LETTERS TO THE EDITOR

To the Editor:—We read with interest the report by Smith et al.¹ describing a new instrument for evaluating teaching faculty, incorporating the changed expectations of today's teachers. Such an instrument is badly needed. Hospital rounds are not what they used to be.

A key issue in this area of research is the definition of "teaching rounds."^{2,3,4} Terms such as "ward rounds," "bedside rounds," "attending rounds," "teaching rounds," or (as in this article) "bedside work rounds" and "postcall rounds" are used without explanation. Because of the idiosyncratic nature of rounds, the same term may refer to entirely different activities.

The instrument described in this article evaluates faculty on "postcall rounds" and "bedside work rounds" (the latter to be conducted "entirely at the bedside" and "daily for the first week, then at least twice a week thereafter"). There is no description of separate "teaching rounds."

We have no comparable rounds at our institution. Faculty round 7 days a week, 50% to 75% at bedside, of which approximately two thirds is formal "teaching" (e.g., reviewing physical findings and exploring diagnostic reasoning) and the rest "work" (reviewing and modifying, if required, management decisions of the residents). We call this entity "attending rounds." "Work rounds" are a separate informal gathering run by the senior resident and devoted to details of management.

Local modifications of the authors' instrument, primarily in the "clinical supervision" component, will be needed. Some elements refer to supervisory requirements rather than teaching excellence (e.g., faculty are to "help speak with consultants and arrange tests" and "see every patient every day"). It would be useful to separate these components to enhance the instrument's generalizability.

Of note, at least 8 resident observations are required for reliability, limiting its usefulness for smaller programs or occasional rotations.

With these caveats, this instrument is a valuable step forward in educational research. We welcome the integrated approach taken by Smith et al. and agree there is no longer any plausible or desirable separation between "teaching rounds" and "work rounds." Classic rounds were a passive strategy that relied largely on faculty expertise, while today's teaching rounds combine active learning with immediate application of knowledge. We think Osler would have approved. —**Anne M. Egbert, MD, Anne D. Walling, MD, University of Kansas—Wichita, Wichita, KS.**

REFERENCES

1. **Smith CA, Varkey AB, Evans AT, Reilly BM.** Evaluating the performance of inpatient attending physicians: a new instrument for today's teaching hospitals. *J Gen Intern Med.* 2004;19:766–71.
2. **Beckman TJ.** Lessons learned from a peer review of bedside teaching. *Acad Med.* 2004;79:343–6.

3. **Irby DM.** How attending physicians make instructional decisions when conducting teaching rounds. *Acad Med.* 1992;67:630–8.

4. **Miller M, Johnson B, Greene HL, Baier M, Nowlin S.** An observational study of attending rounds. *J Gen Intern Med.* 1992;7:646–8.

In Reply:—We are glad that our recent article¹ has produced interest among other medical educators and appreciate the opportunity to respond to some of the points raised by Drs. Egbert and Walling in their letter.

They correctly point out that there are many types of "rounds" and the term is used differently at different institutions. Accreditation requirements for ACGME mandate that training programs provide 4.5 hours of teaching/week that is explicitly separated from "work rounds." Our attending physicians round at the bedside with residents every morning with the primary goals of assessing patients and clarifying management plans. Although teaching frequently occurs during these rounds it is not the main objective. The same attending physician is expected to conduct separately scheduled teaching sessions at least 3 (and hopefully more) times a week.

We respectfully disagree with Egbert and Walling's assertion that requiring 8 evaluations for acceptable reliability limits the usefulness of our instrument for smaller programs or occasional rotations. We believe that to be an effective inpatient teaching attending, a minimum of 2 months/year "on service" for inpatient wards is preferable. In most programs this should generate at least 6 to 8 evaluations.

We note with interest a recent review of assessments of clinical teachers published by Beckman et al.² that was written prior to the publication of our article. We believe that, unlike others reviewed, our instrument satisfies most of the validity and reliability criteria proposed in their article. However, in contrast to their conclusions, we continue to feel strongly that a generalizable valid assessment of clinical teachers (especially those who have dual responsibilities for patient care and resident teaching) requires an assessment of their feedback and clinical supervision skills, in addition to interpersonal and teaching skills. —**Christopher A. Smith, MD, Anita B. Varkey, MD, Arthur T. Evans, MD, MPH, Brendan M. Reilly, MD, John H Stroger Jr Hospital of Cook County (New Cook County Hospital), Chicago, IL.**

REFERENCES

1. **Smith CA, Varkey AB, Evans AT, Reilly BM.** Evaluating the performance of inpatient attending physicians: a new instrument for today's teaching hospitals. *J Gen Intern Med.* 2004;19:766–71.
2. **Beckman TJ, Ghosh AK, Cook DA, Erwin PJ, Mandrekar JN.** How reliable are assessments of clinical teaching? A review of the published instruments. *J Gen Intern Med.* 2004;19:971–7.