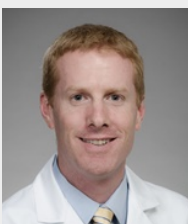
may help us move beyond pimping toward asking questions well:

- Deliberately consider your intention and goal before asking questions.[3]
- Though the role of emotions in learning is complicated, deliberately consider where your learner is emotionally at the time.[15]
- Use questions as a scaffolding to move learners from existing knowledge to new understanding.[9]
- Create a safe learning environment while simultaneously challenging students.[16]
- Look for opportunities to provide praise to learners and apologize publically if you go too far and embarrass a learner.[2]
- Facilitate collaboration and reflection from the whole team by, in lieu of singling out an individual in front of his or her colleagues, ask questions to the group or to individuals one-on-one.
- Ask questions that go beyond memorizing facts to those that encourage metacognition and assist the learner in identifying and correcting their misconceptions.[3]
- Use probing, clarifying, open-ended, and hypothetical questions that encourage student critical thinking, thus achieving higher levels of Bloom's taxonomy.[3,17]

If somehow pimping shows long-term benefit in significant studies that assess higher-order educational outcomes, then I will quietly acquiesce, call my old attending, and answer his questions about ocular anatomy. Until that literature base is established, there is more than enough established harm in pimping, to say nothing of its theoretical and experiential ineffectiveness. We can and should do better.

References

1. Brancati FL. The art of pimping. JAMA. 1989; 262(1):89-90. PMID: 2733128
2. Detsky AS. The art of pimping. JAMA. 2009; 301(13):1379-81. PMID: 19336716
3. Kost A, Chen FM. Socrates was not a pimp: changing the paradigm of questioning in medical education. Acad Med. 2015; 90(1):20-4. PMID: 25099239
4. Jacobellis v. Ohio (1964). In: Encyclopedia of the First Amendment.
5. Libman M. Through the Student's Eyes: On Pimping. Virtual Mentor. 2002; 4(7).
6. Website. Medical school graduation questionnaire: 2015 all schools summary report. Association of American Medical Colleges. Link to PDF. Accessed February 12, 2016.
7. George DR, Green MJ. Lessons Learned From Comics Produced by Medical Students: Art of Darkness. JAMA. 2015; 314(22): 2345-6. PMID: 26647249
8. McCarthy CP, McEvoy JW. Pimping in Medical Education: Lacking Evidence and Under Threat. JAMA. 2015; 314(22):2347-8. PMID: 26647250
9. Vygotsky LS. Mind in Society: The Development of Higher Psychological Processes. Harvard University Press; 1980.
10. Knowles, M. The Adult Learner: A Neglected Species. 1986. Houston: Gulf Publishing.
11. Billington DD. Developmental Aspects of Adult Education: A Comparison of Traditional and Nontraditional Self-Directed Learning Programs. The Journal of Continuing Higher Education. 1990;38(1):31-38.
12. Artino AR, Jr. It's not all in your head: Viewing graduate medical education through the lens of situated cognition. J Grad Med Educ. 2013;5(2):177-179. PMID: 3693674
13. Wear D, Kokinova M, Keck-McNulty C, Aultman J. Pimping: perspectives of 4th year medical students. Teach Learn Med. 2005; 17(2):184-91. PMID: 15833730
14. Zeidman J, Baggett M, Hunt DP. Can One-Minute Preceptor and SNAPPS improve your inpatient teaching? J Hosp Med. 2015; 10(2):131-2. PMID: 25627349
15. McConnell MM, Eva KW. The role of emotion in the learning and transfer of clinical skills and knowledge. Acad Med. 2012; 87(10): 1316-22. PMID: 22914515
16. Wenrich MD, Jackson MB, Maestas RR, Wolfhagen IH, Scherpbier AJ. From Cheerleader to Coach: The Developmental Progression of Bedside Teachers in Giving Feedback to Early Learners. Acad Med. 2015; 90(11 Suppl):S91-7. PMID: 26505108
17. Greenberg LW. Pimping perspectives: response to Wear. Teach Learn Med. 2006; 18(1):87. PMID: 16354147



About the Expert

Dr. Jeff Riddell (@Jeff_Riddell) is an education research fellow at the University of Washington studying digital technology in medical education. He is an engaging teacher, digital innovator, and education scholar who enjoys collaborating with good people, especially those at ALiEM.com and The Teaching Course.

