November 22, 2002

Roman M. Cibirka, D.D.S.
Associate Vice President for Academic Affairs
AB-202

RE: John t. Benjamin, M.D.

Dear Roman:

The Medical College of Georgia School of Medicine is pleased to nominate John T. (Jack) Benjamin, M.D., Professor of Pediatrics and teacher extraordinaire, for the 2003 Board of Regents' Teaching Excellence Award.

I believe you and your selection committee members will appreciate the exceptional and unique contributions Jack has made to enhance the education of our students and residents in the eight years we have been privileged to have him as our colleague.

The attached 20-page packet includes:

- condensed curriculum vitae (3 pages)
- reflective statement about teaching from Dr. Benjamin
- letters of support from colleagues and student (residents and medical)
- documents that provide evidence of Dr. Benjamin's extraordinary teaching

I submit Dr. Benjamin's packet with greatest pride on behalf of the School of Medicine faculty, residents, and students. He is truly a "golden apple".

Sincerely yours,

Ruth-Marie E. Fincher, M.D.
Vice Dean for Academic Affairs

c: William Kanto, M.D. Professor and Chair, Department of Pediatrics
David M. Stern, M.D., Senior Vice President for Clinical Activities
and Dean, School of Medicine

CURRICULUM VITAE

John T. Benjamin M.D.
2111 Gardner Street
Augusta, GA 30904

Education: 1958-1962: Harvard College. Degree: BA cum laude
1962-1966: Columbia College of Physicians and Surgeons. Degree: M.D.

Pediatric Training and Experience:

1966-1969: Pediatric Internship and Residency: North Carolina Memorial Hospital (NCMH); Chapel Hill, N.C.
1969-1972: Pediatrician in US Army stationed in Germany.
1972-1973: Pediatric Hematology Fellowship; NCMH, Chapel Hill, N.C.
1973-1994: Private Practice of Pediatrics: Charlottesville, VA.
1994- present: Department of Pediatrics; Medical College of Georgia:
2002: Current titles at the Medical College of Georgia:
Henri L. Charbonnier Professor of Pediatrics.
Vice-Chair for Clinical Affairs: Department of Pediatrics
Chief of Medicine: Children's Medical Center
Chief: General Section of Pediatrics and Adolescent Medicine
Director: Pediatric Resident Continuity Clinic
Director: Inpatient Service – Children's Medical Center
Director: Pediatric Laboratory Ambulatory Care

Certification: 1967: National Board of Medical Examiners
1972: American Academy of Pediatrics No. 15631
1973-1994: Licensure: The State of Virginia
1994: Licensure: The State of Georgia. Number 39286

Hospital Privileges:

1973-1994: Martha Jefferson Hospital, Charlottesville, VA
1973-1994: University of Virginia Hospital: Clinical Associate Professor
1994- present: Medical College of Georgia and University Hospital, Augusta

Hospital and School of Medicine Committees:

1982-1990: Martha Jefferson Hospital Executive Committee: Chairman: 1984-86
1986-1988: President: Martha Jefferson Hospital Medical Staff
1994-1998: Admissions Committee Medical College of Georgia
1994-2002: Faculty Senate Medical College of Georgia; executive committee
1996-2002: Medical School Promotion Committee: Chair: 2002

National Activities

1998- present: National Faculty Consultant for Bright Futures. Responsibilities: help develop curriculum for residency training.
1999-present: AAP Task Force on Pedialink: the internet home for pediatricians. Responsibilities: Help create program that focuses on the continuing professional development of each pediatrician; in charge of education and support of practicing pediatricians who will utilize this program.

Awards and Honors:

1996, 2000, 2001, 2002: Teacher of the Year: medical school classes of MCG
1996, 1999: Recipient: Appreciation Awards MCG Pediatric Residents
1997: Recipient: Teacher of the Year Award presented by Pediatric Residents
1998: Election: Alpha of Georgia Chapter of AOA (National Honor Society)
Voted by the medical school class of 1998.
1999: Elected: President-Elect: Faculty Senate - Medical College of Georgia
2000: Faculty Senate President – Medical College of Georgia
2001: Named: "Best Doctors of America" 2001-2002 for general pediatrics

Publications (49 publications; 4 chapters)
Categories of Publications:

- Hematology- Oncology (blood disorders): total of 10 articles; 3 samples:
  1. The Management of Wilms' Tumor: A Comparison of Two Regimens. John T. Benjamin, William D. Johnson and Campbell W. McMillan. Cancer 34:2122, 1974.
  2. Congenital Dyserythropoietic Anemia - Type IV. John T. Benjamin, Wendell F. Rosse, Frederick G. Dalldorf, and Campbell W. McMillan. J. Pediatr. 87:210,1975.
  3. Is Universal Screening for Lead in Children Indicated? An Analysis of Lead Results in Augusta Georgia in 1997. John T. Benjamin MD; Cheryll Platt RN. Journ of Med Assoc of Georgia 1999;88:24-27.

