



Teaching Portfolio

Jeff Wiese, MD, FACP

Professor of Medicine

Associate Dean of Graduate Medical Education

Associate Chairman of Medicine

Chief of Medicine, MCLNO

Director, Internal Medicine Residency Program

Course Director, Clinical Diagnosis and Biostatistics

Assoc. Director, Internal Medicine Clerkship

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Jeffrey G. Wiese, MD, FACP



Jeffrey G. Wiese, MD, is a Professor and the Associate Dean for Graduate Medical Education at the Tulane University Health Sciences Center. He is also Vice-Chairman of Medicine, the Chief of the Charity Medical Service and the Director of the Tulane Internal Medicine Program. He is also the course director for the Clinical Diagnosis, Biostatistics, Advanced Internal Medicine, and Medical Education courses.

Dr. Wiese attended Johns Hopkins School of Medicine, where he received his medical degree in 1995. He completed his residency in internal medicine, chief residency and a medical education fellowship at the University of California at San Francisco. He has been on faculty at Tulane since 2000.

Dr. Wiese devotes his time to teaching and educational research, incorporating evolving technologies in clinical reasoning and patient safety. Dr. Wiese has won 42 teaching awards in the first 10 years of being on faculty. He was named the UCSF's Professor of the Year in 2000, and the Tulane Attending of the Year in 2001, 2002, 2003, 2005 and 2007. He was the recipient of The Society of Hospital Medicine' Education Award in 2005, the ACGME's Parker Palmer Courage to Teach Award in 2006, the AAMC's Robert J. Glaser Distinguished Teacher Award in 2006, & the ACP's Walter J. McDonald Award in 2007.

Dr. Wiese has written over 70 articles, books, or book chapters and has made over 200 presentations to national and international audiences. He is a reviewer for six national journals, and serves on the Board of Directors for the Society of Hospital Medicine and the Council for the Association of Program Directors in Internal Medicine.

As Chief of Medicine for Charity and University hospitals, he serves on over twenty different Tulane and MCLNO committees. Over the past two years he has spear-headed an effort to enact a recurrent \$1.2 million dollar hospitalist grant for Charity hospital.

In the wake of Hurricane Katrina, Dr. Wiese drove over 36,000 miles visiting his displaced residents and continuing to teach a curriculum that rotated weekly in the three cities in which they were placed. Under his leadership, Tulane's residency only lost 5 of 115 residents, and completely filled their intern complement within the match. Tulane lost only three weeks of curricular time; all residents found a fellowship position at the end of their training.

II. SECTION 1: PERSONAL PHILOSOPHY OF TEACHING AND LEARNING

Medicine is about the ability to perform... the ability to take intellectual knowledge and put it in act for the benefit of the patient. What a student knows is immaterial if he or she is unable to put the knowledge into action. Where teaching is about the dissemination of knowledge, coaching is about enabling performance. My philosophy of teaching is not to teach, but to coach. Teaching provides knowledge; coaching enables performance.

In the Teaching Teaching (Coaching) class offered to fourth-year students and residents, I begin with asking the students to recognize the four developmental phases of a teacher:

1. Phase 1: After years of struggling with a clinical topic, the teacher seeks to prove to himself that he has finally gained mastery of the topic. This teacher's lectures are full of details and proceed at a blistering pace. The goal is not for the students to learn or use the material, but rather to be a witness to the teacher's self-driven desire to prove mastery of the topic. **The focus is on the teacher's ego, not the students' ability to perform.**
2. Phase 2: Along the way, the teacher receives approbation from her students. The approbation becomes her primary motivation for teaching. Like an artist who has sold out to the popular media, the teacher begins to think less about what the student needs to perform (her art), and more about what will make the student happy. While student satisfaction is important, the teacher is at risk for abandoning important lessons in lieu of popularity. **The focus is on the teacher's ego, not the students' ability to perform.**
3. Phase 3: The teacher discovers that awards are given for teaching, and these awards are important for promotion and pay. The teacher's motivation is for his personal gain, not for the for the student's performance. The risk of popularity driving the teacher's agenda seen in phase II is increased. **The focus is on the teacher's personal gain, not the students' ability to perform.**
4. And then there is Phase 4, where the teacher becomes the coach. Whether recognition or popularity come his way, his focus is undistorted: he is driven by a vision of turning the corner of a hospital ward one day, and seeing a former student doing the right thing for a patient, because of something he had taught him. **The focus is on the student's ability to perform; the coach is content to be anonymous.**

My father was a prolific coach, and while he has not been a part of my life for twenty years, I do remember this important lesson of coaching: to establish greatness in a player, you must begin early in his career, and you must give of yourself *completely* to ensure his development along the way. In my teaching career, I have been through all four levels, and still I struggle with keeping myself from being swayed by popularity and concerns for my career (phase II and III). When it is all said and done, it is my wish that my coaching career will be characterized by my father's first principle: I want to be able to say that I devoted all elements of myself to the development of my students; my success will be measured by students' ability to perform. I wish too that I can find peace with this goal, such that I am content with no recognition of my efforts, save the satisfaction of knowing that the world is a better and healthier place because of what I enabled my students to do.

Perhaps this narrative will give you an idea of how I have tried to accomplish this goal, for even though the different courses I teach seem disparate, there is a common vision that holds them all together.

I evoke the idea of coaching and teams not only because I think it is a better paradigm for an educational venture with performance as its ultimate goal, but also because at the end of all training, medicine is about being a part of a team. I think this team philosophy that underlies each of my courses and teaching ventures not only makes for better physician “players,” but more importantly, it makes for better physician “team players.”

III. SECTION 3: TEACHING RECOGNITIONS

- 2009 Society of General Internal Medicine Mentorship Award**
- 2008 Arnold Drapkin Memorial Award**
- 2008 Leonard Tow Humanism in Medicine Award
- 2008 Arnold Gold Humanism in Medicine Award
- 2007 President's Award for Excellence in Teaching; Graduate Teacher of the Year**
- 2007 Walter J. McDonald Award for Outstanding Achievement (ACP)**
- 2007 Tulane Student Advocate Award
- 2007 Tulane Outstanding Faculty/Class Sponsor
- 2006 Alpha Omega Alpha Robert J. Glaser Distinguished Teacher (AAMC)**
- 2006 Parker Palmer Courage to Teach Award (ACGME)**
- 2006 Category 5 Award: 5 Professors Instrumental in Tulane's Recovery
- 2006 Tulane Third-Year Outstanding Professor
- 2006 Alpha Omega Alpha Distinguished Teaching Award; Tulane
- 2005 Society of Hospital Medicine Excellence in Teaching Award (SHM)**
- 2005 Induction into the Tulane Teaching Scholars Academy (one per year)
- 2005 Tulane Fourth-Year Outstanding Professor
- 2005 Tulane Outstanding Course: Advanced Internal Medicine
- 2005 Tulane Third-Year Outstanding Professor
- 2005 Tulane Second-Year Outstanding Professor
- 2004 Virginia Furrow Award for Medical Innovation
- 2004 Tulane Outstanding Faculty/Class Sponsor
- 2003 Alpha Omega Alpha Distinguished Teaching Award; Tulane
- 2003 Tulane Course of the Year: Clinical Diagnosis
- 2003 Tulane Third-Year Outstanding Professor
- 2003 Tulane Second-Year Outstanding Professor

- 2003 Tulane Internal Medicine Residency Faculty of the Year
- 2002 Homulsky Award (SGIM)**
- 2002 Tulane Outstanding Faculty/Class Sponsor
- 2002 Tulane First-Year Outstanding Professor
- 2002 Tulane Second-year Outstanding Professor
- 2002 Tulane Third-Year Outstanding Professor
- 2002 Tulane Fourth-Year Outstanding Professor
- 2001 Young Researcher Award, American Federation of Medical Research
- 2001 Tulane Third-Year Outstanding Professor
- 2001 Tulane Fourth-Year Outstanding Professor
- 2001 Graduate & Professional School Student Government Teacher of the Year
- 2001 Tulane Internal Medicine Residency Faculty of the Year
- 2000 UCSF Teacher of the Year; Clinical Faculty
- 2000 Outstanding Small Group Instructor, UCSF
- 1999 Outstanding Small Group Instructor, UCSF
- 1999 Alpha Omega Alpha Teaching Award: UCSF
- 1998 Outstanding Clinical Preceptor; UCSF
- 1998 Outstanding Small Group Instructor, UCSF
- 1997 Keith Johnson Award; Outstanding Teaching Resident, UCSF

IV. SECTION 4: LEADERSHIP IN MEDICAL EDUCATION

A. NATIONAL SERVICE

- 1. Committee Chairman; American Board of Internal Medicine Hospital Medicine Certification Committee**
- 2. Course Director: Teaching Hospitalist Educators (THE) Course; SHM 2008**
- 3. Board of Directors; Association of Program Directors in Internal Medicine; 2007 to 2010**
- 4. Board of Directors; Society of Hospital Medicine; 2006-2008**
5. ACP, SGIM, ASP, SHM Joint Task Force of Internal Medicine Recruitment; 2006
6. ABIM Task Force on Ambulatory and Hospital Medicine Certification; 2006-2007
7. National Meeting Planning Committee: Society of General Internal Medicine; 2007
- 8. Chairman, National Society of Hospital Medicine Critical Care Course; 2004**
9. Chairman, National Clinical Vignette Review Committee; SGIM; 2004
10. National Meeting Planning Committee: Society of General Internal Medicine; 2004
11. National Meeting Planning Committee: Society of Hospital Medicine; 2004
12. Chairman, Clinical Medicine Review Committee; SGIM; 2003
13. Society of Hospital Medicine Southern Regional Council; 2003-2004
14. Society of Hospital Medicine Education Committee; 2002-Present
15. Chairman, National SAE Men's Health Committee; July 1, 2000- July 2002
16. Host and Curriculum Director; Louisiana & Mississippi ACP Meeting; 2003, 2005, 2007, 2009
17. Faculty; Association of Program Directors in Internal Medicine; 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009
18. Vignette Review Committee; Society of General Internal Medicine; 2002-2004
19. Abstract Review Committee; Southern Society of General Internal Med.; 2001-2003
20. Vignette Review Committee; Southern Society of General Internal Medicine; 2000-2003

B. UNIVERSITY SERVICE

1. Tulane

- a. Secretary, Tulane General Medical Faculty. 2008-2009
- b. Parliamentarian; University Senate; 2007 to Present
- c. Tulane University Senate; 2006-2008
- d. General Clinical Research Center Oversight Committee; 2006-2008
- e. Chairman T3-T4 curriculum committee; 2005-2008
- f. Medical Education Management Team; 2005- present
- g. Student Academic Progress Committee; 2003- present
- h. Curriculum Committee; 2002-2005
- i. Institutional Review Board, 2002-2008
- j. Tulane Housestaff Appeals Board (dean's appointment) 2003- 2005
- k. Institutional Graduate Medical Education Advisory Committee (IGMEAC) 2002-2005
- l. General Competencies and Outcomes Assessment Committee
- m. T2 curriculum committee; 2002- 2008

- n. SCOPE Advisory Committee; 2001-present
- o. Curriculum Review Committee; Pharmacology 2000-2001
- p. Medicine clerkship review committee 2000-present
- q. Resident review committee; 2000-2002

2. Charity and University Hospitals (MCLNO)

- a. Task force for the VA/MCLNO collaborative hospital design; 2006-present
- b. Clinical Opportunities Study Group Commission (LSU, Tulane,VA)- 2006.
- c. MCLNO Hospital Planning Commission; 2003-Present
- d. President, MCLNO medical faculty 2004-2006
- e. Vice-president, MCLNO medical faculty 2002-2004
- f. Utilization Management Committee; 2002-2004
- g. Executive committee; Charity Hospital; 2000-present
- h. Credentials committee; Charity Hospital; 2000-present
- i. Quality assurance committee; Charity Hospital; 2001-present
- j. Ethics committee; Charity Hospital; 2000-present
- k. Information and technology committee; 2003-present
- l. Pain management committee; Charity Hospital; 2003- present
- m. Tissue Labeling and Processing committee; Charity Hospital; 2003- present
- n. EMTALA committee 2001-2002
- o. Chairman; Root cause analysis/ JCHO Committee; 2001-2002
- p. Operational excellence committee; Charity & University Hospital; 2000-present
- q. MCLNO medical faculty parliamentarian 2002-present
- r. Tulane-LSU joint internal medicine committee; 2000- present

C. VISTING PROFESSORSHIPS

- 1. University of Missouri, Kansas City AOA Visiting Professor; 2010
- 2. University of Minnesota; 2009
- 3. NIH Student Education Visiting Professor; 2009
- 4. Baylor University; 2009
- 5. Miami University; 2009
- 6. Mt. Sinai; 2008
- 7. Tufts University; 2008
- 8. University of Mississippi; 2008
- 9. Legacy Health System; Portland, Oregon; 2008
- 10. University of Alabama Birmingham; 2008
- 11. University of Alabama; Montgomery; 2008
- 12. University of Texas, Houston; 2008
- 13. St. Luke's-Roosevelt Hosp Center, NYC; 2008
- 14. Washington University, St. Louis; 2008
- 15. Texas A&M University, 2007
- 16. Medical University of South Carolina 2007
- 17. University of Virginia, 2007
- 18. Ohio State University, 2007

19. Brigham and Women's Hospital/ Harvard Medical School 2007
20. Legacy Health System; Portland, Oregon; 2007
21. Univ. of Chicago 2007
22. Chicago Medical School AOA Visiting Professor; 2007
23. Univ. of Iowa; 2007
24. Lehigh Valley Hospital, 2007
25. University of Indiana, 2006
26. University of California, Davis 2006
27. University of Michigan, 2006
28. Temple University, 2006
29. University of California, San Francisco, 2005
30. University of Texas, Galveston 2002
31. University of California, San Francisco, 2002
32. Ohio State University; 2001

D. JOURNAL REVIEWER

1. Journal of General Internal Medicine, 2003- present
2. American Journal of Medicine, 1998 – present
3. Editorial Board, American Health Consultants, 2000-2005
4. Internal Medicine Alert, 2000-2005
5. Seminars in Medical Practice, 2003- present
6. Teaching and Learning, 2004-present
7. Addiction; 2002- 2005
8. Alcohol and Alcoholism, 2002-2005

E. MEMBERSHIPS AND OFFICES IN PROFESSIONAL SOCIETIES

1. Society of General Internal Medicine
2. ACGIM
3. Society of Hospital Medicine
4. American College of Physicians (Fellow #1038886)
5. Association of Program Directors in Internal Medicine
6. American Medical Association (Member #02307951625)
7. Southern Society of Clinical Investigation
8. American College of Physician Executives
9. American Federation for Clinical Research
10. New Orleans Academy of Internal Medicine
11. Louisiana Sate Medical Society

V. SECTION 5: TEACHING AND LEARNING RESPONSIBILITIES

See teaching log (Section XI) for details on individual lectures

COURSE DIRECTORSHIP

Course Director; Clinical Diagnosis Course; 2001-2008

Course Director; Biostatistics; 2001-2008

Course Director; Advanced Internal Medicine Course; 2001-present

Course Director; Clinical Teaching Course; 2001-present

Course Director; Research in Internal Medicine; 2001-present

Course Director; Medical Art and Observation Training; 2002-2005

Assoc. Clerkship Director & Curriculum Director: Third-Year Medicine Clerkship (Tuesday School)

Program Director; Tulane Internal Medicine Residency Program

Curriculum Director; Tulane Friday School Curriculum

Curriculum Director; Fellowship Core Conference Curriculum

ADDITIONAL TEACHING

Professor's Rounds, Charity Hospital (MSIII) 2000-present (one hour/ week)

Professor's Rounds, Charity Hospital (MS IV) 2000-present (one hour/ week)

Preceptor; Charity Hospital medical clinic; 2000-2005

Preceptor; Charity morning report (daily) ; 2000-present

Interdisciplinary course instructor; weekly; 2000-2003

Foundations of Patient Care physical exam instructor; 1998- 2002

Foundations of Patient Care group leader; 1998-2000

CLINICAL TEACHING

Attending physician; Charity Hospital:

2000 August, October

2001 March, July, August, September

2002 March, April, June, July, August, September

2003 March, May, June, July, August, September

2004 March, June, July, September

2005 March, June, July, August,

2006 November, December

2007 January, February, March, May, July, September

2008 May, July, September

Medical Consultation Attending: Charity Hospital:

2000 August, December

2001 January, April, August, October, November

2002 January, March, April, June, July, August, September

2003 January, March, April, June, July, August, September

2004 January, March

2006 June, August, October, December

2007 July, August, September

2008 May, July, September

Faculty

Curriculum Director; Tulane Medicine Grand Rounds Curriculum

Graduate Medical Education Faculty Development Curriculum

National Curricular Efforts

Program Director, LA-MS ACP Annual Conference

Faculty; American College of Physicians National Meeting

Faculty; Society of General Internal Medicine National Meeting

Faculty; Society of Hospital Medicine National Meeting

Visiting Professorships (22); See above

VI. SECTION 6: EDUCATIONAL PUBLICATIONS

(other publications removed)

A. ARTICLES

1. Rigby PG, Braun K, Hilton C, Pinsky W, **Wiese JG**, Chesson A, Guidry J. The Medical Education Commission Report 2007: GME is Recovering from Katrina. *J La State Med Soc.*, 161(1): 32-40.
2. **Wiese JG**. Accounting to the Public through Focused-Practice Certification. *Virtual Mentor*. Dec. 2008, Vol. 10, No. 12:797-800
3. **Wiese JG**. Dispensing with Noon Conference: The Friday school alternative to a residency core curriculum. *Academic Medicine* (Under Review)
4. **Wiese JG**. Beginning with the end in mind: Hospital Medicine Electives. *Jo Gen Intern Med*. 2008. xxx(v):pp-pp.
5. **Wiese JG** Leadership in Graduate Medical Education: Eleven Steps Instrumental in Recovering Residency Programs Following a Disaster. *American Journal of Medical Sciences*; 2008, 336(2):168-173.
6. Bagatelle S, **Wiese JG**. The Elite Code Grey Team: A New Model for Residency Preparedness and Training in Advance of a Disaster. *American Journal of Medical Sciences*; 2008, 336(2):174-178.
7. **Wiese JG**, Jaffer A. A New Home Awaits the Hospitalist. *Journal of Hospital Medicine*. 2007; Vol 2(1): 4-5
8. **Wiese JG**. Making SOAPS SAFER: An Outline for Teaching Students How to Perform the Oral Case Presentation. *The Portal of Geriatric Online Education*. October 24, 2006.
9. **Wiese JG**, Holman R, Updates in Hospitalist Medicine, *Annals of Internal Medicine*, 2006; xxx(v):pp-pp.
10. Hauer KE, Teherani A, **Wiese JG**; Fenton CL. A strategy to standardize the learning of core clerkship objectives. *Advances in Health Sciences Education* 2003; 8: 213-221.
11. **Wiese JG**, Saint S, Tierney L; The spoken case presentation: issues and recommendations. *Seminars in Medical Practice*. 2002; 5(3): 29-37.
12. **Wiese JG**, Varosy P, Tierney L; Improving oral presentation skills with a clinical reasoning curriculum: a prospective, controlled study. *American Jo Med*. 2002; 112: 5-12.
13. Mihalopoulos N, Khan A, **Wiese JG**; Influenza: recommendations and public health strategies; *La Med Jo*, 2001; 153: 596-602.
14. **Wiese J**, The Rational Physical Examination; *The Abdominojugular Reflux*, *American Jo Med* 2000; 16; 76-80.
15. Saint S, **Wiese J**, Amory J, Bernstein ML; Lack of Physician Awareness of Urinary Catheters in their Patients: Ignorance is not bliss, *American Jo Med*, 2000; 16; 476-478.
16. **Wiese J**; Didwania A; Kerzner R; Chernow B; Use of different

B. BOOKS:

1. **Wiese JG (editor)** Textbook of Hospital Medicine; McGraw Hill Publishing. (IN PROGRESS)
2. **Wiese JG (editor)**, Teaching in Hospital Medicine; ACP Publishing. (IN PROGRESS)
3. **Wiese JG**. The Answer Book: A Guide to the Clinical Wards, Lippincott, Williams & Wilkins, New York, NY, 2005. (680 pages)
4. Puschett J, **Wiese JG**, Kahn M, (Editors). Biotest Study Aids in Internal Medicine, 2002. (300 pages)
5. **Wiese JG**, Values In Conflict: The Lincoln-Douglas Debate; Kansas City; Clark Publishing, 1991.

C. BOOK CHAPTERS:

1. **Wiese JG**, The Patient History: Evidence Based Approach. Edema. Lange, 2004.
2. **Wiese JG**, The Patient History: Evidence Based Approach. Gait Disorders. Lange, 2004
3. **Wiese JG**, Infectious Disease in the Emergency Department. Pharyngitis. McGraw Hill, 2005.
4. **Wiese JG**, Biotest Study Aids in Internal Medicine; General Medicine; 2004.
5. Parekh N, **Wiese JG**, Biotest Study Aids in Internal Medicine; Ophthalmology; 2004.
6. **Wiese JG** (Reference editor). In Tierney LM, McPhee SJ, Papadakis MA (Ed): Current Medical Diagnosis and Treatment (38th Edition). Appleton & Lange, 1997.
7. **Wiese JG**, Saint-Frances Guide to Outpatient Medicine; Chapter 29: Wrist injuries. Lippincott Williams & Wilkins, Baltimore, Maryland, 2000.

