Things to Think About

The "4" or Extraordinary

"My administrator told us we should not expect to get "4's" very often. I think we should always be aiming for the top in hopes we can get all "4's." What if I told my students they could never get an "A"?

The Evaluate Davis observation rating scale is <u>not</u> meant to be equivalent to a 4.0 GPA grading scale – in other words, a "4" or "Extraordinary " rating is not an "A". It is above and beyond an "A." Think about the following:

We know that as educators, we have an automatic response to anything with a 1-4 rating system and liken it to the 4.0 GPA system typically used in most secondary schools.

In planning meetings and focus groups, our teachers asked for a category that reflected "above and beyond" performance. They indicated that they hoped the evaluation system would give recognition to those times they created "a moment", a time when the observer would see a really incredible, extraordinary strategy or high level of performance on an indicator rarely seen implemented.

Although we often think of a rating scale as analogous to the A, B, C, D grading scale, ours is somewhat different. It is based on a 3 point system with a "3" or "evident" being what we typically would consider an "A" grade. That means it is evident and effective.

But, a "4" or Extraordinary is a special pat on the back your observer gives you for doing something, well, extraordinary. Amazing, astonishing, exceptional, wonderful, remarkable – these are all synonyms for extraordinary.

Because the "4" or "extraordinary is so special, we do ask that administrators not give them out to everyone all the time – that would dilute the importance of getting this special rating.

An Example of Extraordinary

An excerpt from: **Atul Gawande** (2007), *Better*: A Surgeon's Notes on Performance

Several years ago, in my final year of medical school, I took care of a patient who has stuck in my mind. I was on an internal medicine rotation, my last rotation before graduating. The senior resident had assigned me primary responsibility for three or four patients. One was a wrinkled, seventy-something-year old Portuguese woman who had been admitted because – I'll use the technical term here – she didn't feel too good. Her body ached. She had become tired all the time. She had a cough. She had no fever. Her pulse and blood pressure were fine. But some laboratory tests revealed her white blood cell count was abnormally high. A chest X-ray showed a possible pneumonia – maybe it was, maybe it wasn't. So her internist admitted her to the hospital, and now she was under my care. I took sputum and blood cultures and, following the internist's instructions, started her on an antibiotic for this possible pneumonia. I went to see her twice each day for the next several days. I checked her vital signs, listened to her lungs, looked up her labs. Each day, she stayed more or less the same. She had a cough. She had no fever. She just didn't feel good. We'd give her antibiotics and wait her out, I figured. She'd be fine.

One morning on seven o'clock rounds, she complained of insomnia and having sweats overnight. We checked the vitals sheets. She still had no fever. Her blood pressure was normal. Her heart rate was running maybe slightly faster than before. But that was all. Keep a close eye on her, the senior resident told me. Of course, I said, though nothing we'd seen seemed remarkably different from previous mornings. I made a silent plan to see her at midday, around lunchtime. The senior resident, however, went back to check on her himself twice that morning.

It is this little act that I have often thought about since. It was a small thing, a tiny act of conscientiousness. He had seen something about her that worried him. He had also taken the measure of me on morning rounds. And what he saw was a fourth-year student, with a residency spot already lined up in general surgery, on his last rotation of medical school. Did he trust me? No, he did not. So he checked on her himself.

That was not a two-second matter, either. She was up on the fourteenth floor of the hospital. Our morning teaching conferences, the cafeteria, all the other places we had to be that day were on the bottom two floors. The elevators were notoriously slow. The senior resident was supposed to run one of those teaching conferences. He could have waited for a nurse to let him know if a problem arose, as most doctors would. He could have told a junior resident to see the patient. But he didn't. He made himself go up.

The first time he did, he found she had a fever of 102 degrees and needed the oxygen flow through her nasal prongs increased. The second time, he found her blood pressure had dropped and the nurses had switched her oxygen to a face mask, and he transferred her to the intensive care unit. By the time I had a clue about what was going on, he already had her under treatment – with new antibiotics, intravenous fluids, medications to support her blood pressure—for what was developing into septic shock from a resistant, fulminant pneumonia. Because he checked on her, she survived. Indeed, because he did, her course was beautiful. She never needed to be put on a ventilator. The fevers stopped in twenty-four hours. She got home in three days.

*"It is fine to do what is required and expected and even, efficient and effective. It is quite another thing to know when and how to go beyond that and do **something** that changes **everything**."*