- Physician Office Laboratory: total of 12 articles: 5 samples:
  1. The Office Laboratory. John T. Benjamin. Chapter in Management of Pediatric Practice - American Academy of Pediatrics: Office Laboratories. 1991.
  2. Taking the Pain out of CLIA Compliance. John T. Benjamin M.D. Pediatric Management. pg. 28-34; July 1992.
  3. The Effects of CLIA '88 on the Physician Office Laboratory: A Survey of mid-sized Pediatric Practices pre and post CLIA '88. John T. Benjamin M.D. Clinical Pediatrics 1996;35 (No 3):125-128.
  4. The Physician Office Laboratory (POL) in 1997: Waiving the office lab back to life. John T. Benjamin MD. Contemporary Pediatrics 1998;15:38-54.
  5. What Tests Should You Perform in Your Office Laboratory? A Cost/Benefit Analysis of Some Frequently Used Tests. John T. Benjamin MD and Reda W. Bassali MD. Pediatric Annals 1998;27(#8):505-511.

- Infectious Diseases: total of 4 articles: 2 samples:
  1. Pharyngitis due to Group C Hemolytic Streptococci in Children. John T. Benjamin and Vito A. Perriello. J. Pediatr. 89:254,1976.
  2. Diagnosing and Treating Influenza in Children in 1999-2000. John T. Benjamin MD. Contemporary Pediatrics 2000;17:75-81.

Categories of Publications (49 publications; 4 chapters) (continued)

- Articles Written with Residents: total of 7 articles:
  1. Crunchy Peanut Butter: A Cause of Foreign Body Aspiration in Children. Jimmy Roberts MD and John T. Benjamin MD. Clinical Pediatrics 1996;35(11): 591-592.
  2. Pediatric Residents' Telephone Triage System: Good Preparation for Private Practice? John T. Benjamin MD. Archives Pediatr Adol Med 1997;151:1254-1257.
  3. A Description of the Medical College of Georgia Continuity Clinic. John T. Benjamin MD and Dawn L. Vick MD. Continuity Clinic Newsletter Volume 3 Number 2 Fall 1997.
  4. Pediatric Residents' Telephone Triage Experience: Do Parents Really Follow Telephone Advice? Jennifer D. Crane MD and John T. Benjamin MD. Arch Ped & Adolesc Med 2000;154:71-74.
  5. Abdominal Pain in a Six Year Old Child. Karyn L. Hunnicutt and John T. Benjamin MD Clinical Pediatrics 2001;40:#10:563-565.
  6. Evaluation of a Child that Can't Walk. April L. Hartman MD and John T. Benjamin MD Resident Rounds. Clinical Pediatrics 2002;41(9):731-734.
  7. Can Accurate Immunization Rates be Determined in a Tertiary Care Clinic? Kimberly M.Stroud, MD and John T. Benjamin, MD. Journal of the Medical Association of Georgia 2002;91(2):27-30.

- Education-based Articles: total of 10 articles; 7 samples:
  1. Practice Guidelines for Primary Care Pediatricians: A response. John T. Benjamin MD. Letter. Pediatrics.1996;97:604-605.
  2. The Status of Pediatric Surgical Rotations by Pediatric Residents. David A. Rogers, John T. Benjamin, Robyn M. Hatley, Charles G. Howell, Jr., and Sharon M. Beall. Journal of Pediatric Surgery 1996;31(10):1362-1363.
  3. Telemedicine: A Physician Extender in the Delivery of Primary Care. John T. Benjamin MD Va. Med Quarterly 1996;123:180-181.
  4. The Continuity Clinic Notebook: An Unfinished Story. John T. Benjamin MD. 225 pg A compilation of daily interactive talks given to residents each day prior to clinic.
  5. Increasing Recruitment Contacts between Generalist Residents at the Medical College of Georgia and Rural and Underserved Communities. Joseph Hobbs MD, Connie DuPre MD, Christopher White MD, Jack Benjamin MD, and Grace Halstead. Academic Medicine Academic Medicine 99;74(#1);S131-S132.
  6. Identifying and overcoming Impediments to Breastfeeding. John T. Benjamin MD, Habib Shariat MD. Contemporary Pediatrics 1999;16(#11):73-83.
  7. The Pediatric Office Visit: Managing Time for Health Promotion. John T. Benjamin MD, Sabrina A. Cimino BA, Henry H. Bernstein DO and the Bright Futures Health Promotion Workgroup. Contemporary Pediatrics 2002;19(#2):90-107.