Pimping and Palpitations

by John Eicken MD

I felt palpitations and a flush creeping into my cheeks the moment Dr. Lafleur began questioning Jeanette. Why did this case evoke such a visceral response? Probably because I immediately flashed back to the morning when I was the post-overnight ICU intern and the attending was asking me questions in front of the entire team. I didn't know the answers to any of the questions he asked during what seemed like endless patient rounds. These vignettes highlight the complex dynamics and relationships between students, residents, and attendings within a medical team and the practical challenge of cultivating the clinical learning environment. Before discussing the role of "pimping", emotional safety, and strategies to promote an effective learning environment, let's first take a step back and spend a minute in each character's shoes.

Let's start with Jeanette, the medical student, and one of the least experienced clinicians on the team. She only recently left the medical school classroom and started her cardiology rotation. She is "not fitting in well", and to make matters worse, she is coming off an overnight shift. Adding to her angst are fatigue and being unexpectedly questioned about a patient to whom she did not provide care. Her professional motivations are to maximize her learning and assist her team with providing excellent patient care, while not appearing unprepared or unqualified.

Now let's shift our focus to Dr. Lafleur. As the attending on service, he is viewed as possessing the most clinical acumen and experience on the team. Time dedicated to teaching during rounds is valuable, and he wants to ensure it is high-yield and efficient. To succeed, he must teach to the appropriate level of the learners. Ideally, he will use questions during rounds to assess the trainees' knowledge bases and appropriately target follow-up discussion.[1] Ascertaining Jeanette's understanding of cardiology is likely what he is trying to accomplish when he questions her during rounds.

Finally, Sarah is the senior resident on the team. She is the team leader and provides structure and guidance to the junior learners. In this capacity, she likely feels responsible for how Dr. Lafleur interprets the team's functionality and performance.

The following are my answers to the questions in this case.

1. "Pimping" is a term used for the structured public questioning of medical trainees, usually during ward rounds or clinical care. There is some debate about the effectiveness of its use as a teaching tool. Do you think there is a role for it in medical education?

The distinction between "pimping" and constructive questioning in medical education can be subtle. Depending on the context, the act of "pimping" can have positive or negative connotations. [1] Negative scenarios typically occur when an individual is portrayed unfavorably because he or she does not know an answer and another individual (often "superior" in the hierarchy) affirms his or her dominance by unleashing a superior knowledge base. I do not think there is a role for this type of competitive mental jousting in medical education. Students in these scenarios have access to limited protective mechanisms, and academic physicians have acknowledged this unfortunate phenomenon. Allan Detsky developed a humorous set of "pimping protection procedures", which students can employ to avoid becoming victims of pimping. These include "the muffin" technique, where the learner takes a large bite of a muffin if he or she does not know the answer to the question asked.[2]

"Learning on the fly", in contrast to pimping, involves constructive, structured group questioning and can be productive, particularly in emergency medicine, where training how to think quickly is a necessary component of medical education. Distinguishing what a learner will perceive as instructive questioning versus belittling pimping requires honest and thoughtful reflection on the teacher's intention; establishing a safe, productive, and non-threatening learning environment; and incorporating learner feedback.[3] Medical educators' intentions must be to foster the trainees' growth and development, not to instill humiliation that spurs learners to study harder.

Medical school is an intentionally rigorous path of knowledge acquisition. Trainees must emerge with the knowledge and skills needed to safely and effectively care for patients as independent providers. Appropriate application of "learning on the fly" should result in trainees feeling tested and pushed just beyond their comfort zone and into the zone of proximal development. Medical educators must ensure trainees leave the experience with a positive outlook (and likely a to-do list of subjects they should brush up on), rather than with a feeling of failure and

Expert Response

inadequacy. I advocate that trainees' learning shouldn't be pointlessly made more arduous by negative interactions that might have easily been converted into constructive learning experiences.

2. A significant proportion of graduating medical trainees report feeling humiliated during their training. Should we, as medical educators, try to ensure that our trainees are protected from humiliation? What coping strategies can learners employ to protect themselves from feeling humiliated? Is this ever an effective method for learning, or for motivation?

