So again, we're recording, if you can just give permission and hit the button to be recorded. Just want to welcome everyone on behalf of the Center for Medical Education that sponsors this series. It's for those of you who might be new to us and I do think I see a few new names. It's a Friday afternoon series that happens every several weeks. It's called Yes, For Sure. It's the Yale Medical Education Series and if you are with us for the first time,
it’s a faculty development series
and the focus is on teaching
today is our 15th session.
It’s hard to believe this academic
year we’ve had sessions that range from
improving PowerPoint presentations to
improving feedback to trainer trainees,
from leading workshops to teaching
and ambulatory settings.
So we’re winding the series down.
This is our next to the last
improving feedback to trainer trainees,
from leading workshops to teaching
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improving feedback to trainer trainees,
The Yes series is Co directed by doctors Dana Dunn and Andreas Martin of the Departments of Internal Medicine and Psychiatry, respectively and both are faculty associates at the Center for Medical Education. So I’m going to turn it over now to one of these directors, Doctor Martin, who introduced today’s topic and presenter. Thank you so much, John and thank you all for being here. It’s very exciting and I’m looking forward to today’s talk. I’ll be brief and tell you just a couple
00:01:46.351 --> 00:01:48.581 of things about Doctor Jeremy Mueller.
NOTE Confidence: 0.897005996666667
00:01:48.581 --> 00:01:51.595 So the first one is that he sports
NOTE Confidence: 0.897005996666667
00:01:51.595 --> 00:01:54.125 the fanciest bow ties in the campus
NOTE Confidence: 0.897005996666667
00:01:54.125 --> 00:01:56.075 so you can identify him quickly.
NOTE Confidence: 0.897005996666667
00:01:56.080 --> 00:01:59.559 You can see two two season favorite.
NOTE Confidence: 0.897005996666667
00:01:59.560 --> 00:02:02.520 So that’s the silly one.
NOTE Confidence: 0.897005996666667
00:02:02.520 --> 00:02:04.488 The next not silly one is that he’s
NOTE Confidence: 0.897005996666667
00:02:04.488 --> 00:02:06.023 in the Department of Neurology
NOTE Confidence: 0.897005996666667
00:02:06.023 --> 00:02:08.319 where he wears a couple of cats,
NOTE Confidence: 0.897005996666667
00:02:08.320 --> 00:02:11.248 including his advice chair for education,
NOTE Confidence: 0.897005996666667
00:02:11.248 --> 00:02:13.040 which is no surprise.
NOTE Confidence: 0.897005996666667
00:02:13.040 --> 00:02:15.800 He is, as far as I can tell,
NOTE Confidence: 0.897005996666667
00:02:15.800 --> 00:02:16.360 an epileptologist.
NOTE Confidence: 0.897005996666667
00:02:16.360 --> 00:02:18.600 I was trying to see if there’s a
NOTE Confidence: 0.897005996666667
00:02:18.665 --> 00:02:20.040 certification risk but he’s
NOTE Confidence: 0.897005996666667
00:02:20.040 --> 00:02:22.406 done a lot of work in epilepsy and
that’s when I first met Jeremy, when we were both in the Medical education fellowship and he did something very fancy already was just ten years ago on how to instruct Chinese residents about. But the last thing that I’m going to say, he doesn’t even know it because it doesn’t appear in his CV, but only when was it last Thursday or something. Very recently someone came raving to me about this doctor wearing a bow tie. He was a neurologist. Did I know him? Because the care that he had provided
00:02:57.600 --> 00:03:02.280 to this gentleman, he was extraordinary.
NOTE Confidence: 0.897005996666667
00:03:02.280 --> 00:03:04.704 And that really changed the course
NOTE Confidence: 0.897005996666667
00:03:04.704 --> 00:03:06.380 of his family’s struggles.
NOTE Confidence: 0.897005996666667
00:03:06.380 --> 00:03:09.330 And my colleague was so, so grateful.
NOTE Confidence: 0.897005996666667
00:03:09.330 --> 00:03:12.504 And then I could say, well, I know him,
NOTE Confidence: 0.897005996666667
00:03:12.504 --> 00:03:15.240 you know, so that gave me like street credit.
NOTE Confidence: 0.897005996666667
00:03:15.240 --> 00:03:17.058 But I think I wanna end on that because
NOTE Confidence: 0.897005996666667
00:03:17.058 --> 00:03:19.880 in addition to he’s also Canadian.
NOTE Confidence: 0.897005996666667
00:03:19.880 --> 00:03:22.118 We won’t hold that against him.
NOTE Confidence: 0.897005996666667
00:03:22.120 --> 00:03:24.154 So, you know, we, we balance each other out.
NOTE Confidence: 0.895184081666667
00:03:26.440 --> 00:03:28.078 So I think that, you know,
NOTE Confidence: 0.895184081666667
00:03:28.080 --> 00:03:29.490 that that’s kind of an aspiration
NOTE Confidence: 0.895184081666667
00:03:29.490 --> 00:03:31.278 that we all have to be not
NOTE Confidence: 0.895184081666667
00:03:31.278 --> 00:03:32.076 just wonderful teachers,
NOTE Confidence: 0.895184081666667
00:03:32.080 --> 00:03:33.784 but to be the clinicians and
NOTE Confidence: 0.895184081666667
00:03:33.784 --> 00:03:34.920 clinicians with the heart.
So I give you the man with the heart and the bow tie. Warren, thanks so much. Hopefully everyone can hear me OK. I'm going to be using technology to talk about a topic that doesn’t have to use technology at all. Anything more than markers or a whiteboard or a chalkboard. But this is just what we do in this era. So first, I'm just going to share the screen on my iPad, do a few different things. Just give me a moment and I'll get rid of that and we’ll
open this talk and press play.