On Being a Teacher
John T. Benjamin MD

I am a teacher. I discovered rather late in life that I was, and had been, a teacher most of my life. I come from a family of teachers – my mother, my wife, my daughter and my son have chosen to be teachers. Prior to realizing that I too was a teacher, I had thought about myself more as a pediatrician who enjoyed dealing with parents and their children, who was proficient at diagnosing complex medical problems, and who knew how to explain those diagnoses to children and their families.

Eight years ago, I accepted a job at the Medical College of Georgia (MCG) in the Department of Pediatrics. For the previous 21 years, I had practiced pediatrics in Charlottesville, Virginia; in the later years there I came to think that, while dealing with one patient at a time had its rewards, I wanted to broaden my horizons. I had had some interaction with medical students and pediatric residents at the University of Virginia, where I ran a clinic specializing in blood disorders of children one day a week for many years. However, I was unprepared for the joy I discovered when teaching attentive, focused, bright medical students and residents on a full-time basis. This daily activity as a faculty member at MCG has remained a joyful experience that enriches my life. I have found that my background as a general pediatrician prepared me well for my new career in teaching medical students and residents, as well as assuring proper medical care for the children.

Whether on the inpatient service (children admitted to the hospital), or in the outpatient clinic (ambulatory patients), my teaching occurs primarily at the bedside. While I do give didactic lectures to groups of students and faculty, I feel that my teaching is most effective when dealing directly with children and their parents. In my teaching, I emphasize four main areas of the patient interaction: the taking of an accurate history, the development of accurate skills in doing a physical examination including the visual examination, the necessity of residents' "taking ownership" of their patients, and the means by which students and pediatric residents can become life-long learners.

Most diagnoses in medicine are made by taking accurate histories and doing comprehensive physical examinations. Taking a proper history is an art. Many younger physicians do not ask questions properly. They are too focused on asking closed-end questions rather than open-ended questions, which help parents and children explain to the physician their major concerns. Some residents and students ask such questions intuitively, but others need to be taught this technique. I spend a lot of time giving feedback to students and residents on their manner, their approach to the patient, and their ability to discover what the parents want to tell them. In fact, as a member of the Bright Futures Workgroup (a group of pediatricians, nurses, parents, educators), I have helped create teaching modules that teaches pediatric residents the art of eliciting medical histories. This technique is equally important for pediatricians whether taking care of inpatients or outpatients.

Much of my teaching about the physical examination is based on the importance of doing an accurate, careful comprehensive physical examination. I particularly feel that the "visual examination" of the patient is critical to making a correct diagnosis. By looking closely at the patient, and determining whether the child appears well, ill, depressed, or in pain, the pediatrician will be able to understand the child's problems much more completely. For this reason, I make rounds only at the bedside – not in a conference room. When on my 3 months a year of taking care of inpatients, I emphasize the importance of the visual examination by having our entire team (myself, 2 upper level pediatric residents, 3-4 pediatric or family medicine interns, 4-5 medical students) go into a room, greet the family, and then discuss the patient outside the room. Even though patients are assigned to specific medical students and residents, I ask all the other team-members to share their visual examinations, prior to hearing the case presentation, lab data and X-Ray findings. It is quite rewarding for me to see how, over the course of a three-week rotation, students and residents improve dramatically in this essential skill. In fact, by the end of the rotation, medical students will often be able to figure out the diagnosis just by doing a careful visual examination.

Of course the physical examination includes more than the visual examination. When on the inpatient service, I give weekly physical examination sessions to the medical students and first year residents on the rotation. Over the years I practiced pediatrics, I learned many ways to elicit positive physical findings; during these sessions, I share these methods with the students. This can vary from simple things like how to hold an otoscope (instrument to look into the ears), to more complex techniques such as how to perform percussion of the lungs to diagnose pneumonia. Many former students and residents later contact me and thank me for pointing out the importance of "looking at the patient" as well as helping them become proficient in doing the other important parts of the physical examination.

