Have you been to our new Faculty Development website lately www.facdev.ubc.ca? There are resources for Lecturers:
- FAQ about Lecturing
- Checklist for a Good Lecture
- The Art of Lecturing (an article by Dr. Leslie