So we're going to talk about chalk talks. I'm just going to make sure that I can see the chat because I would love for this to be interactive and we just always have to have the disclosure slide. So there is no corporate support and I have no relevant conflicts of interest. I do have a disclosure, and that disclosure is that I am deeply ambivalent about PowerPoint presentations. Deeply, deeply, deeply, and something that brings me great joy, the greatest joy in my educational activities.
And I suppose getting back to this theme of heart is actually being in a room of learners talking about a case or going through some learning activities in a very informal way, using a whiteboard as our only technology. And so we’re trying to thread the needle and we’ve, I appreciate the people at the Center for Medical Education helping me with this of threading the needle to try to talk about something that’s very organic in a slightly less spontaneous way. But I think we figured it out. So here’s my slide as a chalk talk.
slide and I drew a little drawing of a brain.
NOTE Confidence: 0.83789029875
You can see why the Medical education series is called.
NOTE Confidence: 0.83789029875
Yes.
NOTE Confidence: 0.83789029875
So I made that connection and the date
NOTE Confidence: 0.83789029875
and so on and a little illustration.
NOTE Confidence: 0.904722946
Just give me one moment.
NOTE Confidence: 0.904722946
So at the Objective,
NOTE Confidence: 0.904722946
I hope we can all think about developing a plan to deliver a teaching session without any sort of additional audio visual technology markers,
NOTE Confidence: 0.904722946
maybe in a small group and talk a little bit about some best practices.
NOTE Confidence: 0.904722946
I think there’s some keys that I think...
and I look forward to sharing them. Some things I've learned and some things I've found in the literature and talk about the most engaging ways to do that. And to start, I would love for you to think for everyone here to think for a moment and you can either unmute or do it in the chat. And it's going to take me a second to switch to a whiteboard. And so I'll buy some time. But I want to you all to reflect either on your experiences teaching or your experiences learning in with this setting. You know,
broadly speaking what we say is a chalk talk and that would be anything where there aren’t any slides and it’s simply a group of learners with facilitator in a room and we’ve already got started. So I’m gonna switch here. What I said is I’m gonna switch to a whiteboard. So I’ll do that right now. And actually, just for fun afterwards, I’ll show you one of the whiteboards that I did previously.
we'll do a new whiteboard. All right. Can everyone see that? Great. So one of the things you've said is large letters. Everyone can see uncluttered. What else? Organized. I agree with that. Let's see good handwriting. I agree with that. Better with a small group. Emojis grouping topics along the top. Oh, what had just happened there? Something like shut down for a second. We can go back to it,
00:08:40.080 --> 00:08:41.732 Jeremy. I can’t get my
NOTE Confidence: 0.869974386666667
00:08:41.732 --> 00:08:43.160 chat to work, but I was
NOTE Confidence: 0.62963343
00:08:43.160 --> 00:08:44.759 gonna say spontaneous.
NOTE Confidence: 0.9625038
00:08:46.240 --> 00:08:47.920 Agreed. Spontaneous
NOTE Confidence: 0.97059447
00:08:52.040 --> 00:08:53.318 and the the the
NOTE Confidence: 0.6184831
00:08:53.320 --> 00:08:55.424 audience gets us gets to kind of
NOTE Confidence: 0.6184831
00:08:55.424 --> 00:08:59.678 see your mind at work in the moment
NOTE Confidence: 0.797295713333333
00:09:05.640 --> 00:09:10.760 and anything else short. I agree with that.
NOTE Confidence: 0.855014433333333
00:09:16.840 --> 00:09:19.600 Yeah, students participate.
NOTE Confidence: 0.93554592
00:09:26.640 --> 00:09:30.840 I agree it’s sort of real time speed.
NOTE Confidence: 0.93554592
00:09:30.840 --> 00:09:31.984 We’re working through this
NOTE Confidence: 0.93554592
00:09:31.984 --> 00:09:34.680 problem together, right.
NOTE Confidence: 0.93554592
00:09:34.680 --> 00:09:36.880 And there’s something about the
NOTE Confidence: 0.93554592
00:09:36.880 --> 00:09:38.452 way that writing sort of limits
NOTE Confidence: 0.93554592
00:09:38.452 --> 00:09:40.459 on how we write versus the pre
NOTE Confidence: 0.93554592
00:09:40.459 --> 00:09:42.265 structured slide that allows us to
00:09:42.265 --> 00:09:44.239 work through the problem together.

00:09:46.280 --> 00:09:48.268 So I'm going to show you actually

00:09:48.268 --> 00:09:49.872 that we're kind of organizing

00:09:49.872 --> 00:09:51.954 these into a few different things.

00:09:51.960 --> 00:09:59.280 So one is sort of the setting materials,

00:09:59.280 --> 00:10:01.600 you know just sort of where we are,

00:10:01.600 --> 00:10:02.851 what we're doing,

00:10:02.851 --> 00:10:04.519 what materials we're using.

00:10:04.520 --> 00:10:08.650 Some of it is about the actual

00:10:08.650 --> 00:10:10.200 topic or what is learned.

00:10:14.680 --> 00:10:16.185 And those you focused on a lot

00:10:16.185 --> 00:10:17.961 of that you know sort of what is

00:10:17.961 --> 00:10:19.759 learned and how is it’s learned.

00:10:22.520 --> 00:10:23.540 And I just you can all

00:10:23.540 --> 00:10:24.760 zoom out on the whiteboard.
I don’t know how much you can see, but you can all zoom out on the whiteboard so you see the whole thing on your screen.

I want to hear a little bit more about what the student’s responsibility or what makes it good when a student is involved in a chalk. Chalk. And then maybe a little more about the characteristics of the teacher. So any additional thoughts about that, about some of the characteristics of the teacher or the things that are under the control of the teacher and some of the characteristics of the students, both as individually in a group that
00:10:56.498 --> 00:10:58.557 might make for a more effective Choctaw?

00:11:04.440 --> 00:11:06.400 Well, you have to be prepared,

00:11:06.440 --> 00:11:09.479 obviously, right? Both, right.

00:11:10.800 --> 00:11:12.256 Have an idea of what it is

00:11:13.560 --> 00:11:18.276 to to learn and have a plan in mind.

00:11:21.400 --> 00:11:22.800 Agreed. Totally,

00:11:26.520 --> 00:11:28.888 yeah. I think this is this works really

00:11:28.888 --> 00:11:31.760 well if you’re enthusiastic about the topic

00:11:34.440 --> 00:11:37.480 and engaged. Always good to

00:11:37.480 --> 00:11:41.473 to prior knowledge also yeah,

00:11:41.473 --> 00:11:43.960 so build on prior knowledge, right.

00:11:50.560 --> 00:11:51.652 And this is where a chalk talk

00:11:51.652 --> 00:11:52.679 can be very effective too.

00:11:52.680 --> 00:11:56.045 Because the teacher can make
as Layla saying here, the teacher can make the topic relevant to the learner, right? So the teacher if they know the learner right? Or make an effort to know the learner and a chalk talk really nice for that, right? If you show up with a slide set on a topic right, then it’s hard to adjust in real time. But if you go through a case based presentation with a chalk talk or a drawing and you want to adapt, you know you start to get some feedback from the learners and
you’re like oh actually they know this really well and I don’t need to spend so much time on this or they actually need to go back a little bit more to the basics, right? You can adapt in real time. And as Ellie is saying, you know, letting the students choose the topic can really nice, nice that help that even further. And as Andres is saying, sort of not being gaze avoidance, sort of actually being engaged, right, seeking out, Drying in the expertise. So these are sort of the four main
sort of categories of things that I would think about in preparing a shock talk or thinking about it. And I think you all did a really nice job of that. So I’m just gonna stop sharing and actually go back to my screen and I’m going to go back to the PowerPoint. And I’m so grateful. You did exactly what I wanted you to do, which is really put together your experiences, your knowledge, right? We kind of illustrated a lot of the principles. I mean, say what you want about my handwriting, but I think the rest we
00:13:36.024 --> 00:13:37.236 illustrated reasonably well.
00:13:37.240 --> 00:13:40.696 And so I could have started a presentation
00:13:40.696 --> 00:13:43.000 with all of you with this slide, right.
00:13:43.000 --> 00:13:44.527 And I could even have nice animation
00:13:44.527 --> 00:13:46.039 and go through them one by one,
00:13:46.040 --> 00:13:47.240 you know, learner, teacher,
00:13:47.240 --> 00:13:49.040 material setting or something like that.
00:13:49.040 --> 00:13:51.290 And these are some things I came up with
00:13:51.290 --> 00:13:53.556 based on my experiences in the literature.
00:13:53.560 --> 00:13:54.568 And it’s fine.
00:13:54.568 --> 00:13:55.240 You know,
00:13:55.240 --> 00:13:58.237 I think all of this is valid information.
00:13:58.240 --> 00:13:59.500 I think it would be hard
00:13:59.500 --> 00:14:00.640 for you to absorb this.
00:14:00.640 --> 00:14:02.629 I think it would be hard for you to
engage with it in such a meaningful level.

And I gave you a demonstration of a very simple way to start a chalk talk, right, which is that I was prepared for the things you might say or the categories of things you might say based on my experience and knowledge of this topic. I put together a structure that I hope to get to, but I dropped. I drew as much of the material from you as possible, so we can build on that. And I think that’s a much more effective and engaging experience.
00:14:31.829 --> 00:14:34.237 than me just showing you this slide.