In addition to teaching about taking proper histories and doing complete physical examinations, I also ask the students and residents to take responsibility for their patients. Unless emergency situations exist, whether on the inpatient or the outpatient service, I try to have them verbalize decisions on each patient interaction, and give their reasons for making those decisions. In the outpatient clinics, residents see the patient first, then come out to present to me, and give their assessment and plan. I ask the residents – even if unsure – to commit to a diagnosis and plan. I then go into the examination room with the resident, ask some open-ended and some specific follow-up questions, and then go back to the hallway with the resident for a feedback session. This commitment to a plan of action makes the residents feel wonderful when I agree with them, but also points out their weaknesses when my opinion does not agree with theirs. This ownership of the patient is, of course, easier for those in their third year of residency than it is for those in their first year, but the ability to think independently and come to a plan of action, is an essential ingredient of becoming an independent physician.

The fourth focus of my bedside teaching is to encourage the medical students and residents to become aware of what they do not know, then have them take the responsibility for looking up the answers. Self-teaching, in my opinion, is the key to life-long learning. On the inpatient service, if someone is unsure about the answers to questions that come up during rounds, I ask them to give 2-3 minute reports the next day on that subject. Similarly, with outpatients, I urge the residents to look up answers on the spot. We have textbooks and the internet available to us in the clinics and we use these resources frequently. This learner-stimulated approach to education is based on Schon's learning theory (*Educating the Reflective Practitioner.* San Francisco, CA: Jossey-Bass Publishers 1987). Schon identified different stages through which true learning develops: "reflection in action" to "reflection on action" to "learning intervention" to "enhanced care". In other words, when presented with a clinical problem that we are uncertain about, we need to ask ourselves questions (reflection-in-action), know how to go about finding out the answers to those questions (reflection-on-action); if we do that, we then can incorporate meaningful change in our practice (enhanced care). When I first read about this theory, I realized that, in private practice, I had been practicing Schon's theory my entire professional life. I am now trying to pass that method of learning on to the students and residents I teach.

The importance of this method of self-education and learning has been reinforced by my involvement with an Academy of Pediatrics initiative called Pedialink – the internet home for pediatrician. We feel that the most important part of this software program is the "Advanced Features" section, which prompts pediatricians to identify what they don't know, find the answers to their own questions, and then place it on their "bookshelf" for future reference and review. If we can learn what we do not know, find out the answers to those questions, and then incorporate them into our daily practice, we will indeed be life-long learners.

In addition to the bedside teaching, I also give daily talks to residents prior to their going to clinic. Five days a week I give an interactive talk with the 5-7 interns and residents assigned to clinic that day. Each week, I develop a one-page handout to give the housestaff at the end of this talk; a booklet now numbering 250 pages is presented to each pediatric resident at the time of graduation from the program. I arrived at the interactive format after first trying to give more didactic talks. This approach did not work - residents would come to the talks late, not be involved, and have little recall later about whatever topic was being discussed. My talks now start with a 2-3 minute introduction and always end with a summary of the pertinent facts that they should have gotten from the 30-minute experience. Just as in taking an effective history, I have found that the non-threatening approach of asking open-ended questions, encouraging dialogue, giving a few personal experiences with cases of the type being discussed usually makes for a lively learning session. Even though I give the same interactive talk each day for 5 straight days, this experience is quite different each day; each group responds in a unique way.

Over the years, I have changed my thoughts about what constitutes teaching. As a pediatrician, I must explain the facts, the proper diagnosis and the appropriate therapy to parents and children. These interactions certainly represent one type of teaching. However, I believe that, when teaching learners how to become proficient in their profession, a different kind of teaching is needed. I am very grateful to have been put in a position in which I can help students realize that, in the field of medicine where information keeps changing, they will always need to be the ones to determine what they know and what they don't know. I think I feel best about myself as a teacher when the learner states, "I am not sure of the answer to that question; I need to look it up," and then they do.

I am honored to be the Medical College of Georgia School of Medicine's nominee for the FY2003 Regents' Teaching Excellence Award.

On Being a Teacher
John T. Benjamin MD

I am a teacher. I come from a family of teachers – my mother, my wife, my daughter and my son have all chosen to be teachers. Yet, I did not realize that I too was a teacher until eight years ago, when I accepted a position in the Medical College of Georgia (MCG) as Professor of Pediatrics.