Medical educators are *facilitators* on the trainees' journey to acquiring new knowledge that they can apply clinically. Medical educators have failed if all they accomplish is transfer of rote details that the learner tucks into short-term memory for the upcoming test. A learner's emotion plays a significant role in the learning process. If a trainee feels "humiliated" or "terrified" during a particular encounter, he or she will remember the topic discussed (often for the rest of their lives if the experience was traumatic enough – just ask any medical professional who has completed training). If remembering the material is the sole aim, one could argue that this result is exactly the desired outcome. The cost of this single experience, however, far outweighs any benefit because the trainee may become averse to engaging in future similar learning environments.[4] Additionally the increased risk of psychiatric illness and stress in medical students[5] is important to consider when evaluating the risks and benefits of different teaching styles. I recommend medical educators strongly consider alternate teaching methods prior to employing one that leads to humiliation of the learner.

3. What strategies can medical educators use to conduct ward rounds in an effective manner? How could Dr. LaFleur have conducted this differently? How could the Sarah (the resident) or Yumi (the other student) have responded differently?

Medical educators must consider that perception is reality; if learners perceive they are being attacked or demeaned during a teaching session, the "truth" of the situation doesn't really matter. Educators should establish clear expectations for trainees from the beginning of a rotation (or ED shift) to cultivate an effective learning environment. This may include openly discussing that bidirectional questioning is the norm and helps gauge understanding. It may also include acknowledging that

the answer "I don't know" is entirely acceptable. When trainees recognize that being questioned is part of their learning experience, their engagement with this teaching technique increases.

Dr. LaFleur could have improved the learning experience and environment for Jeanette in several ways. Jeanette's answer to his question did not include all the top 5 causes of pericarditis, but her answer was not incorrect. This is a golden opportunity for an educator to embrace a student's struggle and act as a constructive coach who employs a growth mindset.[6] By pausing, deploying an unenthusiastic non-verbal cue (frown the brow), and asking someone else on the team to "help us out" Dr. LaFleur took the negative route by making it seem as though Jeanette were wrong. Imagine if, instead, he reinforced that her initial responses were correct, then asked the rest of the team to work together to complete the list of the remaining causes. He could then turn to Yumi and ask if she could add to the list that Jeanette had started for the team. The medical information imparted would be the same, but the environment would be completely different.

As the senior resident of the team, Sarah needs to focus on leadership development, which includes teaching and fostering team camaraderie. Her response to Jeanette after rounds failed miserably at achieving these goals. In a private setting, Sarah could have asked Jeanette how she thought the morning went, then offer suggestions on how to better prepare for future rounds and on how to maximize her experience while on cardiology.

Yumi benefited from her hard work and preparation prior to rounds, and she appropriately answered the question she was asked. Although she answered the question correctly, it is important to highlight that empathy, collegiality, and professionalism are intangible skills that are highly desirable in medicine. Students who display these skills in addition to a strong knowledge base will excel on their rotations. A more collaborative response from Yumi would have been, "I agree with Jeanette that I would think about infectious causes in addition to other causes such as..."

It is our mission to meet individuals where they are in their learning, particularly when they are struggling, and help move them forward. With a few simple adjustments to the 'pimping' mindset and environment, we can achieve that for learners like Jeanette.

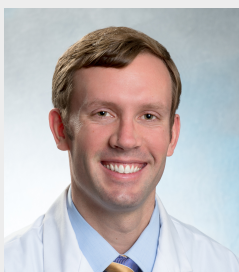
Expert Response

Take Home Points

- Establishment of a collaborative, constructive, and non-threatening learning environment for medical trainees is the key to preventing a positive group learning experience from becoming an undesirable “pimping” session.
- Examining the context of each medical team member is essential to understanding the power differentials, perceptions, and goals of each individual – try to put yourself in their shoes!
- Fostering a ‘growth-mindset’ [6] within a medical trainee will help him/her develop the mental framework necessary to achieve his/her full potential throughout their career.