D. PUBLICATIONS IN PREPARATION

1. Guidry M, Toprani A, **Wiese JG**. A decision analysis of the financial benefit to patients of “free” pharmaceutical samples.
2. Khot S, **Wiese JG**. The Yellow Berets
3. Pollack A, Fernandez C, **Wiese JG**. Parametric auscultation
4. King D, Rosen D, Kahn A, **Wiese JG**. Quantification of peripheral edema
5. **Wiese JG**. Cougar; A curriculum to observe underachievers and give assisted remediation.
6. Choe, E, **Wiese JG**. Assessing a teaching teaching elective.
7. Davidoff S, **Wiese JG**, Assessing a clinical problem solving innovation.
8. Gambala C, Lyons C, **Wiese JG**. Using fine art to improve observation

VII. SECTION 7: REGIONAL, NATIONAL, & INTERNATIONAL PRESENTATIONS

A. PEER-REVIEWED ORAL PRESENTATIONS

1. **Wiese JG**, Mechaber A, Mechaber H, Instructing students and residents in interview skills and constructing the curriculum vitae. Society of General Internal Medicine, Pittsburgh, PA. April 2008
2. **Wiese JG**, Clinical Coaching. Society of Hospital Medicine, San Diego, CA. April 2008
3. **Wiese JG**, Ten Advanced Organizers. Society of Hospital Medicine, San Diego, CA, April 2008
4. **Wiese JG**, Mentoring Skills. Society of Hospital Medicine, San Diego, CA, April 2008
5. **Wiese JG**, Clinical Coaching. Society of General Internal Medicine, Pittsburgh, PA. April 2008
6. **Wiese JG**, Dressler D, McKean S, Integrating the Society of Hospital Medicine Core Competencies into Residency Training. American College of Physicians, San Diego, CA. April 2007
7. **Wiese JG**, Mechaber A, Mechaber H, Instructing students and residents in interview skills and constructing the curriculum vitae. Society of General Internal Medicine, Toronto, Canada. April 2007
8. **Wiese JG**, Clinical Coaching. Society of Hospital Medicine, Dallas, TX. April 2007
9. **Wiese JG**, Price E, Friday school: a novel curricular alternative to noon conference. Association of Program Directors in Internal Medicine, New Orleans, LA. Oct. 2006.
10. **Wiese JG**, Price E, Disaster Preparedness for Residency Programs. Association of Program Directors in Internal Medicine, New Orleans, LA. Oct. 2006.
11. **Wiese JG**, Clinical Coaching. Society of Hospital Medicine, Chicago, IL. April 2006
12. Guidry M, Toprani A, **Wiese JG**. Providing pharmaceutical samples: a cost-effective analysis. Society of General Internal Medicine. New Orleans, LA. May 2005.
13. **Wiese JG**, Baker EA, Cifu AS, Riddle JM, Uchida T. Identification and remediation of problem medical students in the clinical years. Society of General Internal Medicine. New Orleans, LA. May 12, 2005
14. **Wiese JG**, E Green, Designing a spoken case presentation curriculum using the iterative hypothesis. Society of General Internal Medicine. New Orleans, LA. May 12, 2005
15. **Wiese JG**, E Green, Designing a spoken case presentation curriculum using the iterative hypothesis. Association of Program Directors in Internal Medicine, Nashville, TN. Oct. 15, 2004.
16. **Wiese JG**, B Sharp, E Green, Designing a spoken case presentation curriculum using the iterative hypothesis. Society of General Internal Medicine. Chicago, IL. May 12, 2004.
17. **Wiese JG**, Lyons C, The effect of a fine art curriculum in improving observational skills. Society of General Internal Medicine. Chicago, IL. May 12, 2004.
18. **Wiese JG**, Aliota J, The use of an on-line sign-out system to track resident work hours. Association of Program Directors in Internal Medicine, Washington, D.C., Oct 2003
19. **Wiese JG**, Shlipak MS, The effect of *Opuntia ficus indica* on thromboxane production during the alcohol hangover. Society of General Internal Medicine. Atlanta, Ga. May 4. 2002.
20. O'Conner C, **Wiese JG**, Relating the cognitive impairment of the alcohol hangover to that of alcohol intoxication. Society of General Internal Medicine. Atlanta, Ga. May 4. 2002.

21. **Wiese JG**, Shlipak MS, Using previously validated measures of cognitive impairment to assess the severity of the alcohol hangover. Society of General Internal Medicine. Atlanta, Ga. May 4, 2002.
22. **Wiese JG**, Elevation of thromboxane B2 and C-reactive peptide with the alcohol hangover. Society of General Internal Medicine. May 3, 2002.
23. **Wiese JG**, The effect of the alcohol hangover on electrolytes and cortisol, Society of General Internal Medicine. May 3, 2002.
24. **Wiese JG**, Shlipak MS, Cognitive impairment in the alcohol hangover. American Federation of Medical Research. New Orleans, La. Feb. 2002.
25. **Wiese JG**, Shlipak MS, The effect of *Opuntia ficus indica* on the severity of the alcohol hangover. American Federation of Medical Research. New Orleans, La. Feb. 2002.
26. Hauer KE, **Wiese JG**, Fenton CL, A strategy to improve and standardize students' learning of core clerkship objectives. Clerkship Directors in Internal Medicine. Oct 13, 2000.
27. **Wiese JG**, Remediation of Problem Students: A prospective evaluation. Southern Society of General Internal Medicine. March 2, 2001.
28. **Wiese JG**, A prospective evaluation of a curriculum to observe underachieving students and give assisted remediation. (COUGAR) American Program Directors in Internal Medicine. Oct 13, 2000.
29. **Wiese JG**, Varosy P, Tierney L, Improving oral presentation skills with a clinical reasoning curriculum: a randomized, controlled study. Society of General Internal Medicine. May 5, 2000.
30. **Wiese JG**, A curriculum to observe underachieving students and give assisted remediation. (COUGAR) Society of General Internal Medicine. May 5, 2000.
31. **Wiese JG**, Improving resident teaching ability with a venue-specific teaching curriculum. Society of General Internal Medicine. May 5, 2000.
32. **Wiese JG**, The use of the physical examination in the evaluation of medical crisis. Society of General Internal Medicine. May 5, 2000
33. **Wiese JG**, Myopathy due to the interaction of lovastatin-indinavir. Society of General Internal Medicine. May 5, 2000.
34. Saint S, **Wiese JG**, Lack of physician awareness of urinary catheters. National Association of Inpatient Physicians. April, 2000
35. **Wiese JG**, The evaluation of a curriculum for improving oral communication skills. Society of General Internal Medicine. April 29, 1999.
36. **Wiese JG**, Mendelson T; The use of the physical exam in asystolic arrest. Society of General Internal Medicine. April 25, 1998.
37. **Wiese JG**, Miller J, Bhatiani A, Kerzner R, Davison L, Sigal B, Chernow B; Proper handling of blood samples for lactate determinations: a prospective, controlled trial. Society of Critical Care Medicine Scientific Symposium Feb. 1, 1995.
38. **Wiese JG**, Sigal B, Davison L, Bernstein W, Aduen J, Chernow B; Increased blood lactate concentrations in cardiac surgery patients: results of a prospective, longitudinal study. Society of Critical Care Medicine Scientific Symposium Feb. 2, 1995.
39. Aduen J, **Wiese JG**, Kerzner R, Altman M, Chernow B; Discordance between increased circulating lactate concentrations and lactic acidosis: results from a large clinical data base (N= 1,424). Soc. of Critical Care Medicine Scientific Symposium Feb. 4, 1995.

B. INVITED ORAL PRESENTATIONS

1. Wiese JG, *Rose Leibowitz Lecture: 10 Moveable Objects*, Long Island Jewish Medical Center, May, 2009.
2. **Wiese JG**, Plenary Presentation: Creating a Cultural Change in Graduate Medical Education. Association for Hospital Medical Education (AHME), Spring Educational Institute in Savannah, GA in April 2009.
3. **Wiese JG**, Plenary Presentation: Leadership Lessons in the Wake of Disaster. Association for Hospital Medical Education (AHME), Spring Educational Institute in Savannah, GA in April 2009.
4. **Wiese JG**, Updates in Hospital Medicine. Louisiana ACP. New Orleans, LA. March. 2009.
5. **Wiese JG**, Clinical Coaching and Faculty Development; Plenary Presentation, University of Miami Medical Education Seminar. February. 2009.
6. **Wiese JG**, Updates in Hospital Medicine. SECC. New Orleans, LA. Feb. 2009.
7. **Wiese JG**, Updates in Hospital Medicine. Southern Society of General Internal Medicine. New Orleans, LA. Feb. 2009.
8. **Wiese JG**, Plenary Presentation, Mississippi ACP: Leadership Lessons in the Wake of Disaster. Oct. 2008
9. **Wiese JG**, Plenary Presentation, Mississippi ACP: Clinical Coaching and Faculty Development. Oct. 2008
10. **Wiese JG**, Leadership Lessons in the Wake of Disaster. Mt. Sinai Grand Rounds, Sept. 2008
11. **Wiese JG**, Leadership Lessons in the Wake of Disaster. Tufts Univ. Grand Rounds, Sept. 2008.
12. **Wiese JG**, Plenary Presentation, University of Alabama Graduate Medical Education Seminar: Clinical Coaching and Faculty Development. August. 2008.
13. **Wiese JG**, Novel Innovations in Medical Education. Univ. of Texas- Houston. Grand Rounds, Sept. 2008.
14. **Wiese JG**, Using the Hospitalist Model to Facilitate Transitions of Care; Alabama ACP, May 2008.
15. **Wiese JG**, Professionalism in Graduate Medical Education, Grand Rounds: St. Luke's Roosevelt, NY. May 2008
16. **Wiese JG**, Preparing Graduate Medical Education Disaster Policies; Washington University, St. Louis, May 2008
17. **Wiese JG**, Goodenberger D, Medical Crossfire: Hot Topics in Graduate Medical Education. American College of Physicians, May 2008.
18. **Wiese JG**, Effective Mentoring. Southern Society of General Internal Medicine. March 2008.
19. **Wiese JG**, Graduate Medical Education Leadership Lessons In Preparing for a Disaster American Association of Medical Colleges, March 2008.
20. **Wiese JG**, Preparing a Remediation Program for Graduate Medical Education. Accreditation Council of Graduate Medical Education (ACGME), Feb. 2008.
21. **Wiese JG**, Lessons Learned from Hurricane Katrina. Grand Rounds: American College of Allergy and Immunology, Jan. 2008.
22. **Wiese JG**, Hospitalist Management of Heart Failure: American Heart Association, January. 2008
23. **Wiese JG**, Integrating Clinical Reasoning Into Medical Education Training. Legacy Health System; Portland, Oregon, Nov. 2007

24. **Wiese JG**, The Alcohol Hangover. Special Lecture: Legacy Health System; Portland, Oregon, Nov. 2007
25. **Wiese JG**, Integrating Clinical Reasoning Into Medical Education Training. Educational Symposium: Univ. of Iowa. Oct. 2007
26. **Wiese JG**, Lessons Learned from Hurricane Katrina. Educational Symposium: Univ. of Iowa. Oct. 2007
27. **Wiese JG**, Lessons Learned from Hurricane Katrina. Grand Rounds, Ohio State Univ. Grand Rounds, Oct. 2007
28. **Wiese JG**, Lessons Learned from Hurricane Katrina. Grand Rounds, Ohio ACP Visiting Professor. Oct. 2007
29. **Wiese JG**, Ten Movable Objects; Grand Rounds: University of Virginia, Sept 2007.
30. **Wiese JG**, Clinical Coaching; Grand Rounds: Medical University of South Carolina, Sept. 2007
31. **Wiese JG**, Preparing Graduate Medical Education Disaster Policy; Texas A&M University, May 2007
32. **Wiese JG**, Clinical Coaching. Society of Hospital Medicine, Dallas, TX, May 2007
33. **Wiese JG**, Dressler D, Pistoria M, Integrating the SHM Core Competencies into Residency Training. American College of Physicians. San Diego, CA, April 2007.
34. **Wiese JG**, Clinical Coaching (Plenary) APDIM, San Diego, CA, April 2007
35. **Wiese JG**, Lessons Learned from Hurricane Katrina. Grand Rounds: Univ. of Chicago, March. 2007
36. **Wiese JG**, Lessons Learned from Hurricane Katrina. Grand Rounds: AOA Visiting Professor, Chicago Medical School. March. 2007
37. **Wiese JG**, Lessons Learned from Hurricane Katrina. Grand Rounds: Rush University, March. 2007
38. **Wiese JG**, Lessons Learned from Hurricane Katrina. Grand Rounds: American College of Rheumatology, March. 2007
39. **Wiese JG**, Lessons Learned from Hurricane Katrina. Annual Educational Lecture/Grand Rounds, Brigham and Women's Hospital, Boston MA, Feb. 2007
40. **Wiese JG**, Updates in Hospitalist Medicine. Southern Regional Hospitalist Meeting. New Orleans, LA. Nov. 2006
41. **Wiese JG**, Delirium in the Hospitalized Patient; Tampa Bay, FL. Nov. 2006
42. **Wiese JG**, Lessons Learned from Hurricane Katrina. AAIM. New Orleans, LA, October 2006
43. **Wiese JG**, Lessons Learned from Hurricane Katrina. Grand Rounds, St. Vincent's; Indianapolis, IN, Oct. 2006.
44. **Wiese JG**, Lessons Learned from Hurricane Katrina. Grand Rounds, St. Francis Hospital; Indianapolis, IN, 2006.
45. **Wiese JG**, Delirium in the Hospitalized Patient; Chicago, IL. Sept. 2006
46. **Wiese JG**, Lessons Learned from Hurricane Katrina. Grand Rounds, Univ. Indiana, Sept. 2006
47. **Wiese JG**, Strong As Our Weakest Link: Remediating Residents and Students, Univ. Indiana, Sept. 2006
48. **Wiese JG**, Lessons Learned from Hurricane Katrina. Grand Rounds, St. Vincent's; Indianapolis, IN, Sept. 2006
49. **Wiese JG**, Lessons Learned from Hurricane Katrina. Grand Rounds, UC Davis, May 2006

50. **Wiese JG**, Lessons Learned from Hurricane Katrina. Grand Rounds, Univ. Michigan, September 2006
51. **Wiese JG**, Strong As Our Weakest Link: Remediating Residents and Students, Univ. Michigan, Sept. 2006
52. **Wiese JG**, Updates in Hospital Medicine. New Orleans Board Review Course. July 2006.
53. **Wiese JG**, Clinical Coaching SHM, Washington DC, May 2006
54. **Wiese JG**, Lessons Learned from Hurricane Katrina. SGIM. Los Angeles, CA, April 2006
55. **Wiese JG**, Clinical Coaching (Plenary). APDIM, Philadelphia, PA April 2006
56. **Wiese JG**, Lessons Learned from Hurricane Katrina (Plenary). APDIM, Philadelphia, PA April 2006
57. **Wiese JG**, Lessons Learned from Hurricane Katrina. Grand Rounds, UC Davis, April 2006
58. **Wiese JG**, Clinical Coaching, UC Davis, April 2006
59. **Wiese JG**, Lessons Learned from Hurricane Katrina. AAMC. October 2005.
60. **Wiese JG**, Strong As Our Weakest Link: Remediating Residents and Students, UCSF Grand Rounds, May 2005
61. **Wiese JG**, Strong As Our Weakest Link: Remediating Residents and Students, UCSF-VA Grand Rounds, 2005
62. **Wiese JG**, Updates in Hospital Medicine. New Orleans Board Review Course. July 2005.
63. **Wiese JG**, Leadership in Medicine (Plenary). National Youth Leadership Forum. July, 2005
64. **Wiese JG**, The Effect of Resident Work-Hour Limitations on Clinical Training (Plenary); AAMC, New Orleans, LA. April 19, 2005.
65. **Wiese JG**, Homan R, Updates in Hospitalist Medicine, SGIM, New Orleans, LA May 2005
66. **Wiese JG**, Clinical Coaching (Plenary) APDIM, San Francisco, CA April 2005

67. **Wiese JG**, Homan R, Updates in Hospitalist Medicine, ACP, San Francisco, CA April 2005
68. **Wiese JG**, Young Hospitalists Forum, ACP, San Francisco, CA April 2005
69. **Wiese JG**, Homan R, Updates in Hospitalist Medicine, SHM, Chicago, IL April 2005
70. **Wiese JG**, Baudendistal T, Using Hospitalist for RRC Compliance, SHM, Chicago, IL April 2005
71. **Wiese JG**, Instituting a Hospitalist System. LA/MS American College of Physicians. March, 2005.
72. **Wiese JG**, Young Hospitalists Forum, Society of Hospital Medicine, New Orleans, LA. April 21, 2004.
73. **Wiese JG**, Course Director; Critical Care for the Hospitalist, New Orleans, LA. April 19, 2004.
74. **Wiese JG**, Teaching in a lecture format. Association Program Directors in Internal Medicine; April 20, 2004.
75. **Wiese JG**, Designing and implementing clinical research. Ochsner Hospital. New Orleans, LA. March 16, 2004.
76. **Wiese JG**, Designing and implementing clinical research. Tulane Hospital. New Orleans, LA. March 15, 2002.
77. **Wiese JG**, Designing and implementing clinical research. Ochsner Hospital. New Orleans, LA. May 9, 2002.
78. **Wiese JG**, Teaching in a lecture format. University of Texas Galveston. Jan. 18, 2002.
79. **Wiese JG**, Innovative teaching techniques. Visiting professor lectureship. Ohio State University. Dec. 14, 2001.

- 80. Wiese JG**, Management of refractory reflux disease: evidence-based recommendations. American College of Family Practice; Atlanta, Ga. October 3, 2001.
- 81. Wiese JG**, Teaching in a lecture format. Association Program Directors in Internal Medicine; March 28, 2001.
- 82. Wiese JG**, Management of Refractory Reflux Disease: Evidence-based recommendations. American College of Physicians; March 28, 2001.
- 83. Wiese JG**, Hospitalists in the 21st Century. March 3, 2001. American College of Physicians
- 84. Wiese JG**, Cultural aspects of medical care in the United States, European Society of Internal Medicine. Sept 22, 1999. Alicante, Spain.

VIII. Section 8: COURSE AND CURRICULUM DEVELOPMENT & INNOVATION

Curriculum Design

1. Spartacus- Fall 2009
2. The “4+1” Residency Schedule
3. Tuesday School- 2006
4. Friday School- 2005
5. The Matrix- 2003
6. Developing residency firms to increase residency responsibility & to meet duty hours standards, 2003
7. A curriculum to teach and assess systems-of-care competencies, 2002
8. A curriculum to teach and assess practice-based learning skills, 2002
9. A fine-art curriculum to improve medical student observational skills, 2002
10. Clinical teaching course (one month teaching course for MS IV’s); 2002-present
11. Tulane Medical Student Teaching Academy (Night classes for teaching teaching) 2002
12. Clinical Diagnosis Course, 2001
13. Biostatistics Course, 2001
14. Advanced Internal Medicine Course; 2001
15. Research in Internal Medicine Course; 2001
16. Pre-operative and medical consultation curriculum 2000
17. Evidence/physiology-based physical examination curriculum 2000
18. The spoken case presentation and oral communication skills 2000
19. COUGAR: strategies for remediating the problem student 1999
20. Third-year medical clerkship curriculum 1999
21. Adolescent medicine curriculum 1999

IX. SECTION 9: MENTORED PRESENTATIONS

MENTORING: PEER-REVIEWED ABSTRACT PUBLICATIONS

1. Krishnan S, **Wiese JG**, Addison's Disease, JGIM; xx (Suppl. xx); 2009.
2. Beck R, Hymel B, Miller C, A Covert Operation, JGIM; xx (Suppl. xx); 2009.
3. Dhand M, Carhill A, **Wiese JG** A Diplococcal Debacle, JGIM; xx (Suppl. xx); 2009.
4. Rimel B, Teran F, VanSickels N, **Wiese JG** A Tale of Multiple Lesions, JGIM; xx (Suppl. xx); 2009.
5. McDonald-Top J, McConville B, **Wiese JG**, Psychosis or Cerebritis? A Cerebral Dilemma, JGIM; xx (Suppl. xx); 2009.
6. Burns C, Fleury M, The War on Platelets, JGIM; xx (Suppl. xx); 2009.
7. Gloss D, Cartwright K, **Wiese JG**, The Eyes Have It, JGIM; xx (Suppl. xx); 2009.
8. Burns C and Glass M, My Mysterious Myxoma, JGIM; xx (Suppl. xx); 2009.
9. Hymel B, Beck R, Miller C, It's All About Heart, JGIM; xx (Suppl. xx); 2009.
10. Bhutto B, Sherling D, **Wiese JG**, Interfering with Glucose Homeostasis, JGIM; xx (Suppl. xx); 2009.
11. Heimbürger S, **Wiese JG**, Headache in a chronic pain patient, JGIM; xx (Suppl. xx); 2009.
12. **Wiese JG**, Hepatocellular Carcinoma (HCC) with Invasion of the Inferior Vena Cava and Right Atrium: Diagnosis, JGIM; xx (Suppl. xx); 2009.
13. Kothari A, Moehlen MW, Regenstein FG, Using Endovascular Tissue Sampling, JGIM; xx (Suppl. xx); 2009.
14. Whelton S, Carhill A, Denny C, First Do No Harm, JGIM; xx (Suppl. xx); 2009.
15. Gloss D, Cartwright K, **Wiese JG**, Dark Urine Partying Hard, JGIM; xx (Suppl. xx); 2009.
16. Butler I, **Wiese JG**, A Cure Worse than the Disease, JGIM; xx (Suppl. xx); 2009.
17. Sterett J, Richey L, Chakraborti C, Back to 'Bac', JGIM; xx (Suppl. xx); 2009.
18. Janine T. VanSant, MD; Lisa D. Parikh; Chad S. Miller, MD, Appeasing the Masses, JGIM; xx (Suppl. xx); 2009.
19. Parikh L, Kothari A, Miller C, The Perfect Storm, JGIM; xx (Suppl. xx); 2009.
20. Wasson E, **Wiese JG**, Now You See It, Now You Don't: A Case of Charles Bonnet Syndrome, JGIM; xx (Suppl. xx); 2009.
21. Fouche J, **Wiese JG**, A Weak Chief Complaint, But a Strong Diagnosis, JGIM; xx (Suppl. xx); 2009.
22. Hefler H, Gammon B, **Wiese JG**, You Take my Breath Away, JGIM; xx (Suppl. xx); 2009.
23. Richey L, **Wiese JG**, A Catty Cough, Jo Hospital Med.; xx (Suppl. xx); 2009.
24. Bhutto J, Wasson L, Iqbal A, Bagatell S, A Fungus Among Us, Jo Hospital Med.; xx (Suppl. xx); 2009.
25. Whelton S, Carhill A, **Wiese JG**, A Pain in the Neck, Jo Hospital Med.; xx (Suppl. xx); 2009.
26. Patel SA, **Wiese JG**, A Punch in the Gut, Jo Hospital Med.; xx (Suppl. xx); 2009.
27. Gammon B, **Wiese JG**, Hickam's Dictum, Jo Hospital Med.; xx (Suppl. xx); 2009.
28. Stringer E, Percak J, Glass M, Cutaneous Histoplasmosis Lesions Associate with IRIS, Jo Hospital Med.; xx (Suppl. xx); 2009.

