



Online article and related content  
current as of September 21, 2009.

## The Art of Pimping

Allan S. Detsky

*JAMA*. 2009;301(13):1379-1381 (doi:10.1001/jama.2009.247)

<http://jama.ama-assn.org/cgi/content/full/301/13/1379>

### Correction

Correction is appended to this PDF and also available at  
<http://jama.ama-assn.org/cgi/content/full/jama;301/17/1770>  
Contact me if this article is corrected.

### Citations

This article has been cited 2 times.  
Contact me when this article is cited.

### Topic collections

Medical Practice; Medical Education  
Contact me when new articles are published in these topic areas.

### Related Letters

Pümpfrage Redivivus  
Brandon Stone et al. *JAMA*. 2009;302(6):626.

### Subscribe

<http://jama.com/subscribe>

### Permissions

[permissions@ama-assn.org](mailto:permissions@ama-assn.org)  
<http://pubs.ama-assn.org/misc/permissions.dtl>

### Email Alerts

<http://jamaarchives.com/alerts>

### Reprints/E-prints

[reprints@ama-assn.org](mailto:reprints@ama-assn.org)

# The Art of Pimping

Allan S. Detsky, MD, PhD

**T**HE TERM “PIMPING” WAS POPULARIZED BY BRANCATI<sup>1</sup> in 1989. As he defined it, pimping occurs when an attending physician (the Pimper) poses a series of difficult questions to a resident or medical student (the Pimpee). Pimping usually occurs in settings such as “morning report” or “attending rounds,” in which trainees at various levels convene with a faculty member to review patients currently under their care. Among surgeons, pimping may occur when students and residents are a captive audience observing a patient undergoing an operation. Brancati<sup>1</sup> described the origins of the term, which date back to 17th-century London. Koch’s series of “Pümpfrage” (pimp questions) were used on his rounds in the 19th century. The practice migrated to North America in the 20th century and was documented by Flexner while observing Osler making rounds at Johns Hopkins. Brancati<sup>1</sup> outlined suggestions for attending physicians to further hone their pimping skills and methods for students to defend themselves from it. He posited that the art of pimping would disappear in the future with increased specialization and educational reorganization. This Commentary revisits the art of pimping 20 years later and provides an update for faculty members and students alike on modern methods in this important skill.

Pimping is indeed alive and well within academic medicine for several reasons. First, the basic structure of medical teaching has not changed. Ross and Detsky<sup>2</sup> have described the teaching services at 2 academic hospitals on both sides of the Canada/US border. Students and residents still work up patients and report to attending physicians as much in 2009 as they did in the last half of the 20th century. Faculty still meet with small- to medium-sized groups of medical students and residents and use interactive methods that somewhat resemble Socratic techniques. Second, the power relationship between teacher and student still exists and likely always will, because the teacher has more content knowledge and is responsible for evaluating the students. Pimping reinforces that power relationship because the teacher usually controls the questions. The teacher likely knows the answers while the students may or may not. A historical example of the effect of this phenomenon was described by

Ausiello in a brief biography of Their.<sup>3</sup> When Their was chair of medicine at Yale, a resident once fainted from anxiety prior to a case presentation. This experience resulted in giving Thier the nickname “Syncope Sam.” The third reason pimping has flourished is the explosive expansion of the knowledge base in clinical medicine.

## Advice for Students (the Pimpees)

Clinical teaching sessions often involve direct questioning of individual students in the presence of their peers. This differs from most examinations in which the student’s knowledge base is not on public display. In some cases, participants volunteer answers. More often, the faculty member selects 1 or more of the participants to respond. If the first student cannot correctly answer, another student is chosen, and so on until someone answers the question correctly. If no one answers the question correctly, the attending does (assuming he or she knows the answer). If not, a student is usually assigned to investigate the question and report back the next day. Some students thrive on displaying their knowledge (or lack thereof) in public, others do not.

For students, there are several techniques to protect against being pimped (BOX).

Conversely, some students actually prefer that the attending physician directs questions to them. Techniques to achieve this goal include raising the hand or eyebrows, making eye contact, sitting upright, sitting directly in the sight line of the teacher, raising and flailing the right arm, and if all else fails, blurting out the answer without being asked. However, other participants probably will find these methods irritating. Students who feel they are annoying their peers by displaying too much knowledge should place themselves in a position in the room where only the attending can see their face. For those who want the attending physician to ask about an attractive attribute of themselves, students are advised to give a visual clue (such as wearing an Oxford tie if they were a Rhodes Scholar).

**Author Affiliations:** Departments of Health Policy Management and Evaluation, and Medicine, University of Toronto; Department of Medicine, Mount Sinai Hospital, and University Health Network, Toronto, Ontario, Canada.

**Corresponding Author:** Allan S. Detsky, MD, PhD, Mount Sinai Hospital, 600 University Ave, Ste 427, Toronto, ON M5G 1X5, Canada (adetsky@mtsina.on.ca).