References

1. Wear D, Kokinova M, Keck-McNulty C, Aultman J. Pimping: perspectives of 4th year medical students. *Teach Learn Med.* 2005; 17(2):184-91. PMID: [15833730](#)
2. Detsky AS. The art of pimping. *JAMA.* 2009; 301(13): 1379-81. PMID: [19336716](#)
3. Kost A, Chen FM. Socrates was not a pimp: changing the paradigm of questioning in medical education. *Acad Med.* 2015; 90(1):20-4. PMID: [25099239](#)
4. Artino AR, Jr. It's not all in your head: Viewing graduate medical education through the lens of situated cognition. *J Grad Med Educ.* 2013;5(2):177-179. PMCID: [3693674](#)
5. Dyrbye LN, Thomas MR, Shanafelt TD. Systematic review of depression, anxiety, and other indicators of psychological distress among U.S. and Canadian medical students. *Acad Med.* 2006; 81(4):354-73. PMID: [16565188](#)
6. Dweck CS. Mindsets: Developing talent through a growth mindset. *Olympic Coach.* 2009;21(1):4-7.



About the Expert

John Eicken (@johneicken) is an emergency medicine ultrasound fellow at the Brigham and Women's Emergency Department in Boston, MA. He completed his residency training in the Harvard Affiliated Emergency Medicine Residency program (BWH/MGH) and is currently pursuing a Master of Education degree in the Technology, Innovation, and Education (TIE) program at the Harvard Graduate School of Education. John's academic interests focus on contributing to and improving medical and ultrasound education for medical students, trainees, and providers.

Curated Community Commentary

By John Eicken MD & S. Lockett-Gatopoulos MD, FRCPC (candidate)

A qualitative methodology was used to curate the community discussion. Blog comments were analyzed and five overarching themes were extracted.

The “Case of the Pimping Physician” stimulated insightful and thoughtful conversation amongst individuals at varying levels of clinical experience, ranging from medical students to seasoned emergency medicine physicians. Within this commentary, we highlight key points that further clarify how “pimping”, humiliation, teaching strategies, and learning environment influence trainee educational experiences.

Pimping is a double-edged sword

“Pimping” is a topic that is not novel to medical education, in fact, The Journal of the American Medical Association (JAMA) has published on “*The Art of Pimping*” twice!^{1,2} Dr. Scott Wieters notes that even the experts have disagreed about the role of pimping in medical education³, and we were not surprised to find that commentator opinion was similarly divided.

Dr. S. Lockett-Gatopoulos, an emergency medicine resident, reflected upon personal experience to propose that pimping and humiliation can be both motivating and detrimental, with the differentiating factor being how the learner feels about the learning experience. She acknowledged that

...pimping can be motivating. Sometimes that little extra bit of anxious arousal can keep me studying, thinking, and more generally on my toes. This can be good for both education and for patient care, as I spend more time thinking more deeply about my patients than I might otherwise.

She also noted, however, that if, due to pimping, “we feel that our embarrassment is due to *external, stable factors* that are out of our control (like our attending being a jerk), we will start to feel hopeless and lose our motivation to improve for our sake and for the sake of our patients.”

Anali Maneshi, a 4th year medical student, agreed that ‘pimping’ can be either a positive experience or a negative experience. She highlighted the main principles that differentiate ‘good’ pimping from ‘bad’ pimping, saying that “In my personal experience as a learner if I am pipped and I feel as though the purpose is to ridicule me, or to show deficiencies in knowledge to a group of peers it is humiliating. Instead of focusing on learning and performing my duties as a student I become quite anxious about the next moment when I will be pipped while working with that attending.”

Attending physician Dr. Ross Morton was not sure that Jeanette’s situation involved ‘pimping’ behavior at all, which highlights the importance of taking into account individual

Contributors

Thanks to the participants (in alphabetical order) for all of their input:

| | |
|----------------|------------------|
| Michael Beyak | Kaif Pardhan |
| Alvin C | Eve Purdy |
| Teresa Chan | Jordan Spector |
| S Lockett G | Loice Swisher |
| Cathy Grossman | |
| Kory London | J. Scott Wieters |
| Anali Maneshi | @signindoc. |
| Anne Messman | |
| Heather Murray | |

perspectives regarding a scenario. A ‘pimping’ line of questioning, he argued,

would have included asking for the common viruses which cause pericarditis (ICE: influenza, coxsackie and echo), what constituted Beck’s triad (hypotension, muffled heart sounds, distended neck veins), who was Beck (a resident at Case Western who went on to become a Professor of Cardiology); whose sign involved dullness to percussion below the angle of the left scapula in pericardial effusion (Ewart), who was Ewart (I’ll leave you to look that one up!)