29. Oskowitz A, Glass M, Missing Meigs, *Jo Hospital Med.*; xx (Suppl. xx); 2009.
30. Wasson E, Bhutto J, Wiese JG, Beware of the Seemingly Stable Sickle Cell Patient, *Jo Hospital Med.*; xx (Suppl. xx); 2009.
31. Beck R, Rhodes B, Miller C, The Fugative, *Jo Hospital Med.*; xx (Suppl. xx); 2009.
32. Cash M, Widmer K, **Wiese JG**. Under Pressure: Compartmentalizing Renal Failure. *JGIM*; 23 (Suppl. 2); March 2008.
33. Breaux J, **Wiese JG**. Liver Disease Is Skin Deep. *JGIM*; 23 (Suppl. 2); March 2008.
34. Bhutto J, **Wiese JG**. Steroids: Crazy Without, Crazy Within. *JGIM*; 23 (Suppl. 2); March 2008.
35. Fowler J, **Wiese JG**. A Wandering Diagnosis: Vagal Neuropathy Due to The Oldest of Diseases. *JGIM*; 23 (Suppl. 2); March 2008.
36. Carhill A, Huang, J, Ajaykumar R. The Courage of Seven Nights Can Make You Weak. *JGIM*; 23 (Suppl. 2); March 2008.
37. Chang T, **Wiese JG**. Never Say Never, Especially with a Negative Test. *JGIM*; 23 (Suppl. 2); March 2008.
38. Layton J, **Wiese JG**. A Stab In the Back. *JGIM*; 23 (Suppl. 2); March 2008.
39. Chang T, **Wiese JG**. Cholesterol To Stroke, Stroke To Coumadin, Coumadin To Cholesterol. *JGIM*; 23 (Suppl. 2); March 2008.
40. Krishnan S, DeGregoria L, **Wiese JG**. A Bad Day on The Exchange. *JGIM*; 23 (Suppl. 2); March 2008.
41. Montero A, Miller C, **Wiese JG**. Straining At a Diagnosis: Bickerstaff’s Encephalitis. *JGIM*; 23 (Suppl. 2); March 2008.
42. Small A, Palmer M, Menard G. All “Mixed” Up. *JGIM*; 23 (Suppl. 2); March 2008.
43. VanSickels N, **Wiese JG**. Sixty to Zero: Rapidly Progressive Pancytopenia in the HIV Patient. *JGIM*; 23 (Suppl. 2); March 2008.
44. Rice M, Khan Z, **Wiese JG**. A “Not So Foreign” Liver Infection. *JGIM*; 23 (Suppl. 2); March 2008.
45. Skelding P, Miller C, **Wiese JG**. A Hole Problem... A Hole Bunch of Problems. *JGIM*; 23 (Suppl. 2); March 2008.
46. Widmer K, Lauren R, Aubin K. Crystallizing Your Thinking In Diagnosing Spinal Cord Compression. *JGIM*; 23 (Suppl. 2); March 2008.
47. Nguyen S, Widmer K, **Wiese JG**. A Bad Brain Behaves Badly. *JGIM*; 23 (Suppl. 2); March 2008.
48. Broussard C, Nguyen S, **Wiese JG**. A Diagnosis in The Pocket. *JGIM*; 23 (Suppl. 2); March 2008.
49. Kroner C, Skelding P, **Wiese JG**. Ana-vivaxis. *JGIM*; 23 (Suppl. 2); March 2008.
50. Wasson L, **Wiese JG**. Seeing Through The Symptoms: Splenic Rupture as a Complication of Colonoscopy. *JGIM*; 23 (Suppl. 2); March 2008.
51. Wasson L, Howe E, **Wiese JG**. To Whom Much Is Given, Much Can Be Received : The Hyperhemolysis Syndrome. *JGIM*; 23 (Suppl. 2); March 2008.
52. Yalvac E, Khan Z, Miller C. The Wrath of Apollo. *JGIM*; 23 (Suppl. 2); March 2008.
53. Nguyen S, Miller C. Tuberculosis is Not in the History Books; It’s in the History. *JGIM*; 23 (Suppl. 2); March 2008.
54. Small A, **Wiese JG**. The Case of the Psuedo-Heart Attack. *Jo Hospital Medicine*; 4 (Suppl. 1)

55. Nguyen S, Miller C, **Wiese JG**. Belly Bombers: Peritoneal tuberculosis. LA Med Jo. (In Press)
56. Wasson L, **Wiese JG**. A Big Belly Breaking the Rules: Ascites as the Presenting Symptom of a Case of Constrictive Pericarditis. LA Med Jo. (In Press)
57. Teixiara L, Guidry M, **Wiese JG** My lips are sealed; now protect my airway: acquired C1-esterase deficiency. JGIM; 22 (Suppl. 4); April 2007.
58. Beaty E, **Wiese JG** Protracted pyrexia proves problematic for perplexed physicians JGIM; 22 (Suppl. 4), April 2007.
59. Carhill A, **Wiese JG**. Your stomach on drugs: cyclic vomiting in association with chronic cannabis abuse. JGIM; 22 (Suppl. 4): April 2007.
60. Cash M, Gloss D, **Wiese JG**. Mixed drinks and diabetes don't mix: alcohol induced hypoglycemia. JGIM; 22 (Suppl. 4): April 2007.
61. Howe E, **Wiese JG**. Kikuchi-Fujimoto disease. JGIM; 22 (Suppl. 4): April 2007.
62. Feagans J, **Wiese JG** HSV hepatitis in an immuno-competent patient. JGIM; 22 (Suppl. 4): April 2007.
63. Krishnan S, Miller C, **Wiese JG**. True, True, and Related: Crohn's disease as a presentation of HIV. JGIM; 22 (Suppl. 4): April 2007.
64. Lafreniere J, **Wiese JG**. Secretory Diarrhea: A paraneoplastic presentation of hepatocellular carcinoma. JGIM; 22 (Suppl. 4): April 2007.
65. Mohan M, **Wiese JG** Losing Weight and Losing Control: Complications of gastric bypass. JGIM; 22 (Suppl. 4): April 2007.
66. Nyogi A, **Wiese JG**. Tetanus: a forgotten disease makes a comeback. JGIM; 22 (Suppl. 4): April 2007.
67. Small A, Krishnan S, Miller C, **Wiese JG**. Got IRIS? Don't Lose HAART. JGIM; 22 (Suppl. 4): April 2007.
68. Wasson L, **Wiese JG**. **The chicken or the egg: thymoma and myasthenia gravis** JGIM; 22 (Suppl. 4): April 2007.
69. Widmer K, **Wiese JG**. Fungal Endocarditis: The PICC of the Litter. JGIM; 22 (Suppl. 4): April 2007.
70. Holder K, **Wiese JG**. Living in the Past. Louisiana Medical Journal. January, 2007.
71. Agolory S, **Wiese JG**. From bad to worse: one anemia begetting another. JGIM; 21 (Suppl. 4): 239, April 2006.
72. Cash M, Miller C, **Wiese JG**. Brewing up a storm: the management of thyroid Storm. JGIM; 21 (Suppl. 4):227, April 2006.
73. Coleman N, Guidry M, **Wiese JG**. Aseptic meningitis. JGIM; 21 (Suppl. 4):63, April 2006.
74. Feagans J, **Wiese JG**. M.R.E. (Meals Ready to Exacerbate): Re-designing civilian disaster relief supplies. JGIM; 21 (Suppl. 4): 249-250, April 2006
75. Gloss D, **Wiese JG**. Prolongation of primum non nocere: The risk of torsades in single haloperidol administration. JGIM; 21 (Suppl. 4): 261-262, April 2006.
76. Hamblin M, **Wiese JG**. The causes of erythema multiforme. JGIM; 21 (Suppl. 4): 273-264, April 2006.
77. Howe E, **Wiese JG**. Varicella pneumonia. JGIM; 21 (Suppl. 4): 253, April 2006.
78. Howe E, **Wiese JG**. The risk of hyperglycemia due to gatifloxacin. JGIM; 21 (Suppl. 4):239, April 2006.

79. Kahlon S, **Wiese JG**. Obvious Signs to Diagnose the Otherwise Unapparent: Kaposi's Sarcoma. *JGIM*; 21 (Suppl. 4): 257, April 2006.
80. Kurkjian M, Donald C, **Wiese JG**. Myocardial infarction due to menstrual-related iron deficiency. *JGIM*; 21 (Suppl. 4):63, April 2006.
81. Miller C, **Wiese JG**. The clinical presentation of scleroderma. *JGIM*; 21 (Suppl. 4): 275, April 2006.
82. Miller C, **Wiese JG**. Portal vein thrombosis due to alcoholism. *JGIM*; 21 (Suppl. 4): 247, April 2006.
83. Victor D, **Wiese JG**. The clinical presentation of Twiddler's Syndrome. *JGIM*; 21 (Suppl. 4): 275, April 2006.
84. Beaty E, **Wiese JG**. A Hole in my Heart: The Diagnosis and Management of Atrial-Septal Defects. *Louisiana Med Jo.*; Feb. 2006.
85. Feagans J, **Wiese JG**. M.R.E. (Meals Ready to Exacerbate): Redesigning Relief Supplies for Civilian Citizens. *Louisiana Med Jo.*; Feb. 2006.
86. James J, Choe E, **Wiese JG**. Getting A Patient Off the Couch: The Manifestations of Hypothyroidism. *Louisiana Med Jo.*; Feb. 2006
87. Victor D, **Wiese JG**. The clinical presentation of Twiddler's Syndrome. *Louisiana Med Jo.*; Feb. 2006
88. Guidry M, Toprani A, **Wiese JG**. Providing pharmaceutical samples: A cost effective analysis. *JGIM*2005; 20: (in press).
89. King D, **Wiese JG**. The correlation of pit-recovery time with albumin concentration. *JGIM* 2005; 20.
90. Dehghani H, Aliota J, **Wiese JG**. Whose line is it anyway: shared central infections. *JGIM* 2005; 20.
91. Delgado, **Wiese JG**. When a good thing goes bad: learning from medical mistakes. *JGIM* 2005; 20.
92. Donald C, **Wiese JG**. Close cousins: TB and histoplasmosis. *JGIM*2005; 20.
93. Glass M, **Wiese JG**. Don't drink the water: hyponatremia from psychogenic water-drinking. *JGIM* 2005; 20.
94. Gloss D, **Wiese JG**. Those who do not learn from history are condemned to repeat it: the importance of past medical history. *JGIM* 2005; 20.
95. Kenney J, **Wiese JG**. A clinical history that is hard to swallow: Gastroparesis. *JGIM* 2005; 20.
96. Schieffelin J, **Wiese JG**. Ring-enhancing lesions. *JGIM* 2005; 20.
97. Yoon E, **Wiese JG**. It's just pharyngitis, or is it? Lemierre's syndrome. *JGIM* 2005; 20.
98. Wishik G, **Wiese JG**. Fencing zebras: A tragedy of the commons: Iron-deficient thrombocytopenia. *JGIM*; 2005; 20.
99. Towbin J, **Wiese JG**. Feel my thigh, save my life; the clinical presentation of necrotizing fasciitis. *JGIM* 2005; 20.
100. Schieffelin J, **Wiese JG**. Just listen to me. *JGIM*; 2005; 20:
101. Schieffelin J, **Wiese JG**. Body-builder with nausea. *JGIM*; 2005; 20.
102. Wright N, **Wiese JG**. When pneumonia is not pneumonia. *Louisiana Jo of Medicine* 2005.
103. Christopher S, **Wiese JG**. A hip fracture already? Diagnostic criteria for premature osteoporosis. *JGIM* 2004; 19:28.

104. Glass M, **Wiese JG**. A necrotic penis: calciphylaxis. JGIM 2004; 19:29.
105. Guidry M, **Wiese JG**. An essential case of non-essential hypertension. JGIM 2004; 19:34.
106. Evans S, **Wiese JG**. An unusual cause of cirrhosis: Gastric bypass-induced cirrhosis. JGIM; 2004; 19:35.
107. Dravid S, **Wiese JG**. Carpe Diem: Non-convulsive status epilepticus as a cause of altered mental status. JGIM; 2004; 19:41.
108. Hamblin M, **Wiese JG**. Differentiating DIC and TTP. JGIM; 2004; 19:46.
109. Cordone M, **Wiese JG**. Delayed presentation of Hepatitis A. JGIM; 2004; 19:47.
110. Moparty V, **Wiese JG**. HIV-associated nephropathy. JGIM; 2004; 19:52.
111. Burgdorf C, **Wiese JG**. A rare but deadly cause of meningitis. JGIM; 2004; 19:53.
112. Nadimpali A, **Wiese JG**. I'm dizzy could this be cancer? JGIM; 2004; 19:54.
113. Jones K, **Wiese JG**. It's not over until it's over: Diagnosing occult myocardial infarction. JGIM; 2004; 19:56.
114. Aliota J, **Wiese JG**. Left ventricular outflow obstruction. JGIM; 2004; 19:58.
115. King D, **Wiese JG**. Myelitis from West Nile and other flaviviruses. JGIM; 2004; 19:62.
116. Burgdorf C, **Wiese JG**. *Neisseria sicca* as a cause of endocarditis. JGIM; 2004; 19:63.
117. Kahlon S, **Wiese JG**. Diagnostic criteria for MAC. JGIM; 2004; 19:69.
118. Leggett C, **Wiese JG**. Sarcoidosis inducing right-heart failure. JGIM; 2004; 19:72.
119. Anderson B, **Wiese JG**. Saving my life but breaking my heart: Hyperlipidemia from protease inhibitors. JGIM; 2004; 19:72.
120. Quan L, **Wiese JG**. Increased adrenergic tone associated with the alcohol hangover. JGIM; 2004; 19:76.
121. Willis J, **Wiese JG**. Unusual presentation of herpes zoster. JGIM; 2004; 19:77.
122. Chakraborti C, **Wiese JG**. Waiting for the tide to turn: Diagnosing Eisenmenger's syndrome. JGIM; 2004; 19:79.
123. Kahlon S, **Wiese JG**. Diagnosing Wolfe-Parkinson-White syndrome. JGIM; 2004; 19:83.
124. Gambala C, Lyons C, **Wiese JG**. Using fine art to improve observation. JGIM; 2004; 19:217.
125. Burgdorf C, **Wiese JG**. Occult Hyperthyroidism. JGIM; 2004; 19:77.
126. Fotino D, **Wiese JG**. Paralysis in a young adult: Neurologic effects of West Nile virus. JGIM; 2004; 19:77.
127. Toprani A, **Wiese JG**. Distinguishing primary and secondary pulmonary hypertension. JGIM; 2004; 19:77.
128. Choe E, **Wiese JG**. Saggital vein thrombosis as a presenting complaint for lupus. JGIM; 2004; 19:77.
129. Segrest H, **Wiese JG**. Surgical criteria for endocarditis. JGIM; 2004; 19:77.
130. Agresta S, Kane M, **Wiese JG**; An ethical dilemma: the treatment of complications of intravenous drug use. JGIM2003; 18:30.
131. Kendrick DC, Kendrick CG, **Wiese JG**. Acute pustular psoriasis: recognition, differentiation and management. JGIM; 2003; 18:60.
132. Tendler A, **Wiese JG**. SIADH. Causing or caused by psychosis? JGIM; 2003; 18:91.

133. Pearl R, **Wiese JG**. Waldenstrom's macroglobulinemia and heart failure. *JGIM*; 2003; 18:80.
134. Lane J, Hutchings J, **Wiese JG**. Progressive lower extremity weakness. *JGIM*; 2003; 18:69.
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X. SECTION 10: TEACHING LOGS

TOTAL TEACHING; 1998-1999	Total hours	Number of students
	1152	363
Hours/week	24	
TOTAL TEACHING; 1999-2000	Total hours	Number of students
	1413	521
Hours/week	29	
TOTAL TEACHING; 2000-2001	Total hours	Number of students
	1335	741
Hours/week	28	
TOTAL TEACHING; 2001-2002	Total hours	Number of students
	1803	7489
Hours/week	35	
TOTAL TEACHING; 2002-2003	Total hours	Number of students
	1533	7115
Hours/week	32	
TOTAL TEACHING; 2003-2004	Total hours	Number of students
	1407	6605
Hours/week	29	
TOTAL TEACHING; 2004-2005	Total hours	Number of students
	1471	7054
Hours/week	31	

TOTAL TEACHING; 2005-2006	Total hours	Number of students
	852.5	9410
Hours/week	18	
TOTAL TEACHING; 2006-2007	Total hours	Number of students
	1595.5	11700
Hours/week	33	
TOTAL TEACHING; 2007-2008	Total hours	Number of students
	1353.5	11613
Hours/week	28	
TOTAL TEACHING; 2008-2009	Total hours	Number of students
	1182	10575
Hours/week	25	
	Total hours	Number of students
Eleven-Year Totals	15,097	84,523

1998-1999 Log

Teaching Activities 1998-1999 (UCSF)

Teaching Activity- UCSF 1998-1999	Hours/ week	Number of weeks	Total hours	Number of students	Course Type
First and Second Year Medical Students					
Physical Examination; FPC	2	10	20	16	5
Physical Examination Evaluations	10	3	30	15	10
FPC Clinical Preceptor	4	10	40	2	7
FPC Small Group Preceptor	3	10	30	6	7
Physiology Lectures	2	3	6	10	1
OSCE Evaluations	8	2	16	20	10
Third & Fourth Year Medical Students					
Physical Examination Curriculum	2	40	80	40	2
Medicine Clerkship Core Curriculum	2	12	24	16	1
Communication Skills Lectures	1	40	40	16	2
Individual Videotaping and Feedback Sessions of Communication Skills	8	40	320	2	10
Coping with Medical Codes & Crisis	1	1	1	150	6
Medicine Clerkship Core Curriculum	2	12	24	10	1
Intern & Resident Education					
Preceptor; Medicine Clinic	4	45	180	8	7
Remedial Interventions for struggling interns	3	8	24	2	10
Attending Rounds Lectures	6	21	126	5	7
Medicine Core Curriculum ; Adolescent Med.	1	6	6	20	1
Faculty Education					

Quantitative Research Methods	3	1	3	10	1
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Individual Education

Clinical Precepting of Individual Students	2	11	22	11	10
COUGAR (saving the problem student)	10	16	160	4	10

TOTAL TEACHING; 1998-1999			
		Total hours	Number of students
		1152	363
	Hours per week	24	