For the previous twenty-one years, I had been in the private practice of pediatrics in Charlottesville, Virginia. My patients had come from rural settings and inner city neighborhoods, as well as from privileged backgrounds. Listening to these families and explaining diagnoses and treatments to them was a type of teaching, though I did not think about it that way at the time. However, those years of patient interactions served as an important preparation for me when I made the transition from private practice to academics. Now, instead of my asking questions and giving information to families, I was teaching attentive, motivated medical students and residents how to ask the proper questions and how to communicate diagnoses and treatments effectively. In my first months at MCG, I was surprised by the joy that I felt when teaching. This daily activity remains an experience that enriches my life.

Whether on the inpatient service (children admitted to the hospital), or in the outpatient clinic (ambulatory patients), my teaching occurs primarily at the bedside. While I do give didactic lectures to groups of students and faculty, I feel that my most important teaching occurs when dealing directly with children and their parents. In my teaching, I emphasize four main areas of the patient interaction: the taking of an accurate history; the development of proficiency in doing a physical examination, including the visual examination; the necessity of residents' "taking ownership" of their patients; and the means by which students and pediatric residents can become life-long learners.

Most diagnoses in medicine are made by taking accurate histories and doing comprehensive physical examinations. Taking a proper history is an art. Many younger physicians do not know how to ask questions properly. They become too focused on asking factual questions rather than open-ended questions, which help parents and children explain to the physician their major concerns. Some residents and students ask such questions intuitively, but others need to be taught this technique. I spend a lot of time giving feedback to students and residents on their manner, their approach to the patient, and their ability to discover what the parents want to tell them. In fact, as a member of the Bright Futures Workgroup (a group of pediatricians, nurses, parents, educators), I have helped create teaching modules to teach pediatric residents the art of eliciting medical histories. This technique is equally important whether taking care of children as inpatients or outpatients.

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presentation, laboratory data or X-Ray findings. It is quite rewarding for me to see how, over the course of a three-week rotation, students and residents improve dramatically in this essential skill. In fact, by the end of the rotation, medical students will often be able to figure out the diagnosis just by doing a careful visual examination.

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The fourth focus of my bedside teaching is to encourage the medical students and residents to become aware of what they do not know, and then have them take the responsibility for looking up the answers. Self-teaching, in my opinion, is the key to life-long learning. On the inpatient service, if someone is unsure about the answers to questions that come up during rounds, I ask them to give two to three minute reports the next day on that subject. In the outpatient clinic, I urge the residents to look up answers on the spot. We have textbooks and the Internet available to us in the clinics and we use these resources frequently. This learner-stimulated approach to education is based on

Schon's learning theory (*Educating the Reflective Practitioner.* San Francisco, CA: Jossey-Bass Publishers 1987). Schon identified different stages through which true learning develops: "reflection in action" to "reflection on action" to "learning intervention" to "enhanced care". In other words, when presented with a clinical problem that we are uncertain about, we need to ask ourselves questions (reflection-in-action), know how to go about finding out the answers to those questions (reflection-on-action); if we employ such a learning intervention, we then can incorporate meaningful change in our practice (enhanced care). When I first read about this theory, I realized that, in private practice, I had been practicing Schon's theory my entire professional life. I am now trying to pass that method of learning on to the students and residents I teach.

The importance of this method of self-education and learning has been reinforced by my involvement with an Academy of Pediatrics initiative called “Pedialink,” the Internet home for pediatricians. We feel that the most important part of this software program is the "Advanced Features" section, which prompts pediatricians to identify what they don't know, find the answers to their own questions, and then place these references on their "bookshelf" for future reference and review. If we can learn what we do not know, find out the answers to those questions, and then incorporate them into our daily practice, we will indeed be life-long learners and our patients will be better served.

In addition to bedside teaching, I also give daily talks to residents at the start of our outpatient clinic. Each day, a different group of five to seven residents listen to my brief introduction to the topic for that week, and then participate in an interactive discussion. Just as in taking an effective history, I have found that the non-threatening approach of asking open-ended questions encourages dialogue. I end each talk with a summary of the pertinent facts from that day’s discussion and give each resident a one-page handout. A booklet numbering 250 pages is also presented to each resident at the time of their graduation from the residency program. (See CV: number 4: Education-Based Articles).

I am very grateful to have had the opportunity to discover my love of teaching medical students and residents. It is very rewarding to be able to teach young physicians the art of medicine. It is a privilege to help them realize that, in the field of medicine where information is always changing, they will need to be the ones to determine what they know and what they do not know and to be responsible for their own learning. I think I feel best about myself as a teacher when learners state: “I am not sure of the answer to that question; I need to look it up,” and then they do.