00:14:34.240 --> 00:14:35.998 I hope that I’ve demonstrated that

00:14:38.080 --> 00:14:41.064 and you know, I’m so grateful that you

00:14:41.064 --> 00:14:44.490 were so engaged because I think Zoom has

00:14:44.490 --> 00:14:46.680 many advantages in terms of convenience,

00:14:46.680 --> 00:14:48.020 in terms of accessibility,

00:14:48.020 --> 00:14:50.030 in terms of fitting in some

00:14:50.096 --> 00:14:51.956 learning with your busy lives.

00:14:51.960 --> 00:14:53.800 But there are tremendous temptations

00:14:53.800 --> 00:14:55.640 to engage in other ways.

00:14:55.640 --> 00:14:58.307 And one of the big takeaways with

00:14:58.307 --> 00:15:00.856 effective chalk talks is that people

00:15:00.856 --> 00:15:02.636 are relatively not distracted,

00:15:02.640 --> 00:15:06.077 engaged with the material, engaged with you.

00:15:06.080 --> 00:15:09.145 And if you saw this with nobody responding,
00:15:09.145 --> 00:15:10.795 that would be a big problem.
NOTE Confidence: 0.946479557857143
00:15:10.800 --> 00:15:11.606 And actually,
NOTE Confidence: 0.946479557857143
00:15:11.606 --> 00:15:14.024 this is reliving a prior traumatic
NOTE Confidence: 0.946479557857143
00:15:14.024 --> 00:15:16.594 experience of mine where I did a
NOTE Confidence: 0.946479557857143
00:15:16.594 --> 00:15:18.284 teaching session for residents in
NOTE Confidence: 0.946479557857143
00:15:18.357 --> 00:15:21.013 another program at 3:00 PM on a Friday
NOTE Confidence: 0.946479557857143
00:15:21.013 --> 00:15:23.560 afternoon in the midst of the pandemic.
NOTE Confidence: 0.946479557857143
00:15:23.560 --> 00:15:25.276 Absolutely the worst experience I've I've,
NOTE Confidence: 0.946479557857143
00:15:25.280 --> 00:15:26.528 I've had. And.
NOTE Confidence: 0.946479557857143
00:15:26.528 --> 00:15:29.440 And all of the cameras were off.
NOTE Confidence: 0.946479557857143
00:15:29.440 --> 00:15:30.364 Of course they were.
NOTE Confidence: 0.946479557857143
00:15:30.364 --> 00:15:31.519 They were residents at 3:00
NOTE Confidence: 0.946479557857143
00:15:31.519 --> 00:15:32.797 PM on a Friday afternoon,
NOTE Confidence: 0.946479557857143
00:15:32.800 --> 00:15:34.138 except for one person who forgot
NOTE Confidence: 0.946479557857143
00:15:34.138 --> 00:15:35.434 that their camera was still on
NOTE Confidence: 0.946479557857143
00:15:35.434 --> 00:15:36.701 and had their back to me talking
to the rest of the staff.

During the whole time, I tried to do an interactive chalk talk and it was absolute disaster. So, you know, you have to start with a hope and some anticipation that you’re going to have an engaged audience. If you don’t, you know, I don’t see much point in trying on a chalkboard for your own amusement. And I think you, you all said this, Chalk talk does not mean no preparation, right? I mean you have to be very prepared.
to deliver a good chalk talk and and
some of the things you said right.
You have to be enthusiastic
about your material.
You have to be highly knowledgeable of
the material if you have drawings or
or I don’t. I don’t know if
anybody’s had the experience of
anybody’s had the experience of
somebody working through a complex
diagram for the what seems like the
first time during a chalk talk,
and that could be a bit of a problem.
So chalk tuck does can be spontaneous,
it can be highly interactive,
but it does not mean that
there’s no preparation.
In terms of planning your session, there’s a few hints that I’ll give you and again, you can use some of these as you see fit. Of course, think about the space. If it’s a physical board, sort of plan ahead in terms of how big you’re going to write and make sure that you know your general space. If you have diagrams, make sure that you’re going to have room for labels for extra annotations that might come up. But, you know, always leave a little bit extra room around the edges.
for spontaneous circling diagrams, making connections and things like that. But if you didn’t plan ahead, you know, making some humor about the whole thing is is perfectly fine, as I’ve done here. People find that very engaging, actually. If you sort of are able to make fun of yourself because something’s not working well and actually it doesn’t hurt the learning, I don’t think. And we always have erasers if we need to. And so I am going to use some animations here, right? So if you’re planning a session, you talked, you all talked about having learners who
have some level of preparation, right, Previous experience with the material or at least some some knowledge before they start of knowing what they’re, And so you could consider sending pre or question prompts to the learners acknowledging that for medical learners, especially residents, but certainly Med students and their clerkship years, they’re very busy and they might not have time to do that. I think you all did a really good job of mentioning that,
taking some time to understand the level of the learner’s really nice. So if you develop a case prompt or a question prompt or something like that for your chalk talk, start with the learner you know, start by asking them their understanding of the topic and build from there. And again a chalk talk I think is far more effective at doing that than a straight up PowerPoint presentation. And as much as possible considering how you could leverage that learner’s experiences, always root this in the experience.
NOTE Confidence: 0.771862087
00:18:49.222 --> 00:18:50.600 of the learner themselves.
NOTE Confidence: 0.771862087
00:18:50.600 --> 00:18:52.440 I I did that at the start here,
NOTE Confidence: 0.771862087
00:18:52.440 --> 00:18:55.079 rooting this in your experiences or at
NOTE Confidence: 0.771862087
00:18:55.079 --> 00:18:57.590 least your consideration of of your your
NOTE Confidence: 0.771862087
00:18:57.590 --> 00:18:59.680 prior experiences with the chalk talk.
NOTE Confidence: 0.771862087
00:18:59.680 --> 00:19:01.270 And similarly in in clinical settings
NOTE Confidence: 0.771862087
00:19:01.270 --> 00:19:03.272 rooting it in a clinical case or
NOTE Confidence: 0.771862087
00:19:03.272 --> 00:19:04.747 calling back to somebody’s case
NOTE Confidence: 0.771862087
00:19:04.747 --> 00:19:06.594 or talking about a case they might
NOTE Confidence: 0.771862087
00:19:06.594 --> 00:19:08.390 have seen to highlight a point is
NOTE Confidence: 0.771862087
00:19:08.390 --> 00:19:10.160 always going to be very powerful.
NOTE Confidence: 0.9462458175
00:19:10.160 --> 00:19:12.600 The teacher has to understand the
NOTE Confidence: 0.9462458175
00:19:12.600 --> 00:19:13.950 material well, as I said before you
NOTE Confidence: 0.9462458175
00:19:13.950 --> 00:19:15.935 material well, as I said before you
NOTE Confidence: 0.9462458175
00:19:15.935 --> 00:19:17.897 have to understand the material better
NOTE Confidence: 0.9462458175
00:19:17.897 --> 00:19:20.063 than if you’re doing a PowerPoint
NOTE Confidence: 0.9462458175
presentation and you know it’s a little bit like doing the net, right. Get out there and smart students and residents start asking you questions and start to realize what the limits of your own expertise are. Again, you can use that right you start to leverage the expertise of the team and that can be very helpful. I’ll get back to this to practice any drawings ahead of time. Have some experience doing that. And drawing on a board is a little bit different than drawing on a piece of paper. It’s less control. The ergonomics of it are a little
bit different.

So actually, if you are doing this for the first time, practice the drawings on a board, not just on paper, and think about ways that you can buy time. For example, which is to give somebody a question for reflection while I made those technological switches using that time to ask a question using that time. To point people to a case that you might have prepared or something like that,
think about ways that you can buy time without their feeling like there’s this gap while you write or Draw Something.