1999-2000 Log

Teaching Activity- UCSF 1999-2000	Hours/ week	Number of weeks	Total hours	Number of students	Course Type
First and Second Year Medical Students					
Clinical Reasoning Series: Taking a History	2	1	2	150	1, 2
Preceptor: Physical Diagnosis	3	10	30	8	7
Preceptor: History and Physical Examination	3	10	30	4	7
Pharmacology Series: Renal PBL's	2	5	10	20	6
Emergency medicine instruction	4	36	144	4	11
Third & Fourth Year Medical Students					
Professor's Rounds (MS III)	2	50	100	14	5, 6
Professor's Rounds (MSIV)	2	50	100	14	5, 6
Core Curriculum: Oral Case Presentations	1.5	15	22.5	10	1,2
Core Curriculum: Ten Equations	2	5	10	30	1
Core Curriculum: Dyspnea	2	5	10	30	1
Intern & Resident Education					
Morning Report	1	50	50	14	4
Core Curriculum: Teaching Clinical Reasoning	1	4	4	30	1,2,5
Core Curriculum: Journal Club Series	1	12	12	30	5
TIER III Group (Board Study)	2	52	104	10	6
Medical Consult Lectures	5	12	60	3	1
Ten Equations	1	6	6	30	1
Clinic preceptor	3	12	36	12	11
Attending Rounds* (Teaching time only; not management time)	20	28	560	7	8

Faculty Education

Grand Rounds	1	2	2	100	1
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Individual Education

Doug White; Spoken Case Presentation Project	5	24	120	1	10
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TOTAL TEACHING; 1999-2000

	Total hours	Number of students
	1412.5	521
Hours per week	29	

2000-2001 Log

Teaching Activity; Tulane 2000-2001	Hours/ week	Number of weeks	Total hours	Number of students	Course Type
First and Second Year Medical Students					
Clinical Reasoning Series: Taking a History	2	1	2	150	1, 2
Preceptor: Physical Diagnosis	3	10	30	8	1, 2
Preceptor: History and Physical Examination	3	10	30	4	1, 2
Pharmacology Series: Renal PBL's	2	5	10	20	1, 2
Emergency medicine instruction	4	36	144	4	1
Third & Fourth Year Medical Students					
Professor's Rounds (MS III)	1	50	50	14	1, 2
Professor's Rounds (MSIV)	1	50	50	14	1, 2
Inter-disciplinary Curriculum; Evidence-based medicine	1	15	15	10	1
Core Curriculum: Ten Important Equations in Medicine	2	5	10	30	1
Clinical Reasoning	2	5	10	30	1
Intern & Resident Education					
Core Curriculum: Teaching Clinical Reasoning	1	4	4	30	1
Core Curriculum: Journal Club Series	1	12	12	30	5
Core Curriculum: Ten Equations	1	2	2	30	1
Core Curriculum: Literature review	1	2	2	30	1
Core Curriculum: The cardiac exam	1	2	2	30	1, 2
Core Curriculum: The pulmonary exam	1	2	2	30	1, 2
Core Curriculum: Dyspnea	1	2	2	30	1
Morning Report	5	48	240	15	4

Precepting clinic	5	10	50	15	11
Attending Rounds* (Teaching time only; not management time)	20	28	560	7	7,8
TIER III Group (Board Study)	2	52	104	10	5

Faculty Education

Grand Rounds; CPC BOOP	1	2	2	100	1
Grand Rounds; Remediating problem students	1	2	2	100	1

TOTAL TEACHING; 2000-2001		Total hours	Number of students
		1335	741
	Hours per week	28	

2001-2002 Log

Teaching Activity; Tulane 2001-2002	Hours/ week	Number of weeks	Total hours	Number of students	Course Type
First Year Medical Students					
Clinical Diagnosis Course: Taking a History	2	1	2	150	1, 2
Clinical Diagnosis Course: Vital Signs	1	1	1	150	1, 2
Clinical Diagnosis Course: Heart Examination	10	1	10	150	1, 2
Clinical Diagnosis Course: Pulmonary Examination	10	1	10	150	1, 2
Clinical Diagnosis Course: Intro to clinical reasoning I	2	1	2	150	1
Clinical Diagnosis Course: Intro to clinical reasoning II	2	1	2	150	1
Second Year Medical Students					
Clinical Diagnosis Course: Introduction of clinical reasoning	1	1	1	150	1
Clinical Diagnosis Course: Rheumatology	1	1	1	150	1, 2
Clinical Diagnosis Course: Pretest probabilities	1	1	1	150	1
Clinical Diagnosis Course: Treatment thresholds	1	1	1	150	1
Clinical Diagnosis Course: Likelihood ratios	1	1	1	150	1
Clinical Diagnosis Course: Diagnostic decision making	1	1	1	150	1
Clinical Diagnosis Course: Signs of heart failure	1	1	1	150	1, 2
Clinical Diagnosis Course: Signs of valvular disease	1	1	1	150	1, 2
Clinical Diagnosis Course: Signs of pericardial disease	1	1	1	150	1, 2
Clinical Diagnosis Course: Signs of consolidation	1	1	1	150	1, 2

Clinical Diagnosis Course: Signs of obstructive lung disease	1	1	1	150	1, 2
Clinical Diagnosis Course: Heme and spleen	1	1	1	150	1, 2
Clinical Diagnosis Course: Abdominal pain	1	1	1	150	1, 2
Clinical Diagnosis Course: Ortho exam	1	1	1	150	1, 2
Clinical Diagnosis Course: Elicit drugs and toxidromes	1	1	1	150	1, 2
Clinical Diagnosis Course: Endocrine disease	1	1	1	150	1, 2
Clinical Diagnosis Course: Movement disorders and gait	1	1	1	150	1, 2
Clinical Diagnosis Course: Neuro; Motor and reflexes	1	1	1	150	1, 2
Clinical Diagnosis Course: Cranial nerves	1	1	1	150	1, 2
Clinical Diagnosis Course: Genitourinary disease	1	1	1	150	1, 2
Clinical Diagnosis Course: Infectious disease	1	1	1	150	1, 2
Clinical Diagnosis Course: Head and Neck	1	1	1	150	1,2,3
Clinical Diagnosis Course: Heart FEX	8	1	8	150	1,2,3
Clinical Diagnosis Course: Lung FEX	8	1	8	150	1,2,3
Clinical Diagnosis Course: Extremity FEX	8	1	8	150	1,2,3
Clinical Diagnosis Course: Abdominal FEX	8	1	8	150	1,2,3
Clinical Diagnosis Course: Neuro FEX	8	1	8	150	1,2,3
Clinical problem solving exercise	5	3	15	150	4
C. Thorp Ray Society Morning Report	1	4	4	30	1
Preceptorship	3	10	30	7	1
Biostatistics Course (part of clinical diagnosis)	9	1	9	150	1
Biostatistics small group leader	10	1	10	12	5
Physiology preceptor; renal	10	1	10	20	4

Phoenix society lectures	1	1	1	50	4
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Third Year Medical Students

Professor's Rounds (MS III)	1.5	48	72	14	4
Inter-disciplinary Curriculum; Evidence-based medicine	1	15	15	15	1
Core Curriculum: Ten Important Equations in Medicine	1	6	6	30	1
Clinical Reasoning	1	6	6	30	1
ICU Medicine	1	6	6	30	1

Fourth Year Medical Students

Professor's Rounds (MSIV)	1	48	48	14	1
Evidenced Based Medicine Curriculum	2	5	10	10	6
Advanced Internal Medicine	20	18	360	9	4,5,6
Teaching Teaching Course	25	4	100	16	6

Research Mentorship

Sandeep Khot: The Yellow Berets	2	20	40	1	10
Ari Pollack, Chris Frernandez, Niyogi: Parametric auscultation	2	20	40	3	10
David Rosen, Akbar Kahn: Assessment of Peripheral edema	2	20	40	2	10
Steven Brown: Physiology	2	8	16	1	10
Cormac O'Connor: Alcohol cognitive impairment	2	8	16	1	10
Ella Choe: Assessing a teaching teaching elective	2	4	8	1	
Steven Davidoff: Assessing a CPS innovation	2	4	8	1	

Intern & Resident Education

Core Curriculum: Teaching Clinical Reasoning	1	1	1	75	1
Core Curriculum: Journal Club Series	1	10	10	35	5
Core Curriculum: Teaching Teaching	1	4	4	65	5,6
Core Curriculum: Heart exam	1	3	3	75	1,2
Core Curriculum: Lung exam	1	2	2	75	1,2
Core Curriculum: Rheumatology exam	1	1	1	75	1,2
Core Curriculum: Abdominal exam	1	1	1	75	1,2
Core Curriculum: Neuro exam	1	1	1	75	1,2
Core Curriculum: Ortho exam	1	1	1	75	1,2
Core Curriculum: Adolescent Medicine	1	1	1	75	1
Core Curriculum: Antibiotics	1	1	1	75	1
Core Curriculum: Acid Base	1	1	1	75	1
Core Curriculum: Approach to weakness	1	1	1	75	1,2
Core Curriculum: Acute renal failure	1	1	1	75	1
Core Curriculum: Arrhythmias	1	1	1	75	1
Core Curriculum: EKG series	1	4	4	75	1
Morbidity and Mortality	1	10	10	80	1
Morning Report	5	48	240	15	4
Precepting clinic	5	10	50	15	11
Attending Rounds* (Teaching time only; not management time)	20	24	480	7	7,8
Faculty Education					
Grand Rounds; Hangover	1	1	1	200	1
Grand Rounds; CPC	1	1	1	100	1
Cardiology Grand Rounds	1	1	1	30	1
Non-Physician Education					
Standardized patient instruction	2	8	16	15	1,2,5

National Education

Grand Rounds; Ohio State	1	1	1	100	1
Professor's rounds; Ohio State	1	1	1	5	4
Grand Rounds; UT Galvenston	1	1	1	100	1
Noon Conference; UT Galvenston	1	1	1	30	1
Professor's rounds; UT Galvenston	1	1	1	5	4
APDIM: Teaching Teaching	2	2	4	60	1,2,6
COUGAR Workshop; SSGIM	2	1	2	30	1,2,6

TOTAL TEACHING; 2001-2002	Total hours	Number of students
	1803	7489
Hours per week	35	

2002-2003 Log

Teaching Activity; Tulane 2002-2003	Hours/ week	Number of weeks	Total hours	Number of students	Course Type
First Year Medical Students					
Clinical Diagnosis Course: Taking a History	2	1	2	150	1, 2
Clinical Diagnosis Course: Vital Signs	1	1	1	150	1, 2
Clinical Diagnosis Course: Heart Examination	10	1	10	150	1, 2
Clinical Diagnosis Course: Pulmonary Examination	10	1	10	150	1, 2
Clinical Diagnosis Course: Intro to clinical reasoning	2	1	2	150	1
Values in Medicine Retreat	2	1	2	450	1
First Year Orientation: Being a Physician	1	1	1	150	1
Second Year Medical Students					
Clinical Diagnosis Course: Introduction of clinical reasoning	1	1	1	150	1
Clinical Diagnosis Course: Rheumatology	1	1	1	140	1, 2
Clinical Diagnosis Course: Pretest probabilities	1	1	1	140	1
Clinical Diagnosis Course: Treatment thresholds	1	1	1	130	1
Clinical Diagnosis Course: Likelihood ratios	1	1	1	140	1
Clinical Diagnosis Course: Diagnostic decision making	1	1	1	100	1
Clinical Diagnosis Course: Dermatologic disease	1	1	1	120	1, 2
Clinical Diagnosis Course: Signs of heart failure	1	1	1	140	1, 2
Clinical Diagnosis Course: Signs of valvular disease	1	1	1	100	1, 2

Clinical Diagnosis Course: Signs of pericardial disease	1	1	1	100	1, 2
Clinical Diagnosis Course: Signs of consolidation	1	1	1	110	1, 2
Clinical Diagnosis Course: Signs of obstructive lung disease	1	1	1	120	1, 2
Clinical Diagnosis Course: Heme and spleen	1	1	1	100	1, 2
Clinical Diagnosis Course: Abdominal pain	1	1	1	120	1, 2
Clinical Diagnosis Course: Ortho exam	1	1	1	130	1, 2
Clinical Diagnosis Course: Elicit drugs and toxidromes	1	1	1	150	1, 2
Clinical Diagnosis Course: Endocrine disease	1	1	1	110	1, 2
Clinical Diagnosis Course: Gynecology	1	1	1	100	1, 2
Clinical Diagnosis Course: Cranial nerves/ Head and Neck	1	1	1	100	1, 2
Clinical Diagnosis Course: Genitourinary disease	1	1	1	100	1, 2
Clinical Diagnosis Course: Head and Neck	1	1	1	100	1, 2
Clinical Diagnosis Course: Heart FEX	10	1	10	164	1,2,3
Clinical Diagnosis Course: Lung FEX	10	1	10	164	1,2,3
Clinical Diagnosis Course: Extremity FEX	10	1	10	164	1,2,3
Clinical Diagnosis Course: Abdominal FEX	10	1	10	164	1,2,3
Clinical Diagnosis Course: Neuro FEX	10	1	10	164	1,2,3
Clinical problem solving exercise	10	1	10	164	1,2,3
C. Thorp Ray Society Morning Report	1	3	3	40	4
Biostatistics: Study Types	1	1	1	150	1
Biostatistics: Study Types II	1	1	1	140	1
Biostatistics: t test and confidence intervals	1	1	1	90	1
Biostatistics small group leader	1	4	4	14	5

Physiology preceptor; renal	1	1	1	14	4
Phoenix society lectures	1	1	1	50	4

Third Year Medical Students

Professor's Rounds (MS III)	1.5	48	72	14	4
Core Curriculum: Ten Important Equations in Medicine	1.5	6	9	30	1
Clinical Reasoning	1.5	6	9	30	1
ICU Medicine	1.5	6	9	30	1

Fourth Year Medical Students

Professor's Rounds (MSIV)	1	48	48	14	1
Evidenced Based Medicine Curriculum	2	5	10	10	6
Advanced Internal Medicine	20	18	360	9	4,5,6
Teaching Teaching Course	20	4	80	16	6

Research Mentorship

Danielle King: Quantifying the Physical Exam of Edema	2	20	40	1	10
Steve McPherson: Inflammation of the Alcohol Hangover	2	20	40	3	10
Cecilia Gambala; Medical Art and Observation	2	20	40	2	10
Ella Choe: Assessing a teaching teaching elective	2	4	8	1	10
Steven Davidoff: Assessing a CPS innovation	2	4	8	1	10

Intern & Resident Education

Core Curriculum: Teaching Clinical Reasoning	1	1	1	75	1
Core Curriculum: Journal Club Series	1	10	10	35	5

Core Curriculum: Teaching Teaching	1	4	4	65	5,6
Core Curriculum: Heart exam	1	3	3	75	1,2
Core Curriculum: Lung exam	1	2	2	75	1,2
Core Curriculum: Rheumatology exam	1	1	1	75	1,2
Core Curriculum: Abdominal exam	1	1	1	75	1,2
Core Curriculum: Neuro exam	1	1	1	75	1,2
Core Curriculum: Ortho exam	1	1	1	75	1,2
Core Curriculum: Adolescent Medicine	1	1	1	75	1
Core Curriculum: Antibiotics	1	1	1	75	1
Core Curriculum: Acid Base	1	1	1	75	1
Core Curriculum: Approach to weakness	1	1	1	75	1,2
Core Curriculum: Acute renal failure	1	1	1	75	1
Core Curriculum: Arrhythmias	1	1	1	75	1
Core Curriculum: EKG series	1	4	4	75	1
Morbidity and Mortality	1	10	10	80	1
Morning Report	5	48	240	15	4
Precepting clinic	5	10	50	15	11
Attending Rounds* (Teaching time only; not management time)	20	16	320	7	7,8
Non-Physician Education					
Standardized patient instruction	3	6	18	15	1,2,6
National Education					
APDIM: Clinical Coaching Workshop	2	1	2	200	1,2,5
SGIM: Teaching Oral Case Presentations Workshop	2	1	2	40	1,2,5
LA. Board of Medicine Course: Reading the Literature	3	1	3	100	1

TOTAL TEACHING; 2002-2003	Total hours	Number of students
	1533	7115
	Hours/week	32

2003-2004 Log

Teaching Activity; Tulane 2003-2004	Hours/ week	Number of weeks	Total hours	Number of students	Course Type
First Year Medical Students					
Clinical Diagnosis Course: Taking a History	1	1	1	160	1, 2
Clinical Diagnosis Course: Vital Signs	1	1	1	160	1, 2
Clinical Diagnosis Course: Heart Examination	1	3	3	160	1, 2
Clinical Diagnosis Course: Pulmonary Examination	1	3	3	160	1, 2
Clinical Diagnosis Course: Intro to clinical reasoning	1	1	1	160	1
First Year Orientation: Being a Physician	1	1	1	160	1
Second Year Medical Students					
Clinical Diagnosis Course: Introduction of clinical reasoning	1	1	1	150	1
Clinical Diagnosis Course: Rheumatology	1	1	1	140	1, 2
Clinical Diagnosis Course: Pretest probabilities	1	1	1	140	1
Clinical Diagnosis Course: Treatment thresholds	1	1	1	130	1
Clinical Diagnosis Course: Likelihood ratios	1	1	1	140	1
Clinical Diagnosis Course: Diagnostic decision making	1	1	1	100	1
Clinical Diagnosis Course: Dermatologic disease	1	1	1	120	1, 2
Clinical Diagnosis Course: Signs of heart failure	1	1	1	140	1, 2
Clinical Diagnosis Course: Signs of valvular disease	1	1	1	100	1, 2
Clinical Diagnosis Course: Signs of pericardial disease	1	1	1	100	1, 2

Clinical Diagnosis Course: Signs of consolidation	1	1	1	110	1, 2
Clinical Diagnosis Course: Signs of obstructive lung disease	1	1	1	120	1, 2
Clinical Diagnosis Course: Heme and spleen	1	1	1	100	1, 2
Clinical Diagnosis Course: Abdominal pain	1	1	1	120	1, 2
Clinical Diagnosis Course: Ortho exam	1	1	1	130	1, 2
Clinical Diagnosis Course: Elicit drugs and toxidromes	1	1	1	150	1, 2
Clinical Diagnosis Course: Endocrine disease	1	1	1	110	1, 2
Clinical Diagnosis Course: Gynecology	1	1	1	100	1, 2
Clinical Diagnosis Course: Cranial nerves/ Head and Neck	1	1	1	100	1, 2
Clinical Diagnosis Course: Genitourinary disease	1	1	1	100	1, 2
Clinical Diagnosis Course: Head and Neck	1	1	1	100	1, 2
Clinical Diagnosis Course: Heart FEX	10	1	10	164	1,2,3
Clinical Diagnosis Course: Lung FEX	10	1	10	164	1,2,3
Clinical Diagnosis Course: Extremity FEX	10	1	10	164	1,2,3
Clinical Diagnosis Course: Abdominal FEX	10	1	10	164	1,2,3
Clinical Diagnosis Course: Neuro FEX	10	1	10	164	1,2,3
Clinical problem solving exercise	10	1	10	164	1,2,3
C. Thorp Ray Society Morning Report	1	3	3	40	4
Biostatistics: Study Types	1	1	1	150	1
Biostatistics: Study Types II	1	1	1	140	1
Biostatistics: t test and confidence intervals	1	1	1	90	1
Biostatistics small group leader	1	4	4	14	5
Physiology preceptor; renal	1	1	1	14	4

Third Year Medical Students

Professor's Rounds (MS III)	1.5	48	72	20	4
Core Curriculum: Ten Important Equations in Medicine	1	6	6	30	1
Clinical Reasoning	1.5	6	9	30	1
ICU Medicine	1.5	6	9	30	1

Fourth Year Medical Students

Professor's Rounds (MSIV)	1	48	48	5	1
Evidenced Based Medicine Curriculum	1	10	10	10	6
Advanced Internal Medicine	10	20	200	5	4,5,6
Teaching Teaching Course	15	4	60	22	6
			0		

Research Mentorship

Danielle King: Quantifying the Physical Exam of Edema	1	15	15	1	10
Ella Choe: Assessing a teaching teaching elective	1	20	20	1	10
Richie Pearl/David Kendrick ACT Grant	2	40	80	2	10
Individual Resident Mentorship: Clinical vignettes, abstracts and publications	5	20	100	35	10

Intern & Resident Education

Core Curriculum: Teaching Clinical Reasoning	1	1	1	75	1
Core Curriculum: Journal Club Series	1	10	10	35	5
Core Curriculum: Teaching Teaching	1	4	4	65	5,6
Core Curriculum: Heart exam	1	3	3	75	1,2
Core Curriculum: Lung exam	1	2	2	75	1,2
Core Curriculum: Rheumatology exam	1	1	1	75	1,2

Core Curriculum: Abdominal exam	1	1	1	75	1,2
Core Curriculum: Neuro exam	1	1	1	75	1,2
Core Curriculum: Ortho exam	1	1	1	75	1,2
Core Curriculum: Adolescent Medicine	1	1	1	75	1
Core Curriculum: Antibiotics	1	1	1	75	1
Core Curriculum: Acid Base	1	1	1	75	1
Core Curriculum: Approach to weakness	1	1	1	75	1,2
Core Curriculum: Acute renal failure	1	1	1	75	1
Core Curriculum: Arrhythmias	1	1	1	75	1
Core Curriculum: EKG series	1	4	4	75	1
Morbidity and Mortality	1	10	10	80	1
Morning Report	5	48	240	15	4
Precepting clinic	5	10	50	15	11
Attending Rounds* (Teaching time only; not management time)	20	16	320	7	7,8