I am honored to be the Medical College of Georgia School of Medicine’s nominee for the FY 2003 Regents’ Teaching Excellence Award.

Ruth-Marie Fincher, MD
Vice-Dean for Academic Affairs
Academic Affairs Office, CB 1843
Augusta, GA 30912-4765

Dear Dr. Fincher:

It is an honor for me to write this letter of recommendation in support of Dr. John T. Benjamin's nomination for the 2003 Regents' Teaching Excellence Award. I have been the Director of Medical Student Education for the Department of Pediatrics since 1996, and it is in this capacity that I have been able to appreciate Dr. Benjamin's teaching contributions. I have observed him first-hand for a total of eight years.

It is no exaggeration to say that Dr. Benjamin has been the most important faculty addition to the Department of Pediatrics in the last eight years. MCG is a very clinically oriented academic medical center – our students and residents come hear to learn how to take care of patients. Dr. Benjamin's prior experience as a general pediatrician in private practice enables him to speak with great authority on a broad variety of practical pediatric issues that are critical to MCG's teaching mission. Some of the venues I have observed:

- Pediatric Morning Report is a daily conference where newly admitted pediatric patients are discussed. Dr. Benjamin is one of the faculty moderators of Morning Report, and he often leads the discussions. Under his influence and leadership, this conference has changed from a complex discussion of unusual diseases between a few subspecialty faculty to a robust discussion of clinical pediatric patients, with an emphasis on clinical diagnosis and management. He always brings out one or two take home messages for residents, students, and even faculty. Morning Report used to be sparsely attended, but now it is one of the best attended conferences of the day.
- Pediatric Resident Continuity Clinic provides pediatric residents with the opportunity to see their own panel of patients on a weekly basis (one afternoon per week). Through the process of following healthy children as well as children with chronic medical conditions, residents learn how to be a primary care pediatrician. Under his leadership, continuity clinic has become nationally recognized, not just for the clinical experience our residents receive under his guidance, but also for the teaching they receive.
- The Pediatric Outpatient Laboratory was started by Dr. Benjamin when he arrived at MCG. He is nationally recognized for his expertise in the efficient use of the laboratory in the pediatric office, and has written and spoken extensively on this topic. Residents and medical students rotate daily through this lab to learn practical issues about running an office laboratory.
- General Pediatric Inpatient Ward Attending is perhaps where Dr. Benjamin has had his greatest impact. Dr. Benjamin stands head and shoulders above the rest of the faculty for his ability to care for patients while having a profound influence on his learners. He has received the Teacher of the Year award from the pediatric residents on multiple occasions. He has also received the Teacher of the Year award several times from the MCG medical students, as well as the Educator of the Year award from the School of Medicine.

So what is it about Dr. Benjamin that has made him such a successful teacher for a variety of learners? First of all, he teaches what his learners need to know in a context that makes them see their need for the information. He frequently takes a combination of symptoms, physical signs,

and laboratory data, and challenges the residents and students in attendance to think through all the information and make some sense of it (clinical problem solving). He also helps find teaching points and important information to remember from each case. William Osler, a pioneer of medical education, said, "The natural method of teaching the student begins with the patient, continues with the patient, and ends his studies with the patient." Dr. Benjamin personifies this philosophy.

Dr. Benjamin's teaching rounds on the general inpatient service were so highly regarded by the medical students, that I decided to observe them for myself. I was so impressed that I videotaped them and have converted them to CD-ROM's. I plan on developing a workshop on "Master Teachers," and the process of Dr. Benjamin's technique of bedside teaching will be a large part of it. My observations of his teaching reveal several important transferable concepts. First of all, he has respect for everyone in the room, including patients. He gets permission from the parents (and patient if old enough) to use them for his teaching sessions. He also learns the names of all his learners. Second, Jack has his learners make a commitment and/or demonstrate a physical technique (how to hold an otoscope, how to examine the chest, etc.), instead of simply demonstrating things himself. This gets everyone very involved in the process, making them all active learners. Third, he limits the material to be covered: for instance, in a 45-minute session, he will cover only the examination of the head and neck of a child. Fourth, Jack also makes wonderful use of repetition! Many times during each session, he makes all the students and residents repeat in unison what they have learned. This sounds a little silly, but it is extremely effective. Finally, Dr. Benjamin is a master of providing feedback to his learners, which is no small task considering the cognitive abilities and the egos of most medical students and physicians. I think students and residents respond to him because they know that he cares for them and wants them to learn what he has garnered from over thirty years of pediatric experience.

