1. **Valuing the thought process over the answer.**

   The way to “test” students’ ability should not be the tip-of-the-tongue answers. Teacher would ask questions, and what mattered was if you were able to toss out the correct answer akin to being on Jeopardy. The problem is this leads to more trivia than the much more challenging – and much more important – process of clinical reasoning. The latter is what you really need to learn. Try to reason it out. You will be rewarded by working out the steps.

2. **Recognize different learning styles and different personalities can be effective clinicians.**

   Some people are on the quieter side. Some people are loud. Some people think before talking. Some people think by talking. Nothing here is a revelation; people have different learning styles and different personalities. No single one is fundamentally tied to being a good or a bad clinician.

   Strengths-based organizations make jobs fit around personalities and interests rather than the other way around. Medical training might want to take a similar cue, rather than trying to mold students into one concept of what a Good Student (and by extension, good future clinician) looks like.

3. **Learning is nonlinear.**

   Medical training is a lesson in graded responsibility. Start with faxing the outside records, and maybe you can work up to admitting a patient. Start with pushing the bed down the hall, and then maybe you can suture. Hold the retractor steady, and then someday you can lead the family meeting. The way to get increasing responsibility on the wards was to demonstrate some sort of competence. The problem was, sometimes the things we started on were not predictive of – or all that related to – the other activities we were interested in. After all, one can be a skilled secretary and a just okay physician, or vice versa. Learning isn’t linear; these correlations just don’t hold.
As a result, assigning graded responsibility based on these measures places arbitrary limits on what students can or cannot learn. It also overlooks backgrounds that can benefit the team (e.g., some of my classmates had PhDs or entire other careers before school). A friend once joked to me that after letting a retractor slip, she wouldn’t be allowed to do anything else of value that week. What was sad was how much truth there was to that.

4. **Forgetting what is common sense, and what should be taught.**

   Early on in my third year, a resident asked me what can be used to treat a particular type of infection. I had taken the boards a few weeks earlier, so I scanned my brain for an antibiotic that applied. I said it. **The residents laughed.** Turns out, it was technically right but practically wrong (as a very powerful antibiotic, it would never be first-line). I know this now. It was a perfect example of where book knowledge needs to be supplemented by clinical experience.

   But sometimes teachers forget this. The same goes for practical norms. Every rotation (e.g. surgery, psychiatry, ob-gyn) came with a new set of logistical expectations, and I can’t overstate how much more effective I was when my residents made these explicit. The alternative was a culture where medical students were viewed as a source of expected incompetence; the punch lines of jokes they weren’t privy to.

   One can imagine how these trends, pushed over and over, can take a toll on the outward expression of curiosity, and instead make for an army of dolts.

   Then I thought about some of my best teachers, and what made them so good. The compassionate internal medicine resident who not only served as a role model in patient interactions, but who also recognized the effects that witnessing mortality might have on students, frequently checking in on how we were doing. The anesthesia nurse who patiently taught me how to place IV’s, going over each step meticulously, and not judging or pulling the equipment from me when I did not succeed, but instead offering specific tips that enabled me to get it right the next time. The intern who gave us students full responsibility over our patients, letting us direct the conversations and treatment plans, but never absent, always sending resources and offering feedback to help us improve. And there were many more.

   What did they have in common? **Patience, they focused on what matters.** They put the patient at the center of care. They created cultures where everyone was respected, and open communication was welcome. They were enthusiastic about having students active and involved. And the educational glue: they made students feel autonomous yet supported at the same time. That’s how you learn; by doing, supplemented with regular feedback. That’s how you get better.