Non-Physician Education

Standardized patient instruction	3	6	18	15	1,2,6
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National Education

APDIM: Clinical Coaching Workshop	2	1	2	200	1,2,5
SGIM: Teaching Oral Case Presentations Workshop	2	1	2	40	1,2,5

TOTAL TEACHING; 2003-2004		Total hours	Number of students		
		1407	6605		
	Hours/week	29			

2004-2005 Log

Teaching Activity; Tulane 2004-2005	Hours/ week	Number of weeks	Total hours	Number of students	Course Type
First Year Medical Students					
Clinical Diagnosis Course: Taking a History	1	1	1	160	1, 2
Clinical Diagnosis Course: Vital Signs	1	1	1	160	1, 2
Clinical Diagnosis Course: Heart Examination	1	3	3	160	1, 2
Clinical Diagnosis Course: Pulmonary Examination	1	3	3	160	1, 2
Clinical Diagnosis Course: Intro to clinical reasoning	1	1	1	160	1
First Year Orientation: Being a Physician	1	1	1	160	1
Second Year Medical Students					
Clinical Diagnosis Course: Introduction of clinical reasoning	1	1	1	150	1
Clinical Diagnosis Course: Rheumatology	1	1	1	150	1, 2
Clinical Diagnosis Course: Pretest probabilities	1	1	1	150	1, 2
Clinical Diagnosis Course: Treatment thresholds	1	1	1	130	1, 2
Clinical Diagnosis Course: Likelihood ratios	1	1	1	130	1
Clinical Diagnosis Course: Diagnostic decision making	1	1	1	120	1
Clinical Diagnosis Course: Dermatologic disease	1	1	1	100	1, 2
Clinical Diagnosis Course: Signs of heart failure	1	1	1	130	1, 2
Clinical Diagnosis Course: Signs of valvular disease	1	1	1	140	1, 2

Clinical Diagnosis Course: Signs of pericardial disease	1	1	1	140	1, 2
Clinical Diagnosis Course: Signs of consolidation	1	1	1	130	1, 2
Clinical Diagnosis Course: Signs of obstructive lung disease	1	1	1	120	1, 2
Clinical Diagnosis Course: Heme and spleen	1	1	1	120	1, 2
Clinical Diagnosis Course: Abdominal pain	1	1	1	120	1, 2
Clinical Diagnosis Course: Ortho exam	1	1	1	140	1, 2
Clinical Diagnosis Course: Elicit drugs and toxidromes	1	1	1	150	1, 2
Clinical Diagnosis Course: Endocrine disease	1	1	1	100	1, 2
Clinical Diagnosis Course: Gynecology	1	1	1	100	1, 2
Clinical Diagnosis Course: Cranial nerves/ Head and Neck	1	1	1	90	1, 2
Clinical Diagnosis Course: Genitourinary disease	1	1	1	100	1, 2
Clinical Diagnosis Course: Head and Neck	1	1	1	100	1, 2
Clinical Diagnosis Course: Heart FEX	10	1	10	164	1,2,3
Clinical Diagnosis Course: Lung FEX	10	1	10	164	1,2,3
Clinical Diagnosis Course: Extremity FEX	10	1	10	164	1,2,3
Clinical Diagnosis Course: Abdominal FEX	10	1	10	164	1,2,3
Clinical Diagnosis Course: Neuro FEX	10	1	10	164	1,2,3
Clinical problem solving exercise	10	1	10	164	1,2,3
C. Thorp Ray Society Morning Report	1	3	3	40	4
Biostatistics: Study Types	1	1	1	150	1
Biostatistics: Study Types II	1	1	1	140	1
Biostatistics: t test and confidence intervals	1	1	1	90	1
Biostatistics small group leader	1	4	4	14	5

Physiology preceptor; renal	1	1	1	14	4
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Third Year Medical Students

Professor's Rounds (MS III)	1.5	48	72	20	4
Core Curriculum: Ten Important Equations in Medicine	1	6	6	30	1
Clinical Reasoning	1.5	6	9	30	1
ICU Medicine	1.5	6	9	30	1

Fourth Year Medical Students

Professor's Rounds (MSIV)	1	48	48	5	1
Evidenced Based Medicine Curriculum	1	10	10	10	6
Advanced Internal Medicine	10	20	200	8	4,5,6
Teaching Teaching Course	15	4	60	26	6
			0		

Research Mentorship

Danielle King: Quantifying the Physical Exam of Edema	1	15	15	1	10
Michelle Guidry; Cost analysis of pharmaceutical samples	2	20	40	2	10
Ella Choe: Assessing a teaching teaching elective	1	20	20	1	10
Steven Davidoff/Chayan Chakraborti: ACT Grant	2	40	80	2	10
Individual Resident Mentorship: Clinical vignettes, abstracts and publications	5	20	100	35	10

Intern & Resident Education

Core Curriculum: Teaching Clinical Reasoning	1	1	1	75	1
Core Curriculum: Journal Club Series	1	10	10	35	5
Core Curriculum: Teaching Teaching	1	4	4	65	5,6

Core Curriculum: Heart exam	1	3	3	75	1,2
Core Curriculum: Lung exam	1	2	2	75	1,2
Core Curriculum: Rheumatology exam	1	1	1	75	1,2
Core Curriculum: Abdominal exam	1	1	1	75	1,2
Core Curriculum: Neuro exam	1	1	1	75	1,2
Core Curriculum: Ortho exam	1	1	1	75	1,2
Core Curriculum: Adolescent Medicine	1	1	1	75	1
Core Curriculum: Antibiotics	1	1	1	75	1
Core Curriculum: Acid Base	1	1	1	75	1
Core Curriculum: Approach to weakness	1	1	1	75	1,2
Core Curriculum: Acute renal failure	1	1	1	75	1
Core Curriculum: Arrhythmias	1	1	1	75	1
Core Curriculum: EKG series	1	4	4	75	1,2
Morbidity and Mortality	1	10	10	80	1
Morning Report	5	48	240	15	4
Precepting clinic	5	10	50	15	11
Attending Rounds* (Teaching time only; not management time)	20	16	320	7	7,8

Non-Physician Education

Standardized patient instruction	3	6	18	15	1,2,6
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National Education

APDIM: Clinical Coaching Workshop	2	1	2	200	1,2,5
APDIM: Teaching Oral Case Presentations Workshop	2	1	2	50	1,2,5
SGIM: Teaching Oral Case Presentations Workshop	2	1	2	40	1,2,5
SHM: Constructing Hospitalist-based Education Models Workshop	2	1	2	50	1,6
UCSF Visiting Professor; Grand Rounds (Tri hospital)	3	1	3	150	1

UCSF morning report	5	1	5	20	4
UCSF student teaching	7	1	7	30	1,2
UCSF resident teaching	5	1	5	30	1,2,4

TOTAL TEACHING; 2004-2005	Total hours	Number of students
	1471	7054
Hours/week	31	

2005-2006 Log

Teaching Activity; Tulane 2005-2006	Hours/ week	Number of weeks	Total hours	Number of students	Course Type
First Year Medical Students					
Clinical Diagnosis Course: Taking a History	1	1	1	160	1, 2
Clinical Diagnosis Course: Vital Signs	1	1	1	160	1, 2
Clinical Diagnosis Course: Heart Examination	1	3	3	160	1, 2
Clinical Diagnosis Course: Pulmonary Examination	1	3	3	160	1, 2
Clinical Diagnosis Course: Intro to clinical reasoning	1	1	1	160	1
First Year Orientation: Being a Physician	1	1	1	160	1
Second Year Medical Students					
Clinical Diagnosis Course: Introduction of clinical reasoning	1	1	1	150	1
Clinical Diagnosis Course: Rheumatology	1	1	1	150	1, 2
Clinical Diagnosis Course: Pretest probabilities	1	1	1	150	1, 2
Clinical Diagnosis Course: Treatment thresholds	1	1	1	130	1, 2
Clinical Diagnosis Course: Likelihood ratios	1	1	1	130	1
Clinical Diagnosis Course: Diagnostic decision making	1	1	1	120	1
Clinical Diagnosis Course: Dermatologic disease	1	1	1	100	1, 2
Clinical Diagnosis Course: Signs of heart failure	1	1	1	130	1, 2
Clinical Diagnosis Course: Signs of valvular disease	1	1	1	140	1, 2
Clinical Diagnosis Course: Signs of pericardial disease	1	1	1	140	1, 2

Clinical Diagnosis Course: Signs of consolidation	1	1	1	130	1, 2
Clinical Diagnosis Course: Signs of obstructive lung disease	1	1	1	120	1, 2
Clinical Diagnosis Course: Heme and spleen	1	1	1	120	1, 2
Clinical Diagnosis Course: Abdominal pain	1	1	1	120	1, 2
Clinical Diagnosis Course: Ortho exam	1	1	1	140	1, 2
Clinical Diagnosis Course: Elicit drugs and toxidromes	1	1	1	150	1, 2
Clinical Diagnosis Course: Endocrine disease	1	1	1	100	1, 2
Clinical Diagnosis Course: Gynecology	1	1	1	100	1, 2
Clinical Diagnosis Course: Cranial nerves/ Head and Neck	1	1	1	90	1, 2
Clinical Diagnosis Course: Genitourinary disease	1	1	1	100	1, 2
Clinical Diagnosis Course: Head and Neck	1	1	1	100	1, 2
Clinical Diagnosis Course: Heart FEX	0	0	0	164	1,2,3
Clinical Diagnosis Course: Lung FEX	0	0	0	164	1,2,3
Clinical Diagnosis Course: Extremity FEX	10	1	10	164	1,2,3
Clinical Diagnosis Course: Abdominal FEX	0	0	0	164	1,2,3
Clinical Diagnosis Course: Neuro FEX	0	0	0	164	1,2,3
Clinical problem solving exercise	15	1	15	164	1,2,3
C. Thorp Ray Society Morning Report	1	1	1	40	4
Biostatistics: Study Types	1	1	1	150	1
Biostatistics: Study Types II	1	1	1	140	1
Biostatistics: t test and confidence intervals	1	1	1	90	1
Biostatistics small group leader	0	0	0	0	5
Physiology preceptor; renal	0	0	0	0	4

Third Year Medical Students

Professor's Rounds (MS III)	1.5	8	12	20	4
Core Curriculum: Ten Important Equations in Medicine	2	2	4	30	1
Clinical Reasoning	2	2	4	30	1
ICU Medicine	2	2	4	30	1

Fourth Year Medical Students

Professor's Rounds (MSIV)	1	8	8	5	1
Evidenced-Based Medicine Curriculum	1	2	2	10	6
Advanced Internal Medicine	10	8	80	8	4,5,6
Teaching Teaching Course	20	4	80	26	6

Research Mentorship

Individual Resident Mentorship: Clinical vignettes, abstracts and publications	5	20	100	35	10
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Intern & Resident Education

Intern Friday School: Yellojacket	3.5	1	3.5	37	1,2,4,5,6
Intern Friday School: Roach	3.5	1	3.5	37	1,2,4,5,6
Intern Friday School: Mosquito	3.5	1	3.5	37	1,2,4,5,6
Intern Friday School: Dragonfly	3.5	1	3.5	37	1,2,4,5,6
Intern Friday School: Fighting Chicken	3.5	1	3.5	37	1,2,4,5,6
Intern Friday School: Cenla Man	3.5	1	3.5	37	1,2,4,5,6
Intern Friday School: Buffalo	3.5	1	3.5	37	1,2,4,5,6
Intern Friday School: Bettle Juice	3.5	1	3.5	37	1,2,4,5,6
Intern Friday School: Bee	3.5	1	3.5	37	1,2,4,5,6
Intern Friday School: Law Dog	3.5	1	3.5	37	1,2,4,5,6
Resident Friday School: Viper	3.5	3	10.5	57	1,2,4,5,6
Resident Friday School: Insolent Iguana	3.5	3	10.5	57	1,2,4,5,6

Resident Friday School: Tarantula	3.5	3	10.5	57	1,2,4,5,6
Resident Friday School: Tarantula Part Deux	3.5	3	10.5	57	1,2,4,5,6
Resident Friday School: Prehistoric Squirrel	3.5	3	10.5	57	1,2,4,5,6
Resident Friday School: Pernicious Panda	3.5	3	10.5	57	1,2,4,5,6
Resident Friday School: Malingering Monkey	3.5	1	3.5	57	1,2,4,5,6
Resident Friday School: Llama	3.5	1	3.5	57	1,2,4,5,6
Resident Friday School: Lion	3.5	1	3.5	57	1,2,4,5,6
Resident Friday School: Koala	3.5	1	3.5	57	1,2,4,5,6
Resident Friday School: Hammer Head	3.5	1	3.5	57	1,2,4,5,6
Resident Friday School: Grizzly Bear	3.5	1	3.5	57	1,2,4,5,6
Resident Friday School: Gator	3.5	1	3.5	57	1,2,4,5,6
Resident Friday School: Fire Dog	3.5	1	3.5	57	1,2,4,5,6
Resident Friday School: Burnt Dog	3.5	1	3.5	57	1,2,4,5,6
Resident Friday School: Black Swan	3.5	1	3.5	57	1,2,4,5,6
Resident Friday School: Day at the Zoon	3.5	1	3.5	57	1,2,4,5,6
Resident Friday School: Aflac Duck	3.5	1	3.5	57	1,2,4,5,6
Resident Friday School: Buzzard	3.5	1	3.5	57	1,2,4,5,6
Resident Friday School: An Elephant Never Forgets	3.5	1	3.5	57	1,2,4,5,6
Resident Friday School: Brown Rhino	3.5	1	3.5	57	1,2,4,5,6
Resident Friday School: Soui!	3.5	1	3.5	57	1,2,4,5,6
Resident Friday School: The IRB-Approved Guinea Pig	3.5	1	3.5	57	1,2,4,5,6
Intern and Resident Friday School: Noah's Ark Part 1	3.5	1	3.5	57	1,2,4,5,6
Intern and Resident Friday School: Noah's Ark Part 2	3.5	1	3.5	57	1,2,4,5,6
Morbidity and Mortality	1	10	10	80	1
Morning Report	5	24	120	15	4

Attending Rounds* (Teaching time only; not management time)	20	8	160	7	7,8
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Non-Physician Education

Standardized patient instruction	3	6	18	15	1,2,6
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National Education

APDIM: Clinical Coaching Workshop	2	1	2	700	1,2,5
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SHM Clinical Coaching Workshop	2	1	2	200	
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APDIM: Disaster Management	1	1	1	600	1,2,5
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SGIM: Disaster Management	1	1	1	600	1,2,5
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UC Davis Visiting Professor; Grand Rounds	3	1	3	150	1
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UCD morning report	5	1	5	20	4
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UCD student teaching	7	1	7	30	1,2
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UCD resident teaching	5	1	5	30	1,2,4
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TOTAL TEACHING; 2005-2006		Total hours	Number of students		
		852.5	9410		
	Hours/week	18			

2006-2007 Log

Teaching Activity; Tulane 2006-2007	Hours/ wk	# of weeks	Total hours	Number of students	Course Type
First Year Medical Students					
Clinical Diagnosis Course: Taking a History	1	1	1	160	1, 2
Clinical Diagnosis Course: Vital Signs	1	1	1	160	1, 2
Clinical Diagnosis Course: Intro to clinical reasoning	1	1	1	160	1
Clinical Diagnosis Course: Tier I Heart Examination	1	3	3	160	1, 2
Clinical Diagnosis Course: Clinical Electrophysiology	4	3	12	40	4
Clinical Diagnosis Course: Tier I Pulmonary Examination	1	3	3	160	1, 2
Clinical Diagnosis Course: Clinical Pulmonology	4	3	12	40	4
Clinical Diagnosis Course: Tier I Head and Neck Exam	1	3	3	160	1, 2
Clinical Diagnosis Course: Tier I Abdominal Exam	1	3	3	160	1, 2
Clinical Diagnosis Course: Tier I Musculoskeletal Exam	1	3	3	160	1, 2
First Year Orientation: Being a Physician	1	1	1	160	1
Second Year Medical Students					
Clinical Diagnosis Course: Introduction of clinical reasoning	1	1	1	150	1
Clinical Diagnosis Course: Rheumatology	1	1	1	150	1, 2
Clinical Diagnosis Course: Pretest probabilities	1	1	1	150	1, 2
Clinical Diagnosis Course: Treatment thresholds	1	1	1	130	1, 2

Clinical Diagnosis Course: Likelihood ratios	1	1	1	130	1
Clinical Diagnosis Course: Diagnostic decision making	1	1	1	120	1
Clinical Diagnosis Course: Dermatologic disease	1	1	1	100	1, 2
Clinical Diagnosis Course: Signs of heart failure	1	1	1	130	1, 2
Clinical Diagnosis Course: Signs of valvular disease	1	1	1	140	1, 2
Clinical Diagnosis Course: Signs of pericardial disease	1	1	1	140	1, 2
Clinical Diagnosis Course: Signs of consolidation	1	1	1	130	1, 2
Clinical Diagnosis Course: Signs of obstructive lung disease	1	1	1	120	1, 2
Clinical Diagnosis Course: Heme and spleen	1	1	1	120	1, 2
Clinical Diagnosis Course: Abdominal pain	1	1	1	120	1, 2
Clinical Diagnosis Course: Ortho exam	1	1	1	140	1, 2
Clinical Diagnosis Course: Neuro exam; Upper motor	1	1	1	150	1, 2
Clinical Diagnosis Course: Neuro exam; Lower motor	1	1	1	150	1, 2
Clinical Diagnosis Course: Neuro exam: Coma	1	1	1	120	1, 2
Clinical Diagnosis Course: Neuro exam: Altered mental status	1	1	1	130	1, 2
Clinical Diagnosis Course: Elicit drugs and toxidromes	1	1	1	150	1, 2
Clinical Diagnosis Course: Endocrine disease	1	1	1	100	1, 2
Clinical Diagnosis Course: Gynecology	1	1	1	100	1, 2
Clinical Diagnosis Course: Cranial nerves/ Head and Neck	1	1	1	90	1, 2
Clinical Diagnosis Course: Genitourinary disease	1	1	1	100	1, 2
Clinical Diagnosis Course: Head and	1	1	1	100	1, 2

Neck

Clinical Diagnosis Course: Heart FEX	10	1	10	164	1,2,3
Clinical Diagnosis Course: Lung FEX	10	1	10	164	1,2,3
Clinical Diagnosis Course: Extremity FEX	10	1	10	164	1,2,3
Clinical Diagnosis Course: Abdominal FEX	10	1	10	164	1,2,3
Clinical Diagnosis Course: Neuro FEX	10	1	10	164	1,2,3
Clinical Diagnosis Course: Ward Prep Seminar	4	2	8	80	1,2,3
Clinical problem solving exercise	15	1	15	164	1,2,3
C. Thorp Ray Society Morning Report	1	1	1	40	4
Biostatistics: Study Types	1	1	1	150	1
Biostatistics: Study Types II	1	1	1	140	1
Biostatistics: t test and confidence intervals	1	1	1	90	1
Biostatistics small group leader	0	0	0	0	5

Third Year Medical Students

Professor's Rounds (MS III)	1.5	8	12	20	4
Core Curriculum: Tuesday School	4	40	160	30	4

Fourth Year Medical Students

Professor's Rounds (MSIV)	1	8	8	5	1
Evidenced-Based Medicine Curriculum	1	2	2	10	6
Advanced Internal Medicine	20	8	160	8	4,5,6
Teaching Teaching Course	30	4	120	26	6

Research Mentorship

Individual Resident Mentorship: Clinical vignettes, abstracts and publications	5	20	100	35	10
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Intern & Resident Education

Intern Friday School: Yellojacket	3.5	1	3.5	37	1,2,4,5,6
Intern Friday School: Roach	3.5	1	3.5	37	1,2,4,5,6
Intern Friday School: Mosquito	3.5	1	3.5	37	1,2,4,5,6
Intern Friday School: Dragonfly	3.5	1	3.5	37	1,2,4,5,6
Intern Friday School: Fighting Chicken	3.5	1	3.5	37	1,2,4,5,6
Intern Friday School: Cenla Man	3.5	1	3.5	37	1,2,4,5,6
Intern Friday School: Buffalo	3.5	1	3.5	37	1,2,4,5,6
Intern Friday School: Bettle Juice	3.5	1	3.5	37	1,2,4,5,6
Intern Friday School: Bee	3.5	1	3.5	37	1,2,4,5,6
Intern Friday School: Law Dog	3.5	1	3.5	37	1,2,4,5,6
Resident Friday School: Viper	3.5	3	10.5	57	1,2,4,5,6
Resident Friday School: Insolent Iguana	3.5	3	10.5	57	1,2,4,5,6
Resident Friday School: Tarantula	3.5	3	10.5	57	1,2,4,5,6
Resident Friday School: Tarantula Part Deux	3.5	3	10.5	57	1,2,4,5,6
Resident Friday School: Prehistoric Squirrel	3.5	3	10.5	57	1,2,4,5,6
Resident Friday School: Pernicious Panda	3.5	3	10.5	57	1,2,4,5,6
Resident Friday School: Malingering Monkey	3.5	1	3.5	57	1,2,4,5,6
Resident Friday School: Llama	3.5	1	3.5	57	1,2,4,5,6
Resident Friday School: Lion	3.5	1	3.5	57	1,2,4,5,6
Resident Friday School: Koala	3.5	1	3.5	57	1,2,4,5,6
Resident Friday School: Hammer Head	3.5	1	3.5	57	1,2,4,5,6
Resident Friday School: Grizzly Bear	3.5	1	3.5	57	1,2,4,5,6
Resident Friday School: Gator	3.5	1	3.5	57	1,2,4,5,6
Resident Friday School: Fire Dog	3.5	1	3.5	57	1,2,4,5,6
Resident Friday School: Burnt Dog	3.5	1	3.5	57	1,2,4,5,6
Resident Friday School: Black Swan	3.5	1	3.5	57	1,2,4,5,6