I think a lot of you said, you know, short, digestible bits of material are really good. Think about prepared cases, and be really thoughtful about your ambitions with these shock talks. So when it when going in, if this is a structured chalk talk or even if it’s spontaneous, right, whatever you initially think you’re going to be able to cover in the time you have allotted, cut it in half. And one of the nice things
about a chalk talk,
about the spontaneous chalk
talk you can always add, right.
If you have a little extra time at
the end and somebody wants to have
some questions you want to add,
add to that, great.
And if it’s a more structured didactic,
if you’re going to use a chalk talk based,
case based presentation for a
clerkship lecture for example,
or one of your,
consider having a handout afterwards.
And most medical learners in my experience, are anxious perfectionists.
And anxious perfectionists benefit from the illusion of control and handouts are nice. I don’t know if people actually read them but people just like having them. It’s just like a comfortable blanket. So one thing I do for with a session is I actually ask the clerkship coordinator to e-mail the quote, answers to our cases 5 minutes after the start of the session and everybody calms down. I say something like don’t worry, all the answers are in your e-mail right now and everybody looks at...
their phone and sees that e-mail and
they just feel so much better and and
then they can relax and fully engage
then they can relax and fully engage
in it without feeling like they’re
missing something important, right.
There’s always that tension of feeling
like with a spontaneous chalk talk
because it feels more spontaneous,
because it feels more spontaneous,
that maybe it’s not as complete
or as thorough,
when in fact I would argue it’s a much more
effective way of generating understanding.
It could be a much more powerful experience
than a straight dissemination of information.
In terms of the setting,
really think about this a lot,
arrive ahead of time,
make sure the chairs are where you want them.
So one of the places I present has the board on the side,
not not at the front of the room on the side.
So I actually asked people to move around at the start so they can all see the board and stand there.
You can capture.
Judy asked can you capture the whiteboard.
So again,
my preference is real life rather than a virtual board.
But if I do a virtual board,
I’ll show you you can actually save
them on zoom and you can e-mail them or get the coordinator to e-mail them. I always let the students photograph a lot. A lot of them kind of have a Mac of what we’re doing. Yeah. I think having the students allowing the students to photograph the diagram, they really enjoy that and and I’m certainly OK with that. You know, we think about the types of information or the types of learning tasks we engage in, right?
then we move towards understanding, then analysis and then synthesis, right.

Making connections and facts are a very closed ended kind of communication, right, the dissemination of facts.

The top five reasons for new onset seizures in an elderly patient are these. They’re just facts, right?

You could look them up soon will be replaced by artificial intelligence in terms of getting these facts.

If we haven’t been already understanding analysis, synthesis,

you know, making those connections. That’s where I think is the sweet spot for the chalk talks,
and that means leaving some of the learning objectives and certainly leaving the question prompts relatively open-ended. And so in thinking about your preparation or a case prompt or some other prompt for a chalk talk, the more open-ended you leave it, the better. What’s interesting and really fun is if you do a lot of them, or if you do the same presentation year after year or month after month, you’ll notice that patterns emerge in learners because the learners often have similar responses to the same material.
In terms of facilitation,

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you know, one way is to start with the.

NOTE Confidence: 0.832706643333333

So here’s an example of a case prompt

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that I use for for a session that

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I do with the medical students.

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I allocate about 25 minutes

NOTE Confidence: 0.832706643333333

for this discussion.

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So to start with engagement,

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I asked for a volunteer to read this case.

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I’ve distributed ahead of time.

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Most people haven’t looked at that,

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which is fine.

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I’m not bothered by that at all and

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this actually is a is a real case or

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or you know with some facts changed

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for anonymity but it’s is basically
00:25:19.390 --> 00:25:22.575 a patient I’ve seen and again that
00:25:22.575 --> 00:25:25.788 adds to the authenticity and and and
00:25:25.788 --> 00:25:28.252 to the interest you know so this is
00:25:28.252 --> 00:25:30.552 a 45 year old Yale professor who
00:25:30.552 --> 00:25:33.246 had an episode of collapse and then
00:25:33.246 --> 00:25:35.210 shaking she had been feeling unwell
00:25:35.210 --> 00:25:37.570 before that with some vomiting exam
00:25:37.570 --> 00:25:41.525 and and vital signs are normal pretty
00:25:41.525 --> 00:25:43.440 unremarkable history occasional
00:25:43.440 --> 00:25:46.000 alcohol doesn’t smoke cigarettes
00:25:46.000 --> 00:25:47.840 And then I have two questions so I
00:25:47.840 --> 00:25:49.413 allocate 25 minutes for two questions
00:25:49.413 --> 00:25:51.397 and those are what are some other
00:25:51.397 --> 00:25:52.938 information that would guide can
00:25:52.938 --> 00:25:54.184 help confirm that this was a seizure
00:25:54.184 --> 00:25:54.949
and what information might guide the decision about whether or not to start an anti seizure medication.

That's it. And this is very rich, this, it's actually hard to keep this in 25 minutes. And again, you're hoping that the students have some preconceptions or previous thoughts about seizures and what they are and what's going on in this case is just enough information to think about that in the real world. And then you go from there. And so the students might start by saying,
00:26:20.440 --> 00:26:20.660 well,

00:26:20.660 --> 00:26:21.760 some other information would be

00:26:21.760 --> 00:26:23.533 if they have an aura or if they

00:26:23.533 --> 00:26:24.593 have febrile seizures or other

00:26:24.593 --> 00:26:25.720 risk factors for seizures.

00:26:25.720 --> 00:26:27.120 They might ask about that

00:26:27.120 --> 00:26:27.960 stiffness or shaking.

00:26:27.960 --> 00:26:29.199 They might ask about a tongue bite.

00:26:29.200 --> 00:26:31.516 They might ask about confusion afterwards.

00:26:31.520 --> 00:26:33.038 They might about ask about incontinence.

00:26:33.040 --> 00:26:33.208 Right.

00:26:33.208 --> 00:26:34.720 So I start just writing those on the board,

00:26:34.720 --> 00:26:36.133 just like I did with all of you, right.

00:26:36.133 --> 00:26:37.398 We just start with this.

00:26:37.400 --> 00:26:41.240 And again, probably done this session
00:26:41.240 --> 00:26:42.878 30 or 40 times at this point,
NOTE Confidence: 0.832706643333333
00:26:42.880 --> 00:26:44.680 maybe more.
NOTE Confidence: 0.832706643333333
00:26:44.680 --> 00:26:46.850 And it’s interesting it’s it’s
NOTE Confidence: 0.832706643333333
00:26:46.850 --> 00:26:50.000 very similar year to year.
NOTE Confidence: 0.832706643333333
00:26:50.000 --> 00:26:54.878 And the then I start adding some structure.
NOTE Confidence: 0.832706643333333
00:26:54.880 --> 00:26:56.560 So I planned this out.
NOTE Confidence: 0.832706643333333
00:26:56.560 --> 00:26:57.592 So I say, OK,
NOTE Confidence: 0.832706643333333
00:26:57.592 --> 00:26:59.140 what you’re talking about are things
NOTE Confidence: 0.832706643333333
00:26:59.197 --> 00:27:01.368 that might have happened before the episode,
NOTE Confidence: 0.832706643333333
00:27:01.368 --> 00:27:01.936 you know,
NOTE Confidence: 0.832706643333333
00:27:01.936 --> 00:27:03.356 the episode of the shaking,
NOTE Confidence: 0.832706643333333
00:27:03.360 --> 00:27:06.480 or things that might have happened after.
NOTE Confidence: 0.832706643333333
00:27:06.480 --> 00:27:08.720 And I think that’s a great way
NOTE Confidence: 0.832706643333333
00:27:08.720 --> 00:27:11.150 to structure this.
NOTE Confidence: 0.832706643333333
00:27:11.150 --> 00:27:13.899 So, so the way to structure this is

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to think about what happens before,
what happens during,
what happens after.
And that's going to help you remember
the types of questions you're going to
ask and the types of considerations.
And then I say, well, you know,
what else could it be?
They come up with a bilateral tonic,
clonic seizure, new new terminology.