Finally, on a personal note, Jack is a wonderful human being. If you could imagine the kind of pediatrician that you would want to care for your children, Jack would fit the description perfectly. He also lifts up and inspires those around him, not just to learn, but to be better people and to work harder. He is one of the finest physicians I have ever known. Over the past eight years, MCG has consistently graduated more than the national average number of physicians choosing to pursue a career in pediatrics. I believe that a large measure of this can be attributed to Dr. Benjamin's impact on individual students, as well as his influence on his colleagues. I can think of no better teacher at MCG; I strongly support his nomination for the 2003 Regents' Teaching Award Excellence Award.

Sincerely

Christopher B. White, M.D.
Professor of Pediatrics & Director
Pediatric Medical Student Education

November 23, 2002
To the FY 2003 Regents' Teaching Excellence Award Selection Committee:

The first time I met Dr. Jack Benjamin was as a junior medical student walking into his office for my first advisor-advisee meeting. The word on the wards was that he had a unique way of putting the match into perspective. The senior students said he was the best pediatric advisor. I wanted the best advisor so I sought him out early.

As he looked over my senior schedule, he encouraged my enthusiasm while gently pointing out a few deficiencies. Why not work for a month with a private pediatrician in rural Georgia? Why not research? I took his advice; this was wise. I saw forty patients a day and learned what true private practice is like. I began to understand what I wanted professionally. I also published my first paper that year. Dr. Benjamin helped me both focus and expand my horizons at the same time.

That same year, I did my sub-internship on the pediatric wards. Dr. Benjamin was my attending. He was the best teacher and attending I had ever had. Every day was filled with learning opportunities waiting to be recognized; he really knew how to bring them to light. We had physical diagnosis rounds every week in which he would focus on one part of the physical exam. He would show us, and we would practice and perfect it. These sessions started as just the few students on our service; the sessions grew as interns and students from other services heard. He also honed our observational skills. On teaching rounds prior to the presentation of a patient, the team would go into the room and simply look at the child. We were then asked to report what we saw: the age of the child, the interactions with the caregivers, any milestones observed, or any simple observation that we may had been to busy to notice during morning work rounds. Then he taught eloquently about general pediatrics from his solid fund of knowledge. He also gave feedback routinely. He would not simply say, "You're doing great." He would take each team member aside and give pertinent feedback so we could improve ourselves. In one short month, Dr. Benjamin improved my physical diagnosis skills, my observational skills, my fund of knowledge, and my confidence in my abilities.

Finally I began to interview all over the country at some of the most prestigious residency programs. Dr. Benjamin's advising sessions had prepared me well and I knew what I wanted in a program. But every place in which I interviewed I could not find the one thing that I required- a teacher like Dr. Benjamin. I stayed at the Medical College of Georgia for my pediatric residency because I knew I would learn. Under his directorship, Dr. Benjamin has built one of the best continuity clinics in the country. He gives talks to the residents every day about the things you cannot learn in the books- like tips on putting in car seats, how to put together a scientific paper, or how to evaluate a contract. These are the things that you only learn from a man that has been in the private and academic sectors. Dr. Benjamin's very unique blend of experience leads to the marriage of practical and collegiate values.

I am an intern now and Dr. Benjamin is my attending every week in continuity clinic. Just last week at the bedside he taught me how to diagnose clinical sinusitis and how to determine whether an ear infection is acute or chronic. Here is a man who was trained at Harvard and Columbia; who has authored 49 publications and 4 chapters; who has won numerous teaching awards; who was in private practice for 21 years; and he is showing me how to look in a child's ear. Dr. Benjamin never loses sight of the most important aspects of medicine: learning and teaching.

Sincerely,

Amber Gardner, MD
Department of Pediatrics PGY-1
Medical College of Georgia
706-736-2739

Evidence of Teaching Success
John T. Benjamin MD

I have enclosed a summary list of the medical students and pediatric residents that I have advised since 1995. I have personally advised or am advising thirteen pediatric residents and twenty-five medical students who have selected pediatrics as a career. As can be seen from the enclosed table, seven of eight resident advisees have chosen to go into private practice; the other is doing a fellowship in pediatric nephrology (kidney disorders of children). All of my pediatric resident advisees eligible to take their pediatric licensing boards have passed on their first examination. In order to practice pediatrics in most hospitals, physicians must pass the boards, but nationally only 80-85% pass on their first take of the examination. In addition, as can be seen on my CV, I have helped many pediatric residents with their research projects. The seven publications listed resulted from some of those interactions; I have been the faculty advisor for another eight residents with their projects as well.