Resident Friday School: Day at the Zoon	3.5	1	3.5	57	1,2,4,5,6
Resident Friday School: Aflac Duck	3.5	1	3.5	57	1,2,4,5,6
Resident Friday School: Buzzard	3.5	1	3.5	57	1,2,4,5,6
Resident Friday School: An Elephant Never Forgets	3.5	1	3.5	57	1,2,4,5,6
Resident Friday School: Brown Rhino	3.5	1	3.5	57	1,2,4,5,6
Resident Friday School: Soui!	3.5	1	3.5	57	1,2,4,5,6
Resident Friday School: The IRB-Approved Guinea Pig	3.5	1	3.5	57	1,2,4,5,6
Intern and Resident Friday School: Noah's Ark Part 1	3.5	1	3.5	57	1,2,4,5,6
Intern and Resident Friday School: Noah's Ark Part 2	3.5	1	3.5	57	1,2,4,5,6
Morbidity and Mortality	1	10	10	80	1
Morning Report	5	48	240	15	4
Attending Rounds* (Teaching time only; not management time)	20	16	320	7	7,8
Non-Physician Education					
Standardized patient instruction	3	8	24	15	1,2,6
National Education					
APDIM: Clinical Coaching Workshop	2	1	2	700	1,2,5
SHM Clinical Coaching Workshop	2	1	2	200	
APDIM: Disaster Management	1	1	1	600	1,2,5
SGIM: Disaster Management	1	1	1	600	1,2,5
Legacy Health System; Portland, Oregon; Grand Rounds	1	1	1	100	1
Legacy Health System; Portland, Oregon; Visiting Professor	10	1	10	20	4
University of Chicago; Grand Rounds	1	1	1	100	1
University of Chicago; Visiting	10	1	10	20	4

Professor

Brigham and Womens Educational Celebration Keynote	1	1	1	200	1
Brigham and Womens Visiting Professor	10	1	10	20	4
Rush University; Grand Rounds	1	1	1	150	1
Rush University; Visiting Professor	10	1	10	20	4
Univ. of Iowa Educational Celebration Keynote Speaker	1	1	1	200	1
Univ. of Iowa; Visiting Professor	10	1	10	20	4
Lehigh Valley Hospital; Grand Rounds	1	1	1	100	1
Lehigh Valley Hospital; Visiting Professor	10	1	10	20	4
University of Indiana; Grand Rounds	1	1	1	110	1
University of Indiana; Visiting Professor	30	1	30	20	4
Univ. of Michigan; Grand Rounds	1	1	1	150	1
Univ. of Michigan; Visiting Professor	20	1	20	20	4
Temple University; Grand Rounds	1	1	1	100	1
Temple University; Visiting Professor	5	1	5	20	4

TOTAL TEACHING; 2006-2007	Total hours	Number of students
	1595.5	11700
Hours/wk	33	

2007-2008 Log

Teaching Activity; Tulane 2007-2008	Hours/ wk	# of weeks	Total hours	Number of students	Course Type
First Year Medical Students					
Clinical Diagnosis Course: Taking a History	1	1	1	160	1, 2
Clinical Diagnosis Course: Vital Signs	1	1	1	160	1, 2
Clinical Diagnosis Course: Intro to clinical reasoning	1	1	1	160	1
Clinical Diagnosis Course: Tier I Heart Examination	1	3	3	160	1, 2
Clinical Diagnosis Course: Clinical Electrophysiology	4	3	12	40	4
Clinical Diagnosis Course: Tier I Pulmonary Examination	1	3	3	160	1, 2
Clinical Diagnosis Course: Clinical Pulmonology	4	3	12	40	4
Clinical Diagnosis Course: Tier I Head and Neck Exam	1	3	3	160	1, 2
Clinical Diagnosis Course: Tier I Abdominal Exam	1	3	3	160	1, 2
Clinical Diagnosis Course: Tier I Musculoskeletal Exam	1	3	3	160	1, 2
First Year Orientation: Being a Physician	1	1	1	160	1
Second Year Medical Students					
Clinical Diagnosis Course: Introduction of clinical reasoning	1	1	1	150	1
Clinical Diagnosis Course: Rheumatology	1	1	1	150	1, 2
Clinical Diagnosis Course: Pretest probabilities	1	1	1	150	1, 2
Clinical Diagnosis Course: Treatment thresholds	1	1	1	130	1, 2

Clinical Diagnosis Course: Likelihood ratios	1	1	1	130	1
Clinical Diagnosis Course: Diagnostic decision making	1	1	1	120	1
Clinical Diagnosis Course: Dermatologic disease	1	1	1	100	1, 2
Clinical Diagnosis Course: Signs of heart failure	1	1	1	130	1, 2
Clinical Diagnosis Course: Signs of valvular disease	1	1	1	140	1, 2
Clinical Diagnosis Course: Signs of pericardial disease	1	1	1	140	1, 2
Clinical Diagnosis Course: Signs of consolidation	1	1	1	130	1, 2
Clinical Diagnosis Course: Signs of obstructive lung disease	1	1	1	120	1, 2
Clinical Diagnosis Course: Heme and spleen	1	1	1	120	1, 2
Clinical Diagnosis Course: Abdominal pain	1	1	1	120	1, 2
Clinical Diagnosis Course: Ortho exam	1	1	1	140	1, 2
Clinical Diagnosis Course: Neuro exam; Upper motor	1	1	1	150	1, 2
Clinical Diagnosis Course: Neuro exam; Lower motor	1	1	1	150	1, 2
Clinical Diagnosis Course: Neuro exam: Coma	1	1	1	120	1, 2
Clinical Diagnosis Course: Neuro exam: Altered mental status	1	1	1	130	1, 2
Clinical Diagnosis Course: Elicit drugs and toxidromes	1	1	1	150	1, 2
Clinical Diagnosis Course: Endocrine disease	1	1	1	100	1, 2
Clinical Diagnosis Course: Gynecology	1	1	1	100	1, 2
Clinical Diagnosis Course: Cranial nerves/ Head and Neck	1	1	1	90	1, 2
Clinical Diagnosis Course: Genitourinary disease	1	1	1	100	1, 2
Clinical Diagnosis Course: Head and	1	1	1	100	1, 2

Neck

Clinical Diagnosis Course: Heart FEX	10	1	10	164	1,2,3
Clinical Diagnosis Course: Lung FEX	10	1	10	164	1,2,3
Clinical Diagnosis Course: Extremity FEX	10	1	10	164	1,2,3
Clinical Diagnosis Course: Abdominal FEX	10	1	10	164	1,2,3
Clinical Diagnosis Course: Neuro FEX	10	1	10	164	1,2,3
Clinical Diagnosis Course: Ward Prep Seminar	4	2	8	80	1,2,3
Clinical problem solving exercise	15	1	15	164	1,2,3
C. Thorp Ray Society Morning Report	1	1	1	40	4
Biostatistics: Study Types	1	1	1	150	1
Biostatistics: Study Types II	1	1	1	140	1
Biostatistics: t test and confidence intervals	1	1	1	90	1

Third Year Medical Students

Professor's Rounds (MS III)	1.5	8	12	20	4
Core Curriculum: Tuesday School	4	20	80	30	4

Fourth Year Medical Students

Professor's Rounds (MSIV)	1	8	8	5	1
Evidenced-Based Medicine Curriculum	1	2	2	10	6
Advanced Internal Medicine	20	12	240	8	4,5,6
Teaching Teaching Course	30	4	120	44	6

Research Mentorship

Individual Resident Mentorship: Clinical vignettes, abstracts and publications	5	20	100	35	10
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Intern & Resident Education

Intern Friday School: Yellojacket	3.5	1	3.5	37	1,2,4,5,6
Intern Friday School: Roach	3.5	1	3.5	37	1,2,4,5,6
Intern Friday School: Mosquito	3.5	1	3.5	37	1,2,4,5,6
Intern Friday School: Dragonfly	3.5	1	3.5	37	1,2,4,5,6
Intern Friday School: Fighting Chicken	3.5	1	3.5	37	1,2,4,5,6
Intern Friday School: Cenla Man	3.5	1	3.5	37	1,2,4,5,6
Intern Friday School: Buffalo	3.5	1	3.5	37	1,2,4,5,6
Intern Friday School: Bettle Juice	3.5	1	3.5	37	1,2,4,5,6
Intern Friday School: Bee	3.5	1	3.5	37	1,2,4,5,6
Intern Friday School: Law Dog	3.5	1	3.5	37	1,2,4,5,6
Resident Friday School: Viper	3.5	3	10.5	57	1,2,4,5,6
Resident Friday School: Insolent Iguana	3.5	3	10.5	57	1,2,4,5,6
Resident Friday School: Tarantula	3.5	3	10.5	57	1,2,4,5,6
Resident Friday School: Tarantula Part Deaux	3.5	3	10.5	57	1,2,4,5,6
Resident Friday School: Prehistoric Squirrel	3.5	3	10.5	57	1,2,4,5,6
Resident Friday School: Pernicious Panda	3.5	3	10.5	57	1,2,4,5,6
Resident Friday School: Malingering Monkey	3.5	1	3.5	57	1,2,4,5,6
Resident Friday School: Llama	3.5	1	3.5	57	1,2,4,5,6
Resident Friday School: Lion	3.5	1	3.5	57	1,2,4,5,6
Resident Friday School: Koala	3.5	1	3.5	57	1,2,4,5,6
Resident Friday School: Hammer Head	3.5	1	3.5	57	1,2,4,5,6
Resident Friday School: Grizzly Bear	3.5	1	3.5	57	1,2,4,5,6
Resident Friday School: Gator	3.5	1	3.5	57	1,2,4,5,6
Resident Friday School: Fire Dog	3.5	1	3.5	57	1,2,4,5,6
Resident Friday School: Burnt Dog	3.5	1	3.5	57	1,2,4,5,6
Resident Friday School: Black Swan	3.5	1	3.5	57	1,2,4,5,6
Resident Friday School: Day at the Zoon	3.5	1	3.5	57	1,2,4,5,6

Resident Friday School: Aflac Duck	3.5	1	3.5	57	1,2,4,5,6
Resident Friday School: Buzzard	3.5	1	3.5	57	1,2,4,5,6
Resident Friday School: An Elephant Never Forgets	3.5	1	3.5	57	1,2,4,5,6
Resident Friday School: Brown Rhino	3.5	1	3.5	57	1,2,4,5,6
Resident Friday School: Soui!	3.5	1	3.5	57	1,2,4,5,6
Resident Friday School: The IRB-Approved Guinea Pig	3.5	1	3.5	57	1,2,4,5,6
Intern and Resident Friday School: Noah's Ark Part 1	3.5	1	3.5	57	1,2,4,5,6
Intern and Resident Friday School: Noah's Ark Part 2	3.5	1	3.5	57	1,2,4,5,6
Morbidity and Mortality	1	10	10	80	1
Morning Report	5	20	100	15	4
Attending Rounds* (Teaching time only; not management time)	20	16	320	7	7,8

Non-Physician Education

Standardized patient instruction	3	8	24	15	1,2,6
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National Education

APDIM: Clinical Coaching Workshop	1	1	1.5	700	1,2
SHM Clinical Coaching Workshop	1	1	1.5	200	1,2
SGIM: Interviewing, CV's and Mentoring	1	1	1.5	50	1,2,5
SHM: Ten Advanced Organizers	1	1	1.5	110	1,2,5
SHM: Mentoring Skills	1	1	1.5	90	1,2,5
SGIM: Clinical Coaching	1	1	1.5	50	1,2,5
ACP: Integrating the SHM Core Competencies into Residency Training	1	1	1.5	100	1,2,5
Alabama ACP: Developing Hospitalist Models	1	1	1	130	1
St. Lukes-Roosevelt: Commencement	1	1	1	150	1

Speech

Washington University: Disaster Preparedness for GME Programs	1	1	1	120	1
ACP: Medical Crossfire: Hot Topics in Graduate Medical Education.	1	1	1	190	1
SSGIM: Effective Mentoring.	1	1	1	30	1,2,5
AAMC: Graduate Medical Education Leadership Lessons In Preparing for a Disaster	1	1	1	70	1
ACGME: Preparing a Remediation Program for Graduate Medical Education.	1	1	1	30	1
American Association of Allergy and Immunology: Lessons Learned from Hurricane Katrina. Plenary	1	1	1	150	1
AHA: Hospitalist Management of Heart Failure:	1	1	1.5	150	1,5
Legacy Grand Rounds: Integrating Clinical Reasoning Into Medical Education Training.	7	1	1	50	1,5,6,7
Legacy Grand Rounds:: Educational Reform of GME	1	1	1	100	1
Univ. of Iowa GME Symposium, Plenary: Integrating Clinical Reasoning Into Medical Education Training.	1	1	1	150	1,5,6,7
Univ. of Iowa Grand Rounds: Diaster Preparedness for GME	1	1	1	100	1
Ohio State Univ. Grand Rounds: Diaster Preparedness for GME	1	1	1	150	1
Ohio ACP Pleenary Diaster Preparedness for GME	1	1	1	225	1
Univ. of Virginia Grand Rounds:: Educational Reform of GME	7	1	1	140	1,5,6,7
MUSC Grand Rounds:: Educational Reform of GME	5	1	1	150	1,5,6,7

	Total hours	Number of students
	1353.5	11613
Hours/wk	28	

2008-2009 Log

Teaching Activity; Tulane 2008-2009	Hours/ wk	# of weeks	Total hours	Number of students	Course Type
First Year Medical Students					
Clinical Diagnosis Course: Taking a History	1	1	1	160	1, 2
Clinical Diagnosis Course: Vital Signs	1	1	1	160	1, 2
Clinical Diagnosis Course: Intro to clinical reasoning	1	1	1	160	1
Second Year Medical Students					
Clinical Diagnosis Course: Introduction of clinical reasoning	1	1	1	150	1
Clinical Diagnosis Course: Pretest probabilities	1	1	1	150	1, 2
Clinical Diagnosis Course: Treatment thresholds	1	1	1	130	1, 2
Clinical Diagnosis Course: Likelihood ratios	1	1	1	130	1
Clinical Diagnosis Course: Diagnostic decision making	1	1	1	120	1
Clinical Diagnosis Course: Signs of heart failure	1	1	1	130	1, 2
Clinical Diagnosis Course: Signs of valvular disease	1	1	1	140	1, 2
Clinical Diagnosis Course: Signs of pericardial disease	1	1	1	140	1, 2
Clinical Diagnosis Course: Signs of consolidation	1	1	1	130	1, 2
Clinical Diagnosis Course: Signs of obstructive lung disease	1	1	1	120	1, 2
Clinical Diagnosis Course: Heme and spleen	1	1	1	120	1, 2
Clinical Diagnosis Course: Neuro exam; Upper motor	1	1	1	150	1, 2

Clinical Diagnosis Course: Neuro exam; Lower motor	1	1	1	150	1, 2
Clinical Diagnosis Course: Neuro exam: Coma	1	1	1	120	1, 2
Clinical Diagnosis Course: Neuro exam: Altered mental status	1	1	1	130	1, 2
Clinical Diagnosis Course: Ward Prep Seminar	4	2	8	80	1,2,3
Clinical problem solving exercise	15	1	15	164	1,2,3
C. Thorp Ray Society Morning Report	1	2	2	120	4
Biostatistics: Study Types	1	1	1	150	1
Biostatistics: Study Types II	1	1	1	140	1
Biostatistics: t test and confidence intervals	1	1	1	90	1
Biostatistics small group leader	0	0	0	0	5

Third Year Medical Students

Core Curriculum: Tuesday School	4	2	8	30	4
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Fourth Year Medical Students

Evidenced-Based Medicine Curriculum	1	2	2	10	6
Advanced Internal Medicine	20	12	240	8	4,5,6
Teaching Teaching Course	30	4	120	26	6

Research Mentorship

Individual Resident Mentorship: Clinical vignettes, abstracts and publications	5	20	100	35	10
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Intern & Resident Education

Intern Friday School: Yellojacket	3.5	1	3.5	37	1,2,4,5,6
Intern Friday School: Roach	3.5	1	3.5	37	1,2,4,5,6

Intern Friday School: Mosquito	3.5	1	3.5	37	1,2,4,5,6
Intern Friday School: Dragonfly	3.5	1	3.5	37	1,2,4,5,6
Intern Friday School: Fighting Chicken	3.5	1	3.5	37	1,2,4,5,6
Intern Friday School: Cenla Man	3.5	1	3.5	37	1,2,4,5,6
Intern Friday School: Buffalo	3.5	1	3.5	37	1,2,4,5,6
Intern Friday School: Bettle Juice	3.5	1	3.5	37	1,2,4,5,6
Intern Friday School: Bee	3.5	1	3.5	37	1,2,4,5,6
Intern Friday School: Law Dog	3.5	1	3.5	37	1,2,4,5,6
Resident Friday School: Viper	3.5	3	10.5	57	1,2,4,5,6
Resident Friday School: Insolent Iguana	3.5	3	10.5	57	1,2,4,5,6
Resident Friday School: Tarantula	3.5	3	10.5	57	1,2,4,5,6
Resident Friday School: Tarantula Part Deaux	3.5	3	10.5	57	1,2,4,5,6
Resident Friday School: Prehistoric Squirrel	3.5	3	10.5	57	1,2,4,5,6
Resident Friday School: Pernicious Panda	3.5	3	10.5	57	1,2,4,5,6
Resident Friday School: Malingering Monkey	3.5	1	3.5	57	1,2,4,5,6
Resident Friday School: Llama	3.5	1	3.5	57	1,2,4,5,6
Resident Friday School: Lion	3.5	1	3.5	57	1,2,4,5,6
Resident Friday School: Koala	3.5	1	3.5	57	1,2,4,5,6
Resident Friday School: Hammer Head	3.5	1	3.5	57	1,2,4,5,6
Resident Friday School: Grizzly Bear	3.5	1	3.5	57	1,2,4,5,6
Resident Friday School: Gator	3.5	1	3.5	57	1,2,4,5,6
Resident Friday School: Fire Dog	3.5	1	3.5	57	1,2,4,5,6
Resident Friday School: Burnt Dog	3.5	1	3.5	57	1,2,4,5,6
Resident Friday School: Black Swan	3.5	1	3.5	57	1,2,4,5,6
Resident Friday School: Day at the Zoon	3.5	1	3.5	57	1,2,4,5,6
Resident Friday School: Aflac Duck	3.5	1	3.5	57	1,2,4,5,6
Resident Friday School: Buzzard	3.5	1	3.5	57	1,2,4,5,6
Resident Friday School: An Elephant	3.5	1	3.5	57	1,2,4,5,6

Never Forgets					
Resident Friday School: Brown Rhino	3.5	1	3.5	57	1,2,4,5,6
Resident Friday School: Soui!	3.5	1	3.5	57	1,2,4,5,6
Resident Friday School: The IRB- Approved Guinea Pig	3.5	1	3.5	57	1,2,4,5,6
Intern and Resident Friday School: Noah's Ark Part 1	3.5	1	3.5	57	1,2,4,5,6
Intern and Resident Friday School: Noah's Ark Part 2	3.5	1	3.5	57	1,2,4,5,6
Morbidity and Mortality	1	10	10	80	1
Morning Report	5	20	100	15	4
Attending Rounds* (Teaching time only; not management time)	20	12	240	7	7,8

Non-Physician Education

National Education

APDIM: Clinical Coaching Workshop	1.5	1	1.5	700	1,2
SHM Clinical Coaching Workshop	1.5	1	1.5	120	1,2
SHM CPC	1	1	1	250	1
NIH Grand Rounds: CPC	1	1	1	200	1
SHM: Ten Advanced Organizers	1.5	1	1.5	120	1,2,5
Penn State Grand Rounds: Innovations in GME	5	1	5	150	1,5,6,7
NYU Grand Rounds: Innovations in GME	5	1	5	150	1,5,6,7
Long Island Jewish: MUSC Grand Rounds:: Educational Reform of GME	5	1	5	700	1,5,6,7
AHME: Creating a Cultural Change in Graduate Medical Education.	1	1	1	200	1
AHME: Leadership Lessons in the Wake of Disaster.	1	1	1	600	1
Georgia SHM: Hospital Medicine and Quality	1	1	1	50	1,5

LA ACP: Updates in Hospital Medicine.	1	1	1	100	1
South Florida SHM: Hospital Medicine and Quality	1	1	1	50	1,5
Univ. of Miami: Clinical Coaching and Faculty Development	2	1	2	100	1,2,5
SSGIM: Updates in Hospital Medicine.	1	1	1	20	1
SECC: Updates in Hospital Medicine.	1	1	1	100	1
Mississippi ACP Plenary Disaster Preparedness for GME	1	1	1	150	1
Univ. Mississippi: Plenary Clinical Coaching and Faculty Development	3	1	3	200	1,5
Mt. Sinai Grand Rounds: Leadership Lessons in the Wake of Disaster.	2	1	2	150	1,5,6,7
Tufts Grand Rounds: Leadership Lessons in the Wake of Disaster.	2	1	2	150	1,5,6,7
Univ. Alabama Grand Rounds Clinical Coaching and Faculty Development	4	1	4	400	1,5,6
UT Houston Grand Rounds: Novel Innovations in Medical Education.	1	1	1	200	1

TOTAL TEACHING; 2006-2007	Total hours	Number of students
	1182	10575
Hours/wk	25	

XI. Section 11: Teaching & Learning: Methods and Strategies

There are seven years of medical education from the college graduate to the practicing physician; my strategy has been to be a part of each of these seven years to ensure an incremental and successful development of the physicians I train.