BTC used to be GTC, but we say BTC for reasons I can get into with you and the students if you want.

And then they say syncope, you know, that could make you fall down and shake or a psychogenic attack, you know, those are the big three.

This is the synthesis piece, right? OK, how are they different, right? This is the synthesis piece, right? OK, how are they different, right?

And you start filling in well syncope, you have Lightheadedness, it could happen with the chip additional change you get pre syncopal symptoms,
it’s shorter duration,
you’ll cover more quickly afterwards.
We can elaborate on that.
Psychogenic attacks have those
different features and so on.
But you see how I’m using
the students experience,
but building out,
leveraging their experiencing and building
out a structure and making some connections.
And you notice this bottom
part about the incontinence.
This is a great point because
incontinence can be seen with both
psychogenic attacks and with syncope.
49
Sorry, I’m just going to go back to that.

And so again,

you can make these simple connections.

So this is not complex,

this is not, it doesn’t require

any particular artistic ability.

My handwriting’s just OK,

but students love it.

They really love this.

And then at the end,

sort of the metacognitive part is,

I say, this is all you know,

right?

And then we can add a few pieces and

we can make these connections and

we can elaborate and we can decide
why certain things are more or less important when taking a history or evaluating somebody with a new episode,
Right.
If you’re going to do anatomical diagrams, keep it simple. And so I’ll just demonstrate on this just one second.
So I’ve, I’ve drawn this one, I don’t know, 500 or 1000 times.
This is the horizontal gaze pathway.
So basically I can draw this in a few seconds.
This is the midbrain.
This is, this is medulla.
This is the brain stem.
And then the eyeballs are a little, hilariously bad. But people love that. And again, the idea is not to show my artistic brilliance, but actually to show how an understanding of the anatomy of the horizontal gaze pathway is attainable, right. There’s a certain I’m showing the students look, it took me. It took me 10 or 15 seconds to draw this. Then we can say, OK, where is the third nerve nucleus? Where is the 6th nerve nucleus? What do they connect to, right?
00:30:05.520 --> 00:30:07.676 And how do they control horizontal gaze,

00:30:07.680 --> 00:30:09.160 right. They talk through this.

00:30:09.160 --> 00:30:11.539 So this is a really simple diagram,

00:30:11.539 --> 00:30:13.632 but it’s much more powerful to let

00:30:13.632 --> 00:30:15.360 the students see it in real time,

00:30:15.360 --> 00:30:17.196 to see me thinking about it,

00:30:17.200 --> 00:30:18.964 to see that I don’t have any

00:30:18.964 --> 00:30:21.320 particular artistic talent.

00:30:21.320 --> 00:30:24.760 It’s attainable and it’s something

00:30:24.760 --> 00:30:29.039 that has high clinical applicability.

00:30:29.040 --> 00:30:30.076 And then, you know,

00:30:30.076 --> 00:30:31.998 you start drawing in how the vestibular

00:30:31.998 --> 00:30:33.846 input might affect that and you

NOTE Confidence: 0.96920912
00:30:33.846 --> 00:30:35.529 know what what an intranuclear
NOTE Confidence: 0.96920912
00:30:35.529 --> 00:30:37.635 ophthalmoplegia might say and so on.
NOTE Confidence: 0.96920912
00:30:37.640 --> 00:30:39.640 And let me just give you an example,
NOTE Confidence: 0.96920912
00:30:39.640 --> 00:30:41.726 just so you know that I'm not lying
NOTE Confidence: 0.96920912
00:30:41.726 --> 00:30:45.132 about this or or just showing this as
NOTE Confidence: 0.96920912
00:30:45.132 --> 00:30:47.640 something in the abstract that I never do.
NOTE Confidence: 0.96920912
00:30:47.640 --> 00:30:51.388 I'll actually show you an example of
NOTE Confidence: 0.96920912
00:30:51.388 --> 00:30:55.840 something I did with the residents
NOTE Confidence: 0.96920912
00:30:55.840 --> 00:30:57.262 for Morning Report yesterday morning.
NOTE Confidence: 0.96920912
00:30:57.262 --> 00:30:58.920 And I thought it went really
NOTE Confidence: 0.96920912
00:30:58.920 --> 00:31:02.200 well and it was very simple.
NOTE Confidence: 0.8583466855
00:31:02.200 --> 00:31:03.740 So I just pulled out my iPad
NOTE Confidence: 0.8583466855
00:31:03.740 --> 00:31:06.920 because some of the residents are
NOTE Confidence: 0.8583466855
00:31:06.920 --> 00:31:08.320 on zoom and some are in person.
NOTE Confidence: 0.8583466855
00:31:08.320 --> 00:31:10.020 Or let’s just learn loading.
NOTE Confidence: 0.9124666425
00:31:10.020 --> 00:31:17.280 I’m actually going to go back
and try that one more time.

There it is. OK, so you can see the diagram. A couple of my residents were really amused by this picture of somebody with subtle right hemiparesis in a facial drip. I drew the diagram of the horizontal gaze paresis and we worked through this together. We put together the cardinal elements of gaze that’s that’s this section over here and sort of looked at a patient video and and drew how that connected. And this took about 20 minutes. This was a 20 minute discussion showing how it’s attainable and we were able to conclude that the only sole explanation
for this patient in this clinical setting had to be a acute infarct in the medial ponds. There was really no other explanation based on our knowledge of neurotomy. So it’s a very powerful tool. You know, again, I have some expertise and some comfort in doing this, but it was very engaging and not particularly complex or sophisticated on the scale of things that you know, the complexity that we can see in neurology. And I’ll just go back to sharing my screen here. Here’s a rule I would go by,
which is that any diagram or drawing should be simple enough so that a student could recreate it from memory with a bit of practice. And I don’t know if this is hard or fast, but again, this should not be an exercise in you demonstrating your artistic brilliance, right? This is about there’s a learning activity and showing how actually when we worked through this together in real time, this is attainable information. This is this is the place you could get to. Here’s another example so you can build structure into lists.
So I made the example of the causes of new onset seizures in elderly patients and I saw in the chat the ChatGPT was able to come up with a list. Actually I wanted to look at GP TS list pretty good, pretty good. I might have put it in a different order but that's good. So there you go. We're about so you can get chat GP ChatGPT to come up with the list. This in this case is a list of causes for NI secoria. So causes for a dilated pupil on one side.
And so the students might come up with this list, right. It would be very common to say, OK, you have fixed eyelid pupil on one side. What are some of the causes and people know about uncle herniation or aneurysm or an ischemic third nerve palsy. And then you start, you form a structure around that, right? You’re right. OK, that’s the differential diagnosis of dilated pupil. Here’s how I would organize them. And so you’ve drawn it from the students, but then you start to organize.
it in the order, you know,

right, based on your expertise.

So I said, I drew these from the

students and I put them in organized.

And I’ll say, OK, yeah,

aneurysm and uncle herniation

are causes of the dilated pupil.

They’re actually much less common,

but they’re important to consider

because they can’t miss,

right.