There was a common thread amongst the discussants that aligned with Dr. Ross Morton’s thought that, “Being deliberately shamed is unacceptable and has no place in education of any form.”

Committed Answers and Structured Questioning Are Vital

Dr. Wieters highlighted the importance that teachers encourage their learners to commit to an answer when faced with a question. The importance of committing to an answer relates both to the student’s ability to learn new information⁴ as well as to their ability to function within the environment of an emergency department where physicians are continually asked questions by patients and other providers. A randomized controlled trial suggests there is utility in promoting residents to commit to answers.⁵

Several participants expanded upon Dr. Wieters thoughts, particularly in relation to how structured questioning (or the Socratic method) and the desire for students to commit to an answer does not always equate to ‘pimping’.

Alvin C, a senior medical student, noted:

I realize the significant value in getting used to committing to answers/management plans vs. theoretically considering them with no consequences. It really forces us as learners to recognize the importance of being prepared as we slowly advance into a role where our decisions and actions will make an impact.

Curated Community Commentary

Kory London suggested that the Socratic method aligns with the demands, pace, and environment of emergency medicine. Furthermore she tied in the role that power dynamics play in regards to structured questioning for medical education by stating:

Pimping doesn't have to be uncomfortable or feel at all like shaming. I pimp with a smile on my face then if the learner hesitates or appears to be aiming in the wrong direction, I explain how I get to the answer physiologically...And with all things (including feedback) long as the tone of the conversation remains focused on the learning, the mood is never confrontational or patriarchal.

Jordan Spector highlighted that there can be personal growth as a result of enduring uncomfortable situations ([Link to relevant article](#)) by stating:

Like many of us, I find 'pimping done right' to be an integral part of bedside teaching in a busy ED. Dr. London's comment is imperative, it must be a 'power neutral' discussion, which I think has NOT been the case classically....where (as in the case above) pimping is done in a way that transitioned past uncomfortable into the zone of mortifying.

Be a Columbo! Create a Mental Scaffold to Bridge the Gap for Learners

We found Dr. Lockett-Gatopoulos's quote to be the perfect starting point for this theme, "The best teachers know how to reach learners where they are currently, as opposed to where they think they should be."

Instead of taking on a stereotypical pimping role as a teacher, Dr. Wieters provided concrete strategies that teachers can apply to facilitate a more influential connection with their learners. He calls the strategy the 'Columbo Tactic' (named after the infamous television series homicide detective) where the teacher utilizes questions to both bring a team together and acknowledge that the teacher does not have all the answers

Dr. Wieters described this technique first during our discussion: *Another way is what I call the 'Columbo Tactic' ([link for those <40](#)): 'I forget where ketones come from in DKA and it's been a while since biochem... Remind me how these are made?' [This technique] can disarm an anxious learning culture. When teachers embrace their own mistakes in front of learners, it can help lessen the sting of an incorrect answer. Like most communication, "It isn't what you asked... it is how you asked it."*

Dr. Loice Swisher expanded upon the 'Columbo Tactic' and Dr. Wieters thoughts by providing an additional reference (<http://blog.ercast.org/right-way-teach/>) and noting some of the phrases Columbo used which can also be utilized by teachers in the clinical environment:

- I'm curious...
- I'm confused...
- Maybe you can help me out here...

Dr. Wieters suggested that when the teacher, or expert, reframes a clinical concept for the learner by providing an organized scaffolding of concepts the learner is then able to construct the pieces of scaffolding together in a manner that fits within their personal zone of proximal development which will enhance their ability to process that information. He notes that it is important for teachers to appreciate that they may possess the ability to quickly diagnosis or understand a clinical situation much more quickly than the learner standing next to them. To bridge this gap between teacher and learner he suggests, "

There needs to be some diagnosis of the learner and questioning to assess their level (Zone of proximal development). Some ways I use the "Columbo Tactic" are:

Example 1: "Hmmm... he has jaundice and no abdominal pain along with some weight loss... I wonder what could cause this? And then let them come to the diagnosis... <learner answers> Yes, pancreatic cancer is what we need to pursue"

Example 2: "What in the world are these ketones doing in this kids urine who has n/v/d? I just thought he was dehydrated. You just had physiology and its been decades for me? Remind me... Where do those come from? I tend to forget... How did those get there? What should our IV fluids contain?"