Year 1

My father's strategy was to begin early; developing solid fundamentals before the complexities of the game made it impossible to return to fundamentals. I have adopted this strategy by beginning instruction in the first year of medical school. I have four goals to in my first year instruction:

1. Inspire professionalism as the fundamental goal of the physician.
2. Empower students with clinical reasoning as a method for discerning relevant clinical data.
2. Enable students to overcome the fear of touching a patient.
3. Provide students with a rational approach (Tier I/Tier II) to the physical examination.

This begins my departure from teacher to coach. The coach is responsible for not only enabling ability to perform, but also for anticipating the obstacles the player will encounter, and empowering him or her with the ability to overcome these obstacles when they arise. Unlike the vignette-based exams of the pre-clinical years, each patient on the clinical wards has infinity of data to provide. The most common pitfall in physician development is the student's inability to discern between relevant and irrelevant data as it pertains to each patient's presenting complaint. I anticipate this struggle, and I anticipate my students will be admonished by their attending physicians to, "Obtain/present only the relevant data," presupposing they will have a strategy for determining relevance. My goal in the first year is to instill in students the Bayesian theory of clinical reasoning such that they have a method for determining relevance in their clinical practice:

1. Use the characterization of the chief complaint to generate a differential diagnosis.
2. Use the differential diagnosis to determine relevant from irrelevant data.
3. Perform exam maneuvers and obtain tests that test the hypotheses contained in the differential diagnosis.

Albert Bandura noted that it is fear that prevents performance, and an expectation of fear makes the environment more daunting. As technology makes the physical exam more obsolete, I remain a proponent for the exam; not because I believe in the superiority of the physical exam over technology, but because I believe the physical exam brings the doctor closer to the patient. And the closer the doctor is to her patient, the greater the therapeutic result we can expect. I try not to over-teach the physical exam in the first year. My goal is to make students comfortable with touching a patient, absolving them of the fear that may someday keep them from examining their patient. I teach vital signs, and in concert with the Department of Physiology, the Tier I cardiac, pulmonary, abdominal, musculoskeletal, and neurologic examinations.

Perhaps a word about the Tier I and Tier II philosophy is in order. As a coach, I anticipate what the student will see when he enters the clinical wards. He will see residents and attending physicians performing *partial* examinations of their patients; and the content of these partial examinations will change from patient to patient. They will not tell the student why they perform some examination maneuvers on one patient, and different examination maneuvers on another patient. There is a reason for their variability, of course: their examination changes based upon their differential diagnosis, which of course changes from patient to patient. But this skill has become tacit to them, and they do not think to tell the student why they do what they do. The student will model their behavior concretely, mimicking exactly what they do. Without the rationale behind the action, however, the student will quickly become frustrated. To absolve the frustration, the student will abandon the physical examination, and the gap between this future physician and his patients will begin to widen. As time passes, the student (having not done the physical exam in some time) will become afraid of his inadequacy with the physical exam; this fear will prevent him from returning to the exam, and more importantly, to his patient's bedside.

Anticipating this common occurrence, I developed the Tier I/Tier II philosophy to the exam. I teach students the Tier I exam: quick and easy screening maneuvers that should be done on every patient to detect common diseases unlikely to be obvious from the history. I also teach them the Tier II exam: maneuvers that should be done only to evaluate abnormalities detected on the Tier I exam, and to evaluate the diagnoses on their differential diagnosis. This approach enables them to discern why their physician role models do the exams that they do. Once students have made the connection between the differential diagnosis and the Tier II exam, they are better able to learn about constructing a differential diagnosis: they can glean the attending physician's differential by watching his or her Tier II examination. The Tier I/Tier II layout is in the Red Diamond Syllabus (Section 8 Supplement).

In sum, my teaching in the first year is to establish the fundamentals of clinical medicine in order to empower the student to get the most from her second year of medical school training.

Year 2: Clinical Diagnosis and Biostatistics

I teach clinical diagnosis in the second year. The course used to be called Physical Diagnosis, but as the above commentary suggests, the goal of this course is much more than the physical examination.

The course begins with clinical reasoning. This is important in several respects. As their coach, I anticipate that students will struggle with two obstacles. First, their pre-clinical experience will have taught them to search for and recognize "buzz words." A vignette on pneumonia, for example, must contain egophony to be a fair question, but the clinical reality is that many patients with pneumonia do not have egophony, and some patients with egophony do not have pneumonia. If this is not addressed and explained early in training, there is a risk that the student will experience frustration with the physical examination when they reach their clinical years. The sentiment might go something like this: "This exam thing is worthless! My patient has pneumonia, but the exam is normal. I'm throwing out the physical exam from now on." It would be understandable to dispense with one physical examination maneuver; but the reality is that this sentiment prompts disposal of the entire examination. To counteract this, I teach students about tests in general: each test has a sensitivity and a specificity for each disease. The next step is in empowering students to understand how sensitivity and specificity translate into likelihood ratios, both positive LR's (to make a disease

more probable) and negative LR's (to make a disease less probable). This is an important foundation; the remainder of the course describes physical examination maneuvers, with each maneuver's positive and negative likelihood ratios, such that the student can not only learn how to do the maneuver, but also learn the confidence he can have in the maneuver if the result is positive or negative. The whole philosophy is captured in one of the course's four mottos (from Goethe): "**Was mann weiss, mann sieht.**" Translation, what you know (or what you look for), that is what you will find.

Of course the implicit lesson taught in this approach is that *tests have meaning only in the context of the pre-test probability for a disease*, and that tests (including exam maneuvers) have value only when examining a disease on their differential diagnosis. The clinical reasoning component of the course teaches students how to establish pre-test probabilities from their history and from the natural prevalence of disease. This is important, because in the midst of most physical examination courses, the patient's history gets lost. The Clinical Diagnosis course trains students to keep the patient's history preeminent. With the history preeminent, the student physician must remain at the patient's bedside, and this is the ultimate goal of this course: from the outset, *create a system of thinking within the student that drives her to the patient's bedside*. The longer the clinician spends at the bedside, the more likely the patient will come up with the words to describe the disease; the more likely the disease will declare itself. And the word "clinician" is appropriate: from the French "clinique," meaning "at the bedside."

The final component of clinical reasoning is the testing and treatment thresholds. By a mathematical proof, you can prove that the decision to test for or treat a disease depends upon the risks/costs versus the expected benefits. If the probability of a disease is above this threshold it should be treated; if the probability is not above its threshold it should not be treated. The reason I devote so much time to this concept is to prevent a pitfall I anticipate the students will experience in their clinical practice. The obstacle is the temptation to test for and/or treat all "scary" diseases. The erroneous clinical admonition they will receive is, "You have to obtain a spiral CT scan to exclude pulmonary embolism in all patients with dyspnea, because an embolism could kill the patient." The error is that although a pulmonary embolism is potentially fatal, it does not necessarily make it probable. The argument is usually followed by some legal scare ("You'll get sued if you don't"), which is, as Peter Berger would put it "bad faith." Bad faith is the abdication of reasoning and the abdication of responsibility for decisions because of a belief that there is not a choice. Hence, motto number two of the course: "**All you have to do in life is die.**" Once a student accepts this tenet, he is empowered with choice and thus responsibility: we choose to do things in life, including ordering tests for patients, if the expected benefits outweigh the expected costs. The benefit is that it puts the student physician in control of the test, not the tests in control of the physician, and this is the key to efficient resource utilization and preventing unnecessary testing that leads to subsequent unnecessary invasive procedures. As I coach the students, "No test is *non-invasive*; all tests are *pre-invasive*."

The other implicit lesson is that students learn that clinical medicine is not about absolutes: to wait for 100% probability of a diagnosis (i.e., appendicitis) is to kill many patients who needed the therapy but did not receive it in time because the physician was waiting for 100% probability (i.e., The surgical tenet: 20% of all appendectomies should be normal appendices). Clinical medicine is a game of probabilities, and this is a lesson often missed by student physicians, since their pre-clinical vignette-based testing (by design) is quite the opposite; each test question has to have a 100% correct answer. Unless the student makes this paradigm switch from "100% certainty in diagnosis" to "sufficient probability to treat a diagnosis," great frustration and inadequate care will result.

The long-term benefit of this coaching is not clinical; it is philosophical. The elimination of bad faith empowers students to take responsibility for their actions, both within and without medicine. This is central to preventing the learned self-helplessness that is used to rationalize unprofessional behavior. Once you accept choice, you accept responsibility. And unprofessional behavior has this at its core: it the abdication of choice, and thus the abdication of responsibility. Peppered throughout the course are lessons in professionalism, but I never admonish students that they *have to* do an action (i.e., respect a patient's wishes), because the "have to" admonishment builds bad faith, and bad faith is the seed that leads to unprofessional behavior. Rather, I create the case for why respecting a patient's wishes, for example, is the right thing to do because it leads to better clinical care, and because it is consistent with the good person within each student. Respecting a patient's wishes is a choice, and we choose to do this because the benefits of the decision are great and right. Intermittently, I send students some of my writings and thoughts on the professionalism of medicine. A few of which are in Section 12.

The principle that guides my teaching of the physical examination is that the student should not *memorize* the association of physical findings with disease. To the contrary, the student should *understand* why the physical finding is associated with the disease. There are two reasons for this. First, memorized knowledge fades over time. Since my goal is Phase 4 Teaching (i.e., teaching for performance), it is silly to teach any knowledge or skill that will be lost in a year; the student will obviously not use a skill that has been lost. Second, the student that understands the pathophysiology that causes a physical finding understands the pathophysiology of the disease. Aside from bringing the physician back to the bedside, this may be the most compelling argument for teaching the physical exam. The better a student understands the pathophysiology of disease, the better he will be at treating that disease. And importantly, the better the student will be able to predict the consequences of his interventions. Case in point, if a student understands that a third heart sound (S3) is due to volume overload in the left atrium, he is more likely to understand that elimination of fluid from the body is the suggested therapy. There is no need to memorize that fact from a book.

And this is important to clinical medicine. If our failure to find a computer that can practice medicine effectively (and it has been a failure) tells us anything, it tells us this: medicine is not a game of checkers where the player acts and then reacts to his opponent. It is a game of chess: the physician must make decisions not based upon the position of the pieces on the board at present, but rather based upon where he anticipates the pieces will be several moves into the game. Using the example above, the physician must recognize that diuresis is the therapy for a patient with fluid overload, but he must also anticipate that this will eventually result in less blood flow to the kidney, and thus worsening renal failure. Recognizing both, perhaps after-load reduction to allow the heart to mobilize more fluid, while simultaneously maintaining blood flow to the kidney, would have been a better initial plan.

Teaching the exam in the context of physiology enables the student to think like a chess player. When a student is empowered with understanding, instead of facts, he at least has a shot at deriving the right answer when the facts escape him. And since all facts are eventually lost from the memory if not repeatedly used (i.e., my Spanish-speaking skills I learned in high school), this preserves performance over time. It also enables the student to solve problems not previously encountered, which is very much a part of clinical medicine. Though not the goal of this course (clinical performance in third year and beyond is the goal) the dramatic elevation in shelf test scores, both for clinical diagnosis and pathology (see below) are surrogate evidence that this approach has been effective (Section 6).

The other departure Clinical Diagnosis has taken from a standard physical diagnosis course is to address the skills necessary for clinical performance on the wards. The course now has a “preparation for the wards” sub-course built in. The Green Emerald Syllabus summarizes these lessons (Section 8 Supplement). By lecture, students are taught how to use their clinical reasoning (*vida supra*) to construct their admission notes, progress notes, and oral case presentations. An active participation, seminar series of five, thirty-minute small groups allows fourth-year students (from the clinical coaching course; *vida infra*) to coach the second-year students in these skills. The small group structure, and the use of fourth-year students is important: this enables second-year students to ask the questions they need to ask, and it allows them to ask it of people they trust (i.e., those who have just gone through what they are about to go through).

The final component of my year two teaching is biostatistics. If there is a topic more prone to memorization, I don't know of it. Instead of teaching formulas and complex statistical analysis, I elected to sacrifice the details and focus upon the statistical principles necessary for understanding the five major study types encountered in clinical medicine. The sacrifice of details permitted more time to discuss the principles underlying medical research. The goal is to empower students with the skills necessary to engage in practice-based learning early in their career, such that these skills might be fostered during their clinical years in preparation for a lifetime of learning. To this end, the three lectures are followed by five journal club sessions, in which the student's performance is assessed (i.e., find the article using medline, evaluate the article using the Journal Club Kit) (Section 8 Supplement). The goal is to model the behavior the student should embrace during the remainder of her career. Students are evaluated by the quality of the portfolio their team constructs (Section 6 Supplement); the ancillary lesson is teamwork.

Year 3

My third-year teaching is an extension of the first two years. I routinely do three lectures per block for the Internal Medicine Clerkship. The first of which is advanced clinical reasoning that is purposely couched in the context of how to give an oral case presentation. The frustrating part of assessing clinical reasoning is that it is translucent. This makes it difficult for attending physicians and residents to assess a student's clinical reasoning quality, and thus it is challenging to find the area for improvement. The spoken case presentation is the key to this challenge. If the SCP is constructed based upon the student's clinical reasoning, the student's clinical reasoning then becomes available to the attending physician to inspect and critique (See the American Journal of Medicine Article in Section 11). The added benefit is that it prevents the attending physician's admonition, “Present only the relevant data,” which is a huge rhetorical error. This is a *presumption of presupposed knowledge*; that is, it presupposes that the student knew what was relevant and has elected to present irrelevant data. The problem is usually that the student has no definition of relevance. As discussed earlier in the narrative, the student by this point has hopefully (if I did my job) learned that relevance is based upon the differential diagnosis, which is the core of the clinical reasoning process. The goals of this lecture are three-fold: 1. To improve communication skills and thereby increase efficiency on the clinical wards (thereby, increasing teaching time on attending rounds), 2. To make the student's clinical reasoning available for critique and improvement, and 3. To create a feed-forward cycle, where clinical reasoning improves the oral case presentation, and each successful oral case presentation further strengthens a student's familiarity with the clinical reasoning process.

The other two lectures: The Ten Most Important Equations in Medicine, and ICU Medicine (in addition to other ad hoc lectures when a faculty member cancels) are standard knowledge-based lectures. I have to admit that these are probably the lectures I love the most, largely because I just love teaching and talking about clinical medicine. But then again, the principles espoused above apply here as well. The lectures are always physiology-based, with the goal being that while the student may enter the lecture feeling daunted by the topic, he will leave with a greater *understanding* of a topic that is now far less daunting. The goal is not to introduce new knowledge (textbooks are more effective than didactics for this goal), but rather to introduce new ways of thinking about the clinical topics, such that the knowledge seems to compress into a manageable, bite-size portion. Things really should be as simple as possible (so Occam, Einstein, and Osler would say), and my goal is to impart a method of thinking that provides understanding, and enables future problem-solving for clinical tasks not yet encountered.

Speaking of methods, you'll note in the appendix box a copy of the Tulane Intern's Manual. This is given to the students to provide one of Osler's two central components to clinical excellence: **methods** and thoroughness. I authored this book in an effort to reduce the incidence of blind memorization and algorithmic thinking (the death of free thought) on the wards. It seems right to begin an emphasis on methodical problem solving, which is quite different from following algorithms, in the third year. I made it an intern manual such that the residents and interns would be the early adopters, and therefore the disciples of the principle of method-based care as they teach the medical students. The manual is designed to be, as Malcom Gladwell put it, "sticky." It's full of non-medical features (pager numbers, hospital phone numbers, restaurant guides, social calendars, etc) that keep it in the hands of the residents, interns, and now students. The results of this book have taught me a valuable lesson about Phase IV coaching: If you really want to affect clinical performance, you have to come up with methods that maintain the intended clinical performance even when you are not present. Eventually every student of mine will leave me; I can't always be there to ensure they are performing the way I want them to perform. This book is my voice when I am not there; it has established a residency-consciousness of the importance of methods, and this has filtered down to the students in their development. It also enables large adjustments in clinical care with a very fine-tuning. As the recommendations for clinical care change, or as hospital/program policies change, we simply change the book. Case in point, as the JNC VII recommendations for hypertension changed, there was no need to have multiple lectures (with variable attendance); we simply changed the recommendations in the book. Imperceptibly, the clinical practice in our clinics adjusted accordingly.

The clinical wards can be a vast sea, especially in internal medicine where there are no boundaries for its knowledge domain. For this reason, I set aside two hours each Monday afternoon to sit in room 7150. It is an optional conference, sometimes attended by 30 students, sometimes attended by none. It is always a spontaneous discussion: whatever problems the students have on the wards, whatever did not quite make sense to them in a lecture, or perhaps a patient dilemma their team cannot decipher... this is what we discuss in this conference. I don't claim to be the best internist at Tulane, but I do think it is important to role model this feature of the internist: everything is fair game, not just the lecture material I have prepared. I try to model this feature of internal medicine by keeping this time "uncanned" and spontaneous; whatever they bring to me, I will discuss to my limits. Then I will model the action of admitting what I do not know, and I model the practice of looking it up in the medical literature. I usually ask the students to do the looking up with me; engaging in the action solidifies the lesson.

And then there is my favorite teaching (coaching) exercise: attending on the wards. I could write a book (and currently I am) about the components of great ward-based teaching. For the sake of brevity, I'll note the four most important principles.

The most important lesson in teaching on the wards is that *clinical medicine is first and foremost about the patient*. A student may pay astronomical amounts of money to attend medical school, but that does not entitle him to have the *right* to be in a patient's room; it is a privilege to be there. As an attending, I may have logged thousands of hours in medical training, but does not give me the *right* to be in a patient's room; it is a privilege to be there. And yet this lesson is increasingly being lost. I think it is a product of erroneously over-extending a correct concept from the pre-clinical years: evoking student opinion as to what would improve their educational experience. From repeatedly asking, "What do *you* want? What do *you* want?" comes the student's mentality, "Medicine is about what *I* want." While soliciting student opinion are just and valuable, over-extending the mentality leads to the assumption that students have a *right* to provide patient care, and this has created a sense of entitlement and self-righteousness. In the long run, both are disastrous to patient care. I try to offset this mentality, but it is not as easy as to bluntly tell the student "you don't have a right to be here." This would disenfranchise the student. The lesson must be learned subtly, and via actions and not words. Preserving the sanctity of the patient's room is the first step to re-focusing the student physician (including myself) on the patient. My task is to show this to students in small, subtle actions such as knocking before entering, *asking* when would be a good time to return to his room (instead of showing up when it is convenient for me), delivering all patient care opinions as *recommendations* and *not mandates*, and respecting the patient's wishes (and the patient) when he chooses not to follow my recommendations.

I teach also the importance of patient advocacy. Rhetoric will not cut it; it requires consistent role modeling for a student to learn the importance of advocating for a patient, whether that be a necessary surgery or procedure, or social work accommodations. Implicitly, I try to teach that the physician should not be too good for anything. Finding a nursing home bed for a patient is beneath my intellectual abilities, but not beneath my ethical and moral obligations to my patient. It is after all about the patient. I try to teach that medicine is not about what I personally find fun or exciting; it is about caring for my patients, in whatever way they need me to care for them.

I also teach the science of medicine, and I evoke the same principles of seeking understanding (through physiology), and growth (through evidence-based medicine) as in the other parts of my clinical teaching. I could expand about the specifics of what medical topics I teach on the wards, but it would take too much space and really it is not as important as the two lessons I try to teach noted above. Suffice to say, I believe that the noun in the phrase "humanistic doctor," or "caring doctor," or "professional doctor" is still "doctor." Students have to learn the science of the craft; a patient seen in an ICU by a "caring doctor" who does not know how to treat his acid-base disorder would have been equally well-served by going to see his "caring priest." I suspect the result would be the same. My goal on the wards is to deliver substance in addition to the intangibles. Science is taught by words and chalkboards; professionalism is taught by actions. Professionalism at its heart is professing *who you are* in what you do. The sentinel virtue is sincerity, since insincerity by definition is doing something different than whom you are. That said, sincerity is best conveyed by consistency of action. Therefore, professionalism is a product of consistent action, not words.