And then we leave a space at the top,

which in my experience students

might forget about,

but it’s the most common cause and a

common cause of cancelled stroke alerts
across the hospital all the time.

Does anybody know?

And I see Ariel and maybe Claire Lambert, So they can’t answer.

No, no neurologist can answer this question.

Does anybody know most common cause for

a dilated pupil, Unilateral dilated pupil,

So a prior eye surgery.

Good thought.

Yeah.

So a prior eye surgery, I guess what I would say Shannon

would be a new dilated pupil, right.

So that’s a good point.

The common cause of NS Acorio
Beach prior eye surgery,
I'll put that in there.
But this is with the chalk talk,
so I'll put new see how I did that.
This is spontaneous.
Yeah. So Catherine nebulizer.
So I would put drugs pharmacological.
So in the inpatient setting,
you have a nebulizer right?
mask with Ipratropium, right?
Which is anergic, which is going
to cause dilation of the pupil.
The mask doesn’t quite fit,
blows a little asymmetrically into one
eye and you get a fixed dilated pupil.
There are lots of things in the world that are dilating to the eye. Scopolamine patches, they put a patch on and then rub it. Nurses doing a code and using atropine and then accidentally getting some in the eye and then fun things like gardener’s pupil, which is from what’s it called, Oh my God, I’m blanking on the name. But there’s a plant that’s sort of an endemic and actually all over Connecticut which can cause a gardener of pupil it has a
00:36:41.360 --> 00:36:42.715 strong edge of cholinergic effects.
NOTE Confidence: 0.90943556125
00:36:44.800 --> 00:36:46.640 So you see how we learned something new.
NOTE Confidence: 0.90943556125
00:36:46.640 --> 00:36:47.520 It was kind of fun.
NOTE Confidence: 0.90943556125
00:36:49.116 --> 00:36:51.020 I used your experience and then
NOTE Confidence: 0.90943556125
00:36:51.020 --> 00:36:52.474 built on it and I think this is
NOTE Confidence: 0.90943556125
00:36:52.474 --> 00:36:54.244 much more likely in this setting
NOTE Confidence: 0.90943556125
00:36:54.244 --> 00:36:55.995 using this structure for you to
NOTE Confidence: 0.90943556125
00:36:55.995 --> 00:36:57.150 remember that A cause for a new
NOTE Confidence: 0.90943556125
00:36:57.201 --> 00:36:59.154 fixed dilated pupil would be
NOTE Confidence: 0.90943556125
00:37:02.840 --> 00:37:04.552 so. As I said,
NOTE Confidence: 0.903469675
00:37:04.552 --> 00:37:07.120 it's not really about a structure,
NOTE Confidence: 0.903469675
00:37:07.120 --> 00:37:10.340 you can even go a little bit simpler.
NOTE Confidence: 0.903469675
00:37:10.340 --> 00:37:11.920 So this is another epilepsy
NOTE Confidence: 0.903469675
00:37:11.920 --> 00:37:14.080 example because as Andre says,
NOTE Confidence: 0.903469675
00:37:14.080 --> 00:37:16.920 I am an epilepsy Dr.
So this is another basically real case or could be real common enough to be real. A 17 year old girl referred to clinic after a generalized compulsive event five days ago, sleep deprived the night before, occasional twitching, usually after sleep preparation for the last two years. And this would occur while she was on the school bus in the morning along a stretch of the road where the sun would flicker through the trees. This is my artistic poetic component of the story. Medical history is unremarkable. Exams normal, developmentally normal.
CT head with normal.

This is a straight up closed ended question.

What’s the diagnosis?

Because I think this is when medical students should at least have some familiarity with.

So again, I’m not going to ask you, but this is they’re usually by halfway through clerkship probably not most of the time by June, July, it’s interesting, almost always somebody’s able to come up with this and then I say, OK, well it’s JME.
00:38:12.438 --> 00:38:12.744 Why?

And we can just start to flesh out the terms, right?

The J is because of the time of onset, not necessarily when the timer of the seizures are happening.

You could have a 50 year old with JME, but it’s the onset of the seizure.

So there’s a key point, right?

Pretty simple.

Myoclonic is because of the types of seizures that this patient has most common, the type of generalized onset seizure.

They can also have absence and bilateral tonic,
00:38:37.600 --> 00:38:39.024 clonic and photoparoxysmal response.
NOTE Confidence: 0.903469675
00:38:39.024 --> 00:38:41.160 So we can build on that.
NOTE Confidence: 0.903469675
00:38:41.160 --> 00:38:41.904 Let me say,
NOTE Confidence: 0.903469675
00:38:41.904 --> 00:38:43.392 why do they call it epilepsy?
NOTE Confidence: 0.903469675
00:38:43.400 --> 00:38:44.840 And then we get into the
diagnosis of epilepsy,
NOTE Confidence: 0.903469675
00:38:44.840 --> 00:38:45.560 the what that means and what that means
NOTE Confidence: 0.903469675
00:38:45.560 --> 00:38:47.832 is recurring unprovoked seizures.
NOTE Confidence: 0.903469675
00:38:47.832 --> 00:38:49.560 And then we could get into what
NOTE Confidence: 0.903469675
00:38:49.560 --> 00:38:51.401 unprovoked means and we,
NOTE Confidence: 0.903469675
00:38:51.401 --> 00:38:52.400 you know,
NOTE Confidence: 0.903469675
00:38:52.400 --> 00:38:55.940 we could make again another good 1520 minutes
NOTE Confidence: 0.903469675
00:38:55.940 --> 00:38:59.280 out of this just with these three words.
NOTE Confidence: 0.903469675
00:38:59.280 --> 00:39:02.040 And so it doesn’t have to be complicated.
NOTE Confidence: 0.903469675
00:39:02.040 --> 00:39:03.980 And I want to show you all that this is
NOTE Confidence: 0.903469675
00:39:04.035 --> 00:39:05.876 just a very attainable kind of thing.
In terms of wrapping up, this is where a few moments spent reminding everyone what happened really helps a lot. And sometimes you just have to remind students that they learned for them to perceive that they have learned. I'm sure you’ve all had this experience yourselves. And so what I’ll say is what we’ve done today is talked about the differential diagnosis of a new spell. And we talked about ways we can organize our thoughts.
most common generalized onset

epilepsy syndrome and young normal,

neurologically normal what young

adults and why that is and then

we talked about seizures in

And you have amazing information about

that and you now you understand it

better and you can go back to that.

Those notes whether they do or not

is not my concern but they might

that I just emailed you right.

So you were sort of reminded what

happened and and again that.