Clear Expectations - Creating a Safe and Unambiguous Learning Environment

Several participants noted the importance of the creation of a supportive learning environment that is free of humiliation and open to the statement "I don't know..." by learners. Other participants provided guidelines and suggestions regarding how to cultivate an optimal learning environment.

Dr. Lockett-Gatopoulos reflected, "The best environments I have found for learning are ones in which it is possible to say 'I don't know, but I'll look it up' without fear of humiliation and shaming." Anali Maneshi agreed that a supportive environment is important for learners and largely shaped by the attitudes and behaviors of the senior members of the team. Furthermore she noted that seasoned clinicians possess knowledge that cannot be expressed through books,

As a learner we do the work by reading, asking questions and trying to see as much as they can, but at a certain point the knowledge an experienced clinician can bring is unequivocal to books or most other resources.

Dr. Kaif Pardhan noted that there is evidence that a significant number of medical students and residents report experiencing some form of bullying during their training⁶ and therefore a safe learning environment is not something that can be implicit, but rather must be created by the teacher such as the attending

Curated Community Commentary

physician and/or chief resident. Kaif offered the following principles to increase the safety of the learning environment:

- Set the expectation
- Praise in public
- Criticize (or provide constructive feedback) in private
- Be honest - nothing does a trainee (or the system) a greater disservice than artificially inflating your assessment of a trainee's performance
- Will trainees sometimes feel humiliated? Sure they will - but it should never be because malice was aforesight. These should be used as teaching moments - pull the trainee aside and ask the question: *how are we going to do better next time?*
- Move up a level if the question can't be answered (i.e. if the third year med student can't answer, move up to the junior resident.)
- Spread the love: get everyone in the group to give one or two answers.
- Just as a general rule, 'Be Nice to Each Other'

Michael Beyak provided an excellent statement (which we think every medical educator should hold in their back pocket...) that can be utilized to ease learner anxiety when the student may be struggling to answer a question, *"Imagine that, a med student who doesn't know everything yet"*.

Dr. Cathy Grossman provided insight regarding how a teacher can perform a three step 'educational prebrief' at the start of a shift to cultivate an unambiguous learning environment and set clear expectations:

1. **Basic Assumptions** (I believe we are all here to learn and take care of pts the best we can).
2. **Dispel Myths** (asking you questions helps me to know what you do and don't know - not done to embarrass or belittle you - I ask questions to guide your learning and inspire your curiosity).
3. **Set Performance Expectations** (ask questions if you are unsure; it's ok to correct me if I say something wrong - we are all human and make mistakes; it's ok if you don't know something just say 'I don't know')

Dr. Anne Messman and Dr. Swisher brought up the impact that non-verbal cues can have on a learning environment. Non-verbal cues (such as Dr. Lafleur furrowing his eyebrow) can be powerful, non-specific, and misinterpreted. There are many reasons Dr. Lafleur may have furrowed his brow, including meaning to be condescending, being caught off guard with Jeanette's response, or if he had an itch. However, Anne Messman points out, "I think it's more about the perception the student may have had about the furrowed eyebrow. She would likely perceive it negatively no matter what his intention was. As teachers, we just have to be careful about the environment we're creating because students can be very sensitive to these subtle physical clues, regardless of their intention."

Dr. Heather Murray made an interesting and valid point regarding how the learners themselves may also be contributing to an unhealthy learning environment through promotion of detrimental competition. She notes, "...And even the best of us can find ourselves feeling smug and superior when we know an answer that has flummoxed a fellow learner. I sometimes worry that medical training is morphing into a constant unrelenting competition where the act of one-upping someone supersedes the learning process itself."

Alvin C, a senior medical student, highlighted the important and influential role that senior residents have in the eyes of the more junior trainees. Alvin found Sarah's attitude towards Jeanette to be inconsiderate and he postulated that, "Could it be that Sarah is of the opinion that "I used to get pimped and humiliated so this is the norm and this is how you should feel too."? There are many examples in medicine of older generations expecting younger generations to accept a "norm" just because they experienced it and not necessarily because it has been proven to be beneficial (and possibly may even be harmful to learning/patient care)."