Year 4: Sub-Internships

The salient features of my fourth-year sub-internship teaching do not vary from that of third-year ward teaching (*vida supra*), save on key element. Medicine is about learning to make decisions; putting yourself on the line by “putting your nickel down” teaches you to assume responsibility for your actions. Once a student has assumed responsibility for his actions, he is much more likely to think about the consequences of his actions prior to making decisions. And this is a key component to the effective physician. Therefore, I push the fourth-year students a little harder during their sub-internship; I force them to make decisions, and I try to create an environment where decisions that result in adverse outcomes are ok. There is an art to this, and the art is knowing which wrong decisions will be meaningfully harmful to the patient, and which wrong decisions will be benign. In the first case, I must intervene to correct the decision before it is made; in the latter case, the student must have the latitude to learn from the mistake without overbearing intervention on my part.

Year 4: Advanced Internal Medicine

The Advanced Internal Medicine course is perhaps the favorite thing I do in my life. I devote four, month-long electives to this course. On average there are eight students that will select this elective. We spend an hour or two in the morning seeing patients together, and then two to three hours in the late afternoon sitting around a coffee-table discussing science, philosophy, history and the other humanities as they pertain to medicine. It is an Oxford model of teaching, and the discussions teach me as much about myself as I teach the students. The inspiration for many of my philosophical writings (Section 12) originate from these sessions.

Clinical Coaching Course (Teaching Teaching)

To make a big difference in the world, you must be exponential. Seeing one patient at a time with all of the correct methods will never be as powerful as training hundreds of physicians to care for their patients with all of the correct methods. This principle is the genesis of the Teaching Teaching Course (now called the **Clinical Coaching Course**) offered to fourth-year students in February. The month-long course contains many of the principle espoused above. It’s guiding principle, however, is that teaching is a performance sport. Like other performance sports (dancing, music, athletics) the skill cannot be obtained by listening to rhetoric and theory; it cannot be acquired through didactics. The skill is only developed through frequent practice. The outline of the course is attached in Section 7, though you will note that it is comprised of morning discussion groups in which the principle(s) of the day are delivered, and then afternoon teaching practice sessions in which the principle(s) of the day are refined. The back half of the course is real-time teaching, with a secondary goal of developing the ability to “shift gears” to provide content/skills appropriate to different learner levels (note the range of students being taught by the fourth-years: first-year students through residents).

There is also a hidden agenda nestled within the Clinical Coaching month. Many of the topics the student’s teach (the Clinical Problem Solving Exercise, the Preparation for the Wards Seminar) are skills important for their future performance (i.e., clinical reasoning, oral case presentations, writing good admission notes, etc.). The goal is to take advantage of **cognitive dissonance**: *if a student espouses as part of her teaching the importance of doing these skills correctly, it makes it much difficult for her to practice these skills incorrectly in her practice*. Instead of wrestling with the dissonance between what is espoused and what is done, it is easier for her to do the skills correctly. In this way,

the Clinical Coaching month is the last lesson in consolidating a long progression of teaching the key skills of clinical performance.

Internship/Residency

By now, it should be clear that the goal of my coaching strategy is to prepare students for clinical performance on the wards and in their clinics. Residency is the last opportunity to ensure optimal clinical performance prior to the physician beginning her clinical career. The work I have invested in the Tulane residency is beyond the scope of this narrative, but a few salient points are worth mentioning.

The core competencies are correct. My strategy has been to embrace the core competencies and work to empower the residents with the skills necessary not only to satisfy the ACGME, but also to create academic leaders.

Medical Knowledge

Lectures: Friday School

The teaching logs (Section 3) speak to the number of hours I have spent with medical lectures to the residents. While successful, these didactic lectures were still passive. To augment the active form of learning, the lectures in the residency were disbanded, and replaced with the Friday School Curriculum (See Section 7). The success of this curriculum (see Section 6) has been so robust, that 10 other residency programs at Tulane have made the switch to this model of education, as well as 15 other institutions nationwide.

Morning Report

I attend morning report at Charity Hospital each day. As opposed to most training programs, I do not use morning report as a venue for a mini-didactic lecture or a forum for presenting the most fascinating case on the wards. Rather, I have re-designed this conference at Tulane such that the chief resident facilitates, but does not dominate the discussion. Residents are asked, one at a time, to provide their assessment of the case (i.e., differential diagnosis and pre-test probabilities for each diagnosis) and then to clinically reason their way through the case. The session is about how the residents grapple with the case, and the emphasis is on evaluating and correcting their clinical reasoning, not upon the specific knowledge points of the case. It is active learning that drives this conference, and it is from active participation that residents retain the lessons they learn here.

Patient Care

I attend on the wards at least five months a year. My approach to attending as been discussed above (vida supra), and these same teaching principles I try to fulfill for the residents.

Interpersonal and Communication Skills

In June and July I train the residents on how to teach students the art of the oral case presentation and the admission note, and how to use clinical reasoning (Bayesian theory) to establish both. We spend about six hours together learning these skills, with the last two hours of the mini-course being devoted to how to correct common deficits in oral case presentations. We devote this time because 80% of the preceptors in Clinical Diagnosis will come from the internal medicine residency, and certainly all of the internal medicine residents will be on the front lines (on the wards) teaching students these skills. The implicit and hidden objective is that by teaching residents how to teach these skills, they internalize the principles of the skill itself. The goal is that their interpersonal and communication skills will also improve.

Professionalism

I apply the same principles of teaching professionalism (see the discussion above) in my interactions with the residents as I do with the students.

Systems of Care and Practice Based Learning

I am the primary investigator on two RWJ grants: ACT I and ACT III. Both grants are designed to teach systems of care and quality improvement as part of residency training. I restructured the residency into four firms to enable this curriculum. Each firm has a firm leader (chief resident) and a firm faculty. Each firm goes through the QI kit (Section 8 Supplement) in designing their firm's quality improvement project.

I also attend each of the monthly journal club sessions and teach the evidence-based curriculum as part of the core-curriculum series.

Residency Program in General

This section is short, but not for lack of topics upon which to comment. A full narrative about the residency program would require numerous pages. Perhaps the flow diagram at the end of this section will give you an idea of how much effort has been extended here, and how complex this task of graduate medical education really is.

I will note the time that I devote to mentoring residents in their case presentations and scholarly work. I see Tulane's Internal Medicine Residency as being a smaller part of Tulane's vision to be a nationally renowned academic center whose primary mission is develop future academic leaders. It has been a priority to get the Tulane internal medicine residents and students to national meetings so that they can see the standard for academic research, and can begin to be part of the national scientific discussion. Section 16 speaks to this mentorship and the success with which we have had. Make no mistake, each vignette accepted represents hours of work I have devoted to teaching the resident not only how to get the vignette or abstract accepted, but also the skills of scholarly research and medical writing. There are numerous other vignettes/abstracts from the internal

medicine residency not represented on this list because I did not co-author those. The list not presented is the one I am most proud of, however, since the mentors for those vignettes (i.e., the senior authors) are the senior residents I once taught how to write abstracts, who are now teaching the junior residents the same skills. This is exponential teaching.

Faculty Development/ Hospitalists

To ensure student and resident performance in their clinical care, it is important that other faculty are brought together as a team and empowered to provide similar coaching expertise. To this end, I wrote and submitted the proposal that provides 1.2 million dollars from the state each year to pay for teaching hospitalists at Charity Hospital. I am also responsible for the regular faculty development seminars that train these physicians in the education principles espoused in this portfolio.

I am responsible for the Department of Medicine's grand round curriculum, a weekly conference focusing upon clinical reasoning, state of the art standard of clinical care principles, and emerging scientific advancements.

Remediation

As my mentor one told me, "Anyone can teach the good ones... but each and every student will eventually care for the same number of lives. Caring for the struggling student is the most important thing you can do." I designed and implemented the COUGAR curriculum at UCSF in 1999, and have continued here at Tulane to the present day. COUGAR, The Curriculum to Observe Underachievers and Give Assisted Remediation has taken care of 71 struggling students or residents, and 63 of these have been fully restored to successful careers. The details of COUGAR are in Section 7.

National Education

I spend considerable time with national speaking engagements and workshops. The content in this narrative is my philosophy on medical education. I think my hypotheses are correct, but I also recognize that my approach may be incorrect; the hypotheses exist in their current form because of multiple past errors and with subsequent adjustments. And just because I believe in something does not make it true. Like all science, what is thought to be true should be held up for inspection and criticism. The national venues of APDIM, ACP, SHM, SGIM, CDIM and visiting professorships are the forum for this inspection and criticism (Section 10). This is also the driving force for my scholarship in medical education. By publishing my ideas, I happily invite criticism. It is from this criticism that the ideas are modified and thus better approximate the truth. As Mortimer Adler noted in his *Ten Philosophical Mistakes*: the primary philosophical mistake is to believe that what is true for you may not be true for me. Truth is truth, independent of our opinions about it. Only by critical analysis of hypothesis do we better approximate the truth. This applies to medical education as much as it does to bench science.

I am on the Board of Governors for the Society of Hospital Medicine (SHM) and the Board of Governors for the Association of Program Directors in Internal Medicine (APDIM). In both roles, my objective has been to seek ways to make exponential improvements in the field of medical education. There have been numerous other positions (See Section 10), all with the same goal.

XII. Section 12: Methods to Assess and Evaluate Students' Learning

Year 1 and Year 2

Evaluation of student performance is the most important thing I do as a coach. While the teacher imparts a lesson, a coach teaches and then quickly assesses whether the student has mastered the skill.

Focused Clinical Examinations (FEX)

Standardized patients are a critical component to evaluating the performance of the students in the Clinical Diagnosis course. My work with standardized patients begins with quality instruction of the standardized patients prior to the SP experiences. My approach to teaching standardized patients is the same as that with the students: I emphasize distinguishing the Tier I and Tier II exam. The challenge is in speaking to the physiology that underlies each physical examination finding to an audience that does not have the luxury of advanced physiology training. While I do speak to this, it is naturally at a basic level.

There are two key components to this method of evaluation. First, I personally watch each student (via video) perform at least one SP encounter. I watch not for the ability to perform the examination maneuver; this is the domain of the student's preceptor. Rather, I look for the way in which the student interacts with the standardized patient, especially the comfort with the patient. I devote personal and confidential remediation for students who do not demonstrate competency. Second, I do out-take sessions after each SP session (five per day) where I sit with the students and clarify any points of confusion; the seeds of confusion cannot be allowed to grow. I also do a mini-lecture that is largely predicated upon my assessment of what they have missed from my lectures as evidenced by watching (via video) their SP performance.

Clinical Problem Solving/CRAYON

Perhaps the most important skill of a physician is the ability to reason. In today's age, where information is available at the touch of a palm pilot or web browser, medical knowledge has become less important than the ability to ask the right questions. Recognizing this, I developed the Clinical Reasoning Assessment ONLY computer program. During January of their second year of training, students engage in the Clinical Problem Solving Exercise. They see and examine a "mystery" standardized patient, and then are asked to enter (using the internet-based CRAYON program) the diagnoses they were considering. Meanwhile, the standardized patient enters each question the student asked and each exam maneuver performed (also on CRAYON). The computer program matches each question and exam maneuver to the student's list of diagnoses, and generates a quality score. The more a question pertains to a diagnosis being considered (i.e., "have you had blood in your stools" for the diagnosis of colon cancer), the higher the quality score. Even if the student's list

of diagnoses was wrong (i.e., poor medical knowledge), he will receive maximal quality points if he allowed his differential diagnosis to direct his line of inquiry and examination. This is good clinical reasoning, and the CRAYON program allows us to isolate clinical reasoning ability from medical knowledge. The student also enters his orders for the treatment of the patient, as well as the laboratory tests he wishes to obtain. Each laboratory test is also cross-referenced to his differential diagnosis and a quality score is generated here as well. The CRAYON module also generates a cost score for the student's evaluation, giving the student feedback on his frugal (or wasteful) use of medical resources. Finally, the student is asked to write an admission note and return the following day to do a "post-call" attending rounds presentation to one of our mock attendings (fourth year students from the Clinical Coaching class). In sum, the exercise is a mock day on call on the wards, and it prepares the students for the tasks they will encounter in the third year while a clinical clerk (See the Section 5 Supplement for details on the CRAYON module).

SCOPE

Delia Anderson does most of the planning for the SCOPE examinations, though I provide consultation as to the cases involved and, as with the FEX sessions noted above, I watch each SCOPE videotape to ensure the students are mastering the skills.

Preceptor Experiences

The preceptor experience was traditionally the weakest component of the Physical Diagnosis course, not by design, but by lack of consistency amongst the preceptors. For this reason, I invested in building a preceptor training course, and I recruited internal medicine residents to serve as preceptors for the students. While residents may know less knowledge than faculty, they certainly have more time to spend directly observing the students, and they definitely remember what it was like to not know clinical skills. Again, this evokes the principle of cognitive dissonance- the more a resident admonishes the students to perform the examination correctly, the more likely she is to do it correctly herself. To supplement the training, I designed the Black Diamond Syllabus (Section 8 Supplement) to guide the preceptors in the instruction of the physical examination. This syllabus contains the content the students learn (clinical reasoning, physical examination) as well as useful tricks for teaching students difficult concepts as it pertains the physical examination.

Mid-term Examination

The Clinical Diagnosis Course emphasizes reasoning and understanding over memorization and facts. To be consistent, therefore, I took out the multiple-guess mid-term examination and replaced it with a two-phase essay examination (Section 5 Supplement). Phase I presents twenty short-answer questions and five clinical vignettes. Students are asked to explain their clinical reasoning for each vignette, and to identify the physical examination maneuvers they would perform based upon the differential diagnosis they generated as part of their clinical reasoning. Phase II is the same vignettes but with the examination results provided. Students are asked to design their final assessment and a plan for treating each patient in the clinical vignettes. The goal of this exercise is to consolidate the physical examination and clinical reasoning skills the student has learned during the first semester, and to begin practicing documenting their clinical reasoning in the admission note. I have to tell you,

reading 328, twenty-page essay examinations is not fun, and I suppose there is a better use for my time. But I have become proficient in using this exercise to identify which students will struggle on the wards the following year, and that makes it worth it. I meet with these students personally to begin early remediation in their clinical reasoning or communication skills.

To extend the value of this exercise, I have incorporated fourth-year students as clinical coaches. Fourth-year student volunteers are asked to read four student's examinations and provide comments. While I over-read and grade the exams, it is the fourth-year clinical coach (student) who sits down with the second-year students to review the examination. There are three benefits to this: 1. It allows person-to-person feedback for the second-year students in a small-group (i.e., safe) environment. 2. It allows the second-year students who are nervous about coming onto the clinical wards to assuage some of this fear (remember, it is fear that paralyzes performance), and 3. It re-consolidates the lessons learned in clinical diagnosis in the fourth-year student (see the discussion on cognitive dissonance above).

Shelf-examination

I use the shelf-examination as part of the course, mostly for me to evaluate where the course stands with respect to delivering knowledge to the students as compared to national norms. The grade weight for the students is large enough so that they try, but small enough so that they stay with the central message: knowledge is necessary, but not sufficient, for clinical excellence. **The shelf scores have been impressive over the past four years, with a class mean rising from the 46% (prior to taking over the course) to the 80% over the past three years (Section 6 Supplement).**

Year 3 & Year 4

Most of my evaluation of student performance is by watching their clinical reasoning as part of morning report (*videtur supra*) and by soliciting resident feedback as to their performance on the wards. Five months of the year I have the luxury of direct evaluation. During my attending months I make it a point to observe at least two full history and physical examinations performed by each student on my team. That seems passé these days, but I think it is important.

For the teaching teaching course, all students are videotaped before, during and after the month. I review each of these videotape sessions to assess their interval progress and to derive areas for improvement in their teaching.

Intern/Residency

I attend on the ward five times a year, and during this time I have the luxury of direct observation and evaluation of the interns and residents. I meet with each resident twice a year to review their evaluations, and this too is a measure of their effectiveness by proxy (from their evaluator). My primary evaluation of their performance, however, comes in reading their admission and progress

notes and by talking with their patients. I make a practice of doing this at MCLNO at least once a week. In addition, I use morning report as a venue for evaluating their clinical reasoning (vidā supra). Finally, there are the standardized tests we use to assess competency. Section 6 has a sample of the improvement in board pass rate and in-service test scores the Tulane Residency has experience over the past five years.

The Tulane Internal Medicine Residency was one of the first programs to institute patient and nurse evaluations of residents. These evaluations provide great insight into the success or failure of the teaching sessions designed to augment professionalism, communication skills and bedside manner in our young physicians ([Section 5 Supplement](#)).

XIII. Section 13: Assessment and Evaluation of Teaching Effectiveness

I evaluate my coaching effectiveness based upon the performance of my students. There are surrogates such as tests and standardized patient examinations, but the ultimate evaluation is in the student's performance in patient care. See above for methods used to assess this student performance.

As you might have guessed from the first page of this narrative (the four phases of teaching), I try to mentally keep student opinion separate from my teaching. It's difficult, because there is a balance to be struck here. I do believe student opinion is important, especially when it comes to determining how well a topic/skill has been taught (i.e., eliminating points of confusion), and I actively solicit feedback as to the effectiveness of how I have taught a topic or skill. The nice thing is that I have the luxury of being close enough to the students that this feedback usually comes directly from the student to me. However, there are some topics/skills that are not as fun as others, and there is always a risk that over-concern for teaching awards will result in abandoning these skills/topics since they are not as popular with the students. An analogy may be appropriate: if you survey a football team's players, they are apt to say they do not enjoy running wind sprints. The coach, however, knows that physical condition is important for fulfilling the team's goals and for improving each player's performance; thus, the team runs wind sprints. The coach overly concerned with the opinions of the players, however, is apt to dispense with running wind sprints in an effort to augment his popularity. As a coach, I have my agenda for what I think will make the student a great physician, and I try to stick to this agenda in deference to public opinion. The method in which this agenda is delivered, however, is always open to improvement, and student opinion, and this I actively pursue.

So what then to evaluate effectiveness of my coaching? I follow class attendance, and you will note on the teaching logs that the class attendance varies from lecture to lecture, but all numbers are accurate (i.e., they are not estimates based on class size). Almost all students attend the clinical diagnosis lectures, and this speaks to some effectiveness: people vote with their feet (100% class attendance is not a feature of the standard Tulane pre-clinical years). The ultimate measure, however, is how the students do on the clinical wards. The appendix has a recent course review where the students were surveyed ([Appendix 2.5](#)) as to how well the Clinical Diagnosis course prepared the students for their wards. Feedback from the T3/T4 clerkship directors and faculty, however, is what I primarily use in adjusting the content of the course and evaluating my effectiveness in teaching each skill.

As for the residency, well, the same standards apply. Students vote with their feet. This is not to say that I am the sole reason for coming to Tulane, but a residency program (like any organization) is largely defined by its leader. I have recognized over the years that the residency cannot be all about me, and in some large part, you could glean my teaching effectiveness by looking at the quality teachers I have recruited and maintained as part of the residency faculty (namely, the hospitalists). As the team prospers, so do I; and as a leader, I see the effectiveness of the team as commentary on my effectiveness. There is no question that the Tulane Internal Medicine Residency has never been stronger, and while the credit goes to so many people, I take personal pride in seeing it prosper. To some extent, perhaps small, but existent nonetheless, it is commentary on my effectiveness as a teacher and as a leader.

Satisfaction with teaching is one measure of success, but not the definitive measure. After all, had my football coach asked me to rate my satisfaction with running wind sprints, I would have given it a zero. Nonetheless, it was important for my development. The ultimate outcome is performance, especially as it pertains to patient care. **The Section 6 Supplement** contains evidence of the success of our team's students and residents. Highlights from the past few years of this longitudinal curriculum are listed below:

Medical Students

- The class mean for the Clinical Diagnosis Shelf examination has risen from the 46 percentile (prior to taking over the course) to the 80 percentile over the past three years

- The average NBME Step 1 score in clinical diagnosis and biostatistics has risen five points in the past five years.
- The average NBME medicine clerkship shelf score rose five points in the first two years of the clerkship curriculum, and another ten points following the institution of Tuesday School.
- All Tulane graduates seeking a career in internal medicine have matched to a residency program in their top three choices in the past five years.
- 64% of the graduates of the Clinical Coaching Course go on to win "intern teacher of the year" recognition at their respective programs.
- Forty-four Tulane students (in the past seven years of the above curriculum) have received the honor of being a "Chief Resident" at their respective residency programs around the country.
- Of the 71 students and residents who have entered the COUGAR remediation curriculum, all but 8 have finished their training with distinction.

Residents

- The residency board pass rate has risen from 82% to 97% over the past six years.
- In the past six years, a Tulane resident has presented at a regional or national scientific meeting 183 times.
- In-service scores have risen 50% over the past two years.
- The Tulane residency fills all of its positions in the NRMP match within two people per position offered, making Tulane one of the most competitive residency programs in the country (including post-Katrina).

- 100% of Tulane residents who seek fellowship training receive a fellowship training opportunity of their choosing upon completion of training.