Ability to remind somebody that

this wasn’t spontaneous,
that this was planned out, that there was some thought put into this and into the students learning objectives and what they might want to know really kind of seals the deal. And so here’s an example of the handout with the answers to that first case right the BTC, the PNES and Syncope. And it has probably more information than the students would come up with in terms of that before, during, after and the three differential diagnosis. But this is, and I think you would,
I hope you would all agree that if I showed this at the start, the likelihood that students would remember one or many of these elements is much lower, much lower than if we work it through it together. And then I give them to this afterwards so that they don’t have to feel like they’ve gotten short shrift. In fact, they’ve gotten a deeper dive, and they have this to refer to in the future.
in the spirit of knowing that talking about chalk talks means that we want to be brief. I'm just going to open it up for discussion. So I'm actually going to stop my slide share and actually I'll leave this on for the moment and I hope nobody will complain about a few minutes back if you have that. But I'd love for people to reflect. So Linda, it looks like I has put in the chat has put in the in the chat and I'll stop the share. And any thoughts, comments, Sharon? Yes, that was the complaints
department slide the classic. They’re actually all on Netflix now, Monty Python’s Flying Circus. Again, medical students may or may not get that reference. The first word he goes into was the argument department been misdirected, was supposed to be the complaint. All right, Michael, thanks a lot, Jeremy. So your example was very structured and very planned out ahead. Is there a role for chalk talks to be much more spontaneous and improvisational? What do you think? I I think...
so I mean I think the person’s got to be skilled, but I don’t know I think the students really get something to see somebody’s mind at work, you know, a good clinician who can do a sort of a hypothesis driven history and physical and draw them in, draw them into it. I mean that’s something that I enjoy watching and I think students do as well. But it’s just a different flavor of a chalk talk.
a few things that are probably important in that, right.
And and hold to some of the principles, right.
This is somebody who’s expert who has some skill or facility or comfort in this type of presentation, Who’s done it before, right.
You know, you have to. Even then, I think that’s actually in some ways harder.
It can be in some ways harder, in some ways easier because there is an element of a prior experience being the preparation, right.
OK. I’ve done this one before.
I know it’s going to take me 15 minutes, right. One of those things is. So I would argue it’s not a complete lack of preparation, but maybe it’s a little bit more spontaneous. I don’t know. What do you think about that, Mike? Yeah, I think there’s probably a little bit of planning out in there subconsciously I guess. Yeah, I think there’s probably a little bit of what I will say is people are busy, and if you don’t have any structure,
unless you’re really good at this or really experienced, you’ll run into time management issues. I think a lot of people run into time management issues, which can be really tough. ‘cause that can be very disengaging too. So I like it. I like the idea of in a morning report, a little diagram about your approach to whatever problem is being presented at morning reports. Really powerful, really nice, right? And can bring people together.
some structure in it ahead of time, you know, in some way or other.

Ellie,

hi, Thank you so much.

That was a lot of fun to watch and made me want to learn all about neurology. And I’m a big proponent. I’m a big fan of cha talks, Cha talks myself. I have my little board in here, my office too.

And I try to do that as much as possible with my students and residents.
I think one of the things that I sometimes feel awkward about, and I well this is might be more of a meat problem that I need to work on on, on my own therapy at my due time. But I have an issue with other people feeling uncomfortable or making, you know, putting them on the spot. And I also know that it’s a big part of learning, right? Like the idea of pimping and quizzing Med students. And so I wonder if you had any tips with your, you know, in your experience and expertise about how
to do so in a way that’s not, you know,
awkward or uncomfortable but that’s still,
yeah, I’m gonna,
I’m gonna use the strategy that
I would use in these types of
presentations and ask you what,
what things have you noticed work better
in terms of overcoming that bearing
for me, You mean, Yeah.
Yeah. End up doing is sort
of asking the question and kind of
guiding them towards the answer
so they don’t have to sort of
fumble and feel a bit awkward.
Yeah, you know, you know,
one thing that can help is just simply being very clear about your intention and asking the question, right. So I've even said something like I'm going to ask you questions, 'cause I really am passionate about this and want you to learn and I'm not judging, but it helps me sort of meet you where you are and achieve your objectives. So I've. I have found that a very effective way to do that is to ask question prompts. But this is not a test. You know, I'll even say something like that, you know, even then, yeah.
You know, sometimes it’s a generational thing. And I’m seeing some things in the chart about comfort or discomfort. But as clear as you can be about the intentions and then how you respond to the answer, right. Is going to make all the difference, right. That can set the tone. So you know if the answer is not exactly what you were looking for and you say wrong, you’re going to kill somebody by doing that. You know you’re not going to invite further discussion if you can say.
if you know the best strategy and very effective teachers, I enviue this and I think they do it well. Find something, right. Find bridge the students answer to what they're looking for their thought and sort of make that connection right. So you can ask a a probing question, you know. Oh, that’s interesting. I wonder why, you know, tell me more about that. Right. Something very open-ended. Tell me more about what you’re thinking and maybe you’ll get them closer right to what you were thinking about.
And then you can say, I think your thought about this part is good. And then in my experience that here’s something else that you could think about it. It’s two strategies I’d love to hear if anybody else has some good ideas. But. But those are two things I do that I find very effective. I do something similar, Jamie, like, and I’ve started just doing this in the last year or so because I think that the culture of like, medical training,
there’s maybe like it’s not as intense
with the quizzing as when we went through.
So at the beginning of like,
usually usually it’s a fellow when
usually we’re talking about like goals for
the block or like what they are.
And I always tell them sort of like
this is my style, this is what I do.
But like let me know if it’s like not
working for you and I do the same thing.
I’d be very explicit.
I ask a lot of questions when we’re
talking about cases on rounds or whatever.
And I’m like, it’s never a test.
I’m never angry if you don’t know the answer.
Like I say this very explicitly, I'm not upset if you don't know, it's really a chance for to get conversation going to like, for me to like see where you're at. So if I'm like, so I'm not telling you stuff but I can like add to what you do know and then I tell them something similar to what you were saying, Jeremy. Like I that I like. I think that when you have to think through something yourself and try to
come up with the proposed you know,
answer or plan,
you’ll learn it better than when
you just like if I just tell you,
you know what I think and what the answer is.
And so I kind of explained to them that,
like,
it’s gonna be helpful for their
learning to like,
try to think through something.
If I ask them, like,
what do you think is going on here or
what do you think about this or that?
But that they’re never in trouble
if they don’t know.
And I try to put that as like a
00:49:49.145 --> 00:49:51.077 baseline so that they understand.

00:49:51.080 --> 00:49:52.136 And then I try to kind of what

00:49:52.136 --> 00:49:52.875 you were saying, too.

00:49:54.240 --> 00:49:55.479 Like if like they say something that’s

00:49:54.240 --> 00:49:55.479 not quite what I was getting at,

00:49:55.480 --> 00:49:57.044 I’ll be like, OK,

00:49:57.044 --> 00:49:58.999 like that can happen sometimes,

00:49:59.000 --> 00:49:59.760 you know, or like, oh,

00:49:59.760 --> 00:50:01.566 that’s that’s something that we see

00:50:01.566 --> 00:50:05.157 not Y syndrome that we’re talking about.

00:50:05.160 --> 00:50:08.644 And then try to like bridge it

00:50:06.280 --> 00:50:08.644 over so that they know.

00:50:08.644 --> 00:50:09.990 And I tell them like, you know,

00:50:09.990 --> 00:50:11.160 feel free to ask me questions.
It’s a give and take like.

And so that I can make it a better learning experience for you.

And how does that go for you, Shannon? I’m still learning ’cause I just started doing it over the last year.

I think overall it goes, it goes OK or well.

I think it somewhat depends on the personality of the trainee, right.

Like some of them really get that and they get really engaged, and they ask lots of questions.

I think some who are quieter, it can be a little hard to read,

you know, like, yeah,
yeah, well, you know and that’s why with the chalk talk, having a group is very helpful. You know, nobody has to talk. Some people prefer to sort of engage by listening and and I never force anybody to talk for that reason. But but at least, you know, it’s a one minute preceptor, right? You know, get it, get a commitment to then teach, you know, refine that and and teach general rules. That’s what we’re doing, right. You know it never hurts to be as explicit as possible of what but what your goal is.
I think, you know, again this is sort of the meta teaching kind of thing but I always tell people exactly what’s happening. There’s no secrets here and I tell them you know what, I just like this more. I’m sorry, I just believe it’s more effective. So bear with me. And most people see that as authentic and are OK with it. Ariel asked about engaging learners with different levels. And I actually think chalk talks, much like any other clinical case discussion,
could be great for learners of different levels, right? Because you can.