### Box. Pimping Protection Procedures

#### Avoidance

Do not have visual contact with the teacher. There are several variations of this technique including (1) “eclipse” (make sure that another person’s head is always in the direct sight line between student and teacher); (2) “camouflage” (the student sits very still, hoping the attending does not notice him or her); and (3) “meditation” (the student lowers his or her head, leans slightly forward and puts the palms of the hands together).

#### The Muffin

This technique is particularly useful for senior residents who are fearful that the attending physician will embarrass them with a question they should be able to answer but cannot. The resident holds a large muffin in the dominant hand with the elbow flexed, and slowly makes motions with the elbow that move the muffin toward and away from the mouth, somewhat like the graphical lines representing the attitudes of focus group members used by television networks while watching the recent presidential debates (ie, closer to the mouth if the resident does not know the answer, further if he or she does). If the resident feels that the teacher will call on him or her to answer a question to which he or she cannot respond, the muffin should be placed into the mouth. Most attendings will not ask residents or students to speak with their mouth full of food. If the attending does, the resident should pretend to choke, thus avoiding all future questions.

#### The Hostile Response

If a student is singled out to answer and is embarrassed because he or she cannot, the student should be sure to respond in a hostile fashion, both with the tone of voice and body language. Most teachers will refrain from asking that student questions in the future. An answer that always works is “I don’t know,” with a 1-second pause between each successively louder spoken word.

#### The List

If a list of answers is being compiled from several students (eg, what are the life-threatening causes of chest pain?) and the student does not have one, the student should just repeat the response given by a previous respondent and pretend he or she

did not hear it. This is particularly effective if the student holds the patient list in front of him or her and looks like he or she is preoccupied with patient care responsibilities. The student or resident can amplify the sympathy by constantly checking his or her pager. (Who can blame anyone who puts patients first?)

#### Honorable Surrender

Tell the teacher you are uncomfortable. Few students try this, but sometimes the direct approach is best. Those who are uncomfortable being put on the spot in public should just say so. This can be done in the presence of the group or in private after the teaching session.

#### Pimp Back

The student or resident should find a knowledge area in which he or she has a comparative advantage over the teacher and turn the tables on him or her. In the era of increased subspecialization in which the teacher may not be familiar with the patient presented, this is not as difficult as it sounds. However, pimpers usually do not like to be pimped so be careful.

#### The Politician’s Approach

Do not answer the question that the attending asked but talk straight to the audience (ie, ignore the pimper) by answering a question you would have preferred being asked. This is even more effective if combined with pimping back (see previous procedure).

#### Use PDA (personal digital assistant)

Modern students have an advantage: instant electronic mobile devices that, if used properly, can provide the answers in “real time.” Pimpers might avoid students with visible PDAs because they know these students can pimp back.

#### Do Not Sulk/Cry

Students who answer incorrectly should not become overly discouraged. Attendings rarely remember students who give wrong answers (especially to difficult questions); they often remember those who lose their composure.

### Advice for Attending Physicians, Faculty, Teachers, or (the Preferred Term) “Professors” (the Pimpers)

There is proper etiquette that should be followed in teaching sessions that keep the good will of all participants.

1. Respect educational order. Never ask a medical student to respond to a question after a resident has answered incorrectly. One way to avoid this faux pas: always start at the bottom of the educational chain and move serially up a level if no one at the first level has a correct answer (ie, third-year students before fourth-year students, before interns, before residents). There is an important corollary for the junior residents and medical students: do not break ranks by

showing up the senior resident on the team (or the junior resident or student’s next admission may be a very difficult patient).

2. Do not embarrass other attending physicians. Never call on other attending physicians who are present unless you are sure they know the answer. Conversely, if a topic arises for which others know more than you, ask them to make comments so you do not embarrass yourself by saying something wrong (and having them point it out).

3. Look for the eclipser, camouflageur, meditator, or muffin eater and use opportunities to comfortably draw them into the conversation. These include asking them the easiest possible questions so that they are less stressed. Use

humor to acknowledge that this form of teaching can be intimidating and state that your expectations are low (ie, the question is difficult and you do not expect any of the medical students to answer correctly).

4. The public apology. If you say something wrong or embarrass a student, use the next opportunity to publicly apologize. A teacher apologizing to a student always goes over well.

5. Find an opportunity to provide praise, either in a public fashion (eg, a round of applause for a student for an especially good presentation) or privately. A compliment from the attending physician can be very powerful for the student or resident.

### Pimping in Perspective

This Commentary has refreshed some of the advice on pimping based on the author's experiences in thousands of morning reports and attending rounds in general internal medicine over 26 years. How does this advice differ from that offered by Brancati?<sup>1</sup> For the student, it is similar in tone but perhaps expands the arsenal of protective weapons. For the faculty member, it offers methods for mitigating the consequences of defeat (or humiliation) for participants when answers are incorrect. Perhaps this means attending physicians have "gone soft" in 20 years or simply have buried their arrogance and become more interested in explaining how they think.