No Two Students Are Alike - Beware of the One-Size Fits All Teaching Approach

Kaif Pardhan astutely noted that each student is a unique learner and recommended that teachers be sensitive to different learner characteristics to promote inclusion within group learning experiences. He stated:

...regardless of their clinical strength or depth of knowledge, some trainees will always perform better in front of a crowd than others. Whether it's because they are introverted and simply need time to formulate an answer, have stage fright or have had overall negative experiences with "pimping" - it just may not be their thing.

Eve Purdy highlighted the subtle differences between embarrassment and humiliation and how students can vary in their perception and internalization of a scenario similar to Jeanette's - a concept that all teachers should appreciate. She stated,

To me embarrassment is an emotion felt when I one recognizes she could have performed better or he could have been more prepared but there is no demolition of self-worth. Humiliation on the other hand erodes at that sense of self. After an embarrassing situation one might think, "I FELT stupid when I answered incorrectly when I should have known the answer so I will go home and read about it After being humiliated one might think, "I AM stupid for not knowing the answer to that question. Why did I think I could become a physician? I will never know all that I need to".

Dr. Swisher builds upon the concept that perception of similar situations can vary between individuals by noting,

There seems to be times when a virtually identical interaction rolls right off one resident's back and to another pierces right through their very soul. If it is one that hurts, it seems residents don't feel empowered to discuss what happened, how they feel and what they can do to do better.

Curated Community Commentary (continued)

While teachers should do their best to utilize teaching techniques that align with the trainee's learning style, Dr. Swisher points out the importance of trainee's learning to become flexible and open to different types of teaching styles. She noted, "Just because a learner feels they tend to freeze with direct questioning in a group doesn't mean it won't happen. There are other factors that play into this. That is just life."

To wrap up the community commentary for the 'Case of the Pimping Physician', we would like to highlight Dr. Loice Swisher's thoughts regarding the relationship between courage, teamwork, and learning:

Learning how to work as a team for betterment of all is a great skill to develop. It takes courage to say that one doesn't know or suggest better ways or to step in when someone else is having a hard time. Yet maybe those hard interactions are where some of the most important learning is done- both for the teacher and the student. ... There has been quite a bit of hard learning in my career- and some of those lessons likely have affected patients, some have affected students and some have affected my mentors. Perhaps a way to think of it that steel is tempered by fire and diamonds are made under pressure.

"Courage is not the absence of fear, but rather the assessment that something else is more important than fear." -- Franklin D Roosevelt

1. Brancati FL. The art of pimping. *JAMA*. 1989; 262(1): 89-90. PMID: [2733128](#)
2. Detsky AS. The art of pimping. *JAMA*. 2009; 301(13): 1379-81. PMID: [19336716](#)
3. Reifler DR. The Pedagogy of Pimping: Educational Rigor or Mistreatment? *JAMA*. 2015; 314(22):2355-6. PMID: [26647254](#)
4. Kornell N, Hays MJ, Bjork RA. Unsuccessful retrieval attempts enhance subsequent learning. *J Exp Psychol Learn Mem Cogn*. 2009; 35(4):989-98. PMID: [19586265](#)
5. Furney SL, Orsini AN, Orsetti KE, Stern DT, Gruppen LD, Irby DM. Teaching the one-minute preceptor. A randomized controlled trial. *J Gen Intern Med*. 2001; 16(9):620-4. PMID: [11556943](#)
6. Chadaga AR, Villines D, Krikorian A. Bullying in the American Graduate Medical Education System: A National Cross-Sectional Survey. *PLoS One*. 2016; 11(3):e0150246. PMID: [26982705](#)

References

About

The Medical Education In Cases (MEdIC) series puts difficult medical education cases under a microscope. We pose a challenging hypothetical dilemma, moderate a discussion on potential approaches, and recruit medical education experts to provide their insights. The community comments are also similarly curated into a document for reference.

Did you use this MEdIC resource?

We would love to hear how you did. Please email MEdIC@aliem.com or tweet us @Brent_Thoma and @TChanMD to let us know.

Purpose

The purpose of the MEdIC series is to create resources that allow you to engage in "guerrilla" faculty development – enticing and engaging individuals who might not have time to attend faculty development workshops to think about challenging cases in medical education.

Usage

This document is licensed for use under the creative commons selected license:
Attribution-NonCommercial-NoDerivs 3.0 Unported.