A common approach would be to seek that commitment from a more junior learner first, and then maybe even point to a more senior learner and say, hey, what do you think about this? Right.

you have to make sure there’s a safe learning environment and the senior learner’s not gonna, you know, do that negative thing of saying.

I don’t know why the junior learner
would have possibly said that, ’cause it’s ridiculous. You know, you don’t want that to happen, so there has to be some control there, but you can leverage the knowledge of the group and you know, that’s that’s another point. Maybe I didn’t emphasize enough with the chalk talk or something more spontaneous is facilitating and being part of a discussion in which learners can learn from each other just as much as they learn from me, right.
So if you start with that and allow learners to learn from each other even if they're at equal levels or if they’re at different levels, it's very powerful and it can go really well.

And on that sort of aspirational point, I think when you have different levels of learners, but they're close, you know, only a year or two apart, it really allows that junior learner to see how that knowledge might be attainable at some point, right?
Any other comments or questions?

Jeremy, using your last example, I wonder if you could I I like the idea of starting with the younger learner or the newer learner.

But I wonder if you could also do it in reverse and have the more experienced learner talk out of a case or a problem and then have the newer learners ask them questions. Or you know, have have the newer learners then reflect on what they might have learned from the discussion of the case. So that might avoid you know the risk of an older learner saying you know...
I don’t know why the newer learner said that if you do it reverse. So I don’t know. I just brainstormed up. I’m just curious of what you think I mean. No, I think what I would encourage all of you to do is to try and practice stuff. You try something, you draw a diagram and it’s just more confusing. You know or you explain something in a way that’s not clear. Right. And you’re like oh I won’t do that again the next time.
But I think that’s a valuable experience. I’ve just gotten over the fact that it’s OK, and I think that’s very different from a PowerPoint. I think you have to be much more comfortable with the idea that you might fail, that you might explain something and it’s confusing, or you might run out of time, or you might not quite have your facts straight, or a student might ask you a question that you don’t know the answer to, and you feel like you should, right.
You just have to be OK with that. But I don’t think that’s bad. I actually think that can strengthen the bond between you and a learner to be honest.

Another question I love when you have the senior or the junior learner, if it’s a case based discussion why would you have, and somebody asks another question as this is any clinical teaching, but for chalk talks works is why, Why would you have, why do you ask that question, right. So you have a case and somebody asks for more details about that case, especially if they’re more senior learner.
Why did you ask that?

What are you thinking?

You know,

something like that And that can really be very powerful and can help explain to the junior learners why a more senior experienced clinician might ask that question.

Can you see nasagmus in normal people?

Yes, but I can’t elaborate.

And then along the same lines, do you have any thoughts about employing bites like chalk talk during bedside rounds with a patient present?

I this is a totally different I actually love to the physical exam
00:55:35.238 --> 00:55:37.506 at the bedside which is a neurology
NOTE Confidence: 0.746542915714286
00:55:37.506 --> 00:55:40.028 thing I think although you can do it
NOTE Confidence: 0.746542915714286
00:55:40.028 --> 00:55:42.416 in other settings and there I think
NOTE Confidence: 0.746542915714286
00:55:42.416 --> 00:55:44.720 some strategies that’s a whole other
NOTE Confidence: 0.746542915714286
00:55:44.795 --> 00:55:48.504 talk rarely you know I have done
NOTE Confidence: 0.746542915714286
00:55:48.504 --> 00:55:51.288 drawings at the bedside for patients
NOTE Confidence: 0.746542915714286
00:55:51.288 --> 00:55:53.904 to teach patients and that can be
NOTE Confidence: 0.746542915714286
00:55:53.904 --> 00:55:55.434 very instructive for the learner.
NOTE Confidence: 0.746542915714286
00:55:55.440 --> 00:55:57.659 So a common drawing that I’ll show
NOTE Confidence: 0.746542915714286
00:55:57.659 --> 00:56:01.330 is spreading cortical depression
NOTE Confidence: 0.746542915714286
00:56:01.330 --> 00:56:02.680 with migraine to explain why a person
NOTE Confidence: 0.746542915714286
00:56:02.680 --> 00:56:04.161 and then sensory and then language
NOTE Confidence: 0.746542915714286
00:56:04.161 --> 00:56:05.908 dysfunction you know and why that wasn’t
NOTE Confidence: 0.746542915714286
00:56:05.908 --> 00:56:07.476 a stroke and why we understand that.
Well and it very reassuring for a patient to hear that and know that that’s not a stroke and that’s actually really common to have with migraine aura And I draw a little picture simple brain and you know if a learner’s there that’s great you know they can learn that too. So I guess I do that I draw diagrams for patients a fair bit I just love the speed of this. You know it’s just Andre said that I I think you’re just thinking of the speed that everybody else is and you’re just making a much deeper connection. And you know we talk about burnout.
00:56:47.410 --> 00:56:49.125 and and wanting to feel fulfilled
NOTE Confidence: 0.973769032857143
00:56:49.125 --> 00:56:50.680 in our jobs and so on.
NOTE Confidence: 0.973769032857143
00:56:50.680 --> 00:56:53.930 And I really think that this type
NOTE Confidence: 0.973769032857143
00:56:53.930 --> 00:56:56.584 of teaching and learning is for me
NOTE Confidence: 0.973769032857143
00:56:56.584 --> 00:56:58.344 very energizing and empowering and
NOTE Confidence: 0.973769032857143
00:56:58.344 --> 00:56:59.847 generally strengthens my connections
NOTE Confidence: 0.973769032857143
00:56:59.847 --> 00:57:02.211 with my learners because there’s just
NOTE Confidence: 0.973769032857143
00:57:02.211 --> 00:57:04.199 there’s no technological barrier there.
NOTE Confidence: 0.60920525
00:57:11.100 --> 00:57:12.940 You’re muted on Trace,
NOTE Confidence: 0.9451763
00:57:22.040 --> 00:57:23.640 OK. The 3rd is a charm
NOTE Confidence: 0.901906756875
00:57:23.640 --> 00:57:26.032 that as a cohort, I think that we’re
NOTE Confidence: 0.901906756875
00:57:26.032 --> 00:57:28.339 just so burned out by PowerPoint
NOTE Confidence: 0.901906756875
00:57:28.339 --> 00:57:31.120 because 90% of PowerPoint is so bad.
NOTE Confidence: 0.901906756875
00:57:31.120 --> 00:57:33.232 And it’s just refreshing to go
NOTE Confidence: 0.901906756875
00:57:33.232 --> 00:57:35.719 back to some of the comments.
NOTE Confidence: 0.901906756875
Note, go back to our roots and you know, so thank you for taking us back to our roots and the double whammy of doing it through Zoom. Wow, very, very meta, Very meta. I like doing it like, during rounds sometimes, too. Kind of like you alluded to, like, there are certain topics that come up a lot in my like, ’cause I do transplant infectious diseases. So like CMV and CMV treatment and prophylaxis comes up a lot. And like, whenever there’s a new learner, it’s almost like easier. I do it on paper, ’cause we’re usually like on the wards,
pull out a piece of paper and

let’s just take like 10 minutes and

talk about like CMV status and you know,

And that’s kind of,

I think, a nice way to like,

connect and feel like you’re throwing

some teaching into the mix too while

you’re walking around on the hospital.

We still like going to watch live music,

right? Even if we’ve heard the song before.

Something different about the experience.

Well, I think it’s time to say goodbye.

We don’t want to leave,
Jeremy, but, you know, goodbye.

So thank you for a wonderful presentation.

Bye. Thanks.