All twenty-five medical students I have advised matched in their top choices of pediatric residency programs. The matching program is a computerized method to link medical students to specific pediatric programs. Pediatric residencies make up a list of their desired applicants; the applicants similarly make up a rank list of their preferred programs, and then, by a computerized system, they are "matched" with a specific institution. I spend many hours with my medical student advisees making sure their applications are made out properly, their personal statements are done well, and that their match lists are appropriate for their scholastic performances.

The major course syllabus I have collated is the 250 page "Continuity Clinic Notebook." This collection is composed of one- to two-page handouts, which I have prepared for each interactive continuity talk prior to clinic. I give the same talk five days a week to the five to seven residents who are scheduled for continuity clinic that day. I focus on well child issues the first half of each year, and sick child issues the second half of each year. I update each subject discussed every year by reviewing current literature, and by doing searches on the Internet. At the end of the three-year residency, we will have covered almost every topic in the notebook. Since residents have been so positive about these talks, then are now included as part of the daily schedule for medical students interviewing at MCG for pediatric positions.

At the end of the three-year pediatric residency, I give each resident a copy of the "Continuity Clinic Notebook." Many former residents tell me that they depend on this resource for information in their first years of practice. I have included copies of two different handouts for this packet: Body Language and the Office Visit, and Influenza: Diagnosis and Prevention.

Also included in this packet are representative evaluations by medical students and pediatric residents. I am very proud of my election to AOA by the medical students of the class of 1998, and the "Teacher of the Year" awards both students and residents have awarded me.

John T. Benjamin MD
Lists of Resident and Medical Student Advisees

Resident Advisees since 1994

Year	Name of Pediatric Resident	Current Employment
1994-1996	Garrick Bailey	Private Practice, Gainesville, GA
	Ingrid Newman	Private Practice, Athens, GA
1996-1999	Gena Bonitatibus	Private Practice, Allergy, Augusta, GA
	Kimberly Parente	Private Practice, Massachusetts
	Andrew Shulstad	Private Practice, Charlotte, NC
1999-2002	Nancy Wright	Private Practice, Las Vegas, N.M.
	Timothy Kinsey	Private Practice, Augusta, GA
	Giang Nguyen	Nephrology Fellowship, Kansas City, MO
2002-2005	Kathleen McKie	Current Pediatric Resident
	Amber Gardner	Current Pediatric Resident
	Elizabeth Fudge	Current Pediatric Resident

Medical Student Advisees: 1996-2003

Year	Name of Student	Current Position
1996	Elizabeth Bloodworth	Private Practice, Greenville, SC
	Kimberly Parente	Private Practice, Massachusetts
1997	Heather Butler	Faculty, General Section, MCG, Augusta, GA
	Lisa Leggio	Faculty, General Section, MCG, Augusta, GA
	Clay Stallworth	Private Practice, Augusta, GA
	Rose Tran	Private Practice, Augusta, GA
1998	Todd Kelly	Private Practice, Location unknown
	Melanie Henderson	Private Practice, Location unknown
	Melanie Sims	Private Practice, Cleveland, GA
	Ryan Walley	Private Practice, Birmingham, AL
1999	Jennifer Pritchard	Faculty, UVA, Charlottesville, VA
	Joel Tieder	Fellowship, Infectious Disease
	Laurie Brown	Chief Resident, UAB, Birmingham, AL
2000	Amy Canavan	Pediatric Resident, Chatanooga, Tenn
	Ross Campbell	ER Resident, Atlanta, GA
	Stephanie Walsh	Pediatric Resident, Emory
	David Roe	Pediatric Resident, Cincinatti
2001	Lori McClanahan	Pediatric Resident, MCG
	Kimbery Shanks	Pediatric Resident Wake Forest
	Steve Johnson	Pediatric Resident, Columbia, SC
2002	Heather Franks	Pediatric Resident, Wake Forest
	Elizabeth Fudge	Pediatric Resident, MCG
	Amber Gardner	Pediatric Resident MCG
2003	Jennifer Azbell	4th year medical student MCG
	Douglas Atkinson	4th year medical student MCG
	Joanna Chandler	4th year medical student MCG