Students and teachers should recognize that the small group interactive method of clinical teaching is aimed at imparting important knowledge in the right context and in a

memorable fashion. Throughout history, pimping has been viewed as a "sport" aimed at reinforcing the teacher's position of power. The unspoken truth is that these teaching methods reinforce the pecking order from student to intern to resident to staff. Everyone in the room wants to appear smarter than their own level peers and as smart as those above them, with the faculty seemingly "taking notes" all the time.

However, a more modern perspective is that the purpose of pimping is to increase retention of the key teaching points by being provocative. Most students recall these sessions very well. It is important that students remember both the material and the method, not just the method. For teachers, finding the right balance between humiliating the student who gives incorrect answers, and boring the audience by simply providing the answers is a real skill. The lesson is to not take pimping too seriously and remember that often more can be learned from incorrect answers than from correct ones. Unlike Brancati,<sup>1</sup> this author has no fears that this art will disappear but, like him, hopes that these tips will help it flourish.

**Additional Contributions:** The author thanks Andrew Smaggus, MD, Eric Venos, and Michael Detsky, MD, for their comments on earlier drafts.

### REFERENCES

1. Brancati FL. The art of pimping. *JAMA*. 1989;262(1):89-90.
2. Ross JS, Detsky AS. Comparison of the US and Canadian health care systems: a tale of 2 Mount Sinai's. *JAMA*. 2008;300(16):1934-1936.
3. Ausiello DA. Introduction of Samuel O. Their, MD. *J Clin Invest*. 2008;118:3805-3810.

The many reasons for this were outlined in another article regarding epilepsy surgery<sup>3</sup> that appeared in the same issue of *JAMA* as ours, as well as the Editorial by Dr Engel<sup>4</sup> that accompanied both articles.

Donald L. Schomer, MD  
dschomer@bidmc.harvard.edu  
Department of Neurology  
Peter M. Black, MD, PhD  
Department of Neurosurgery  
Harvard University  
Boston, Massachusetts

**Financial Disclosures:** None reported.

1. Engel J Jr, Birbeck G, Diop AG, Jain S, Palmieri A. *Epilepsy: Global Issues for the Practicing Neurologist: World Federation of Neurology Seminars in Clinical Neurology*. New York, NY: Demos Press; 2005:chap 7.
2. Williamson PD, Jobst BC. Epilepsy surgery in developing countries. *Epilepsia*. 2000;41(4)(suppl 4):S45-S50.
3. Choi H, Sell RL, Lenert L, et al. Epilepsy surgery for pharmacoresistant temporal lobe epilepsy: a decision analysis. *JAMA*. 2008;300(21):2497-2505.
4. Engel J Jr. Surgical treatment for epilepsy: too little, too late? *JAMA*. 2008;300(21):2548-2550.

### Movement Away From Phenolphthalein in Laxatives

**To the Editor:** In the enjoyable *JAMA* Classics discussion by Dr Evens<sup>1</sup> regarding the 1924 article describing roentgenologic examination of the gallbladder, I spotted 1 factual error. Evens mentioned that the contrast agent used by Graham and Cole in the original study, phenolphthalein, is still marketed today under the brand name of ex-lax. Phenolphthalein was formally banned by the Food and Drug Administration as an ingredient in over-the-counter laxa-

tives in 1999 due to concerns of possible carcinogenicity.<sup>2</sup> Products containing phenolphthalein, including ex-lax, were reformulated in 1997 in anticipation of the ban; the active ingredient in ex-lax is now senna.

James Murphy, RPh  
james@prnnewsletter.com  
PRN Publishing  
Forest Hills, New York

**Financial Disclosures:** None reported.

1. Evens RG. Roentgenologic examination of the gallbladder (cholecystography): the article that launched a new era of radiology. *JAMA*. 2009;301(1):100-101.
2. Federal Register volume 64, No. 19; Friday, January 29, 1999; Rules and Regulations 4535-4540. <http://www.fda.gov/OHRMS/DOCKETS/98fr/012999b.pdf>. Accessed March 3, 2009.

**In Reply:** I thank Mr Murphy for clarifying the current composition of this over-the-counter pharmaceutical.

Ronald G. Evens, MD  
rgevens5556@bjc.org  
Mallinckrodt Institute of Radiology  
Washington University School of Medicine  
St Louis, Missouri

**Financial Disclosures:** None reported.

### CORRECTION

**Misspelled Name:** In the Commentary titled "The Art of Pimping," published in the April 1, 2009, issue of *JAMA* (2009;301[13]:1379-1381), the surname of a physician was misspelled. At the top of column 2 on page 1379 and in reference number 3 on page 1381, the name should have read "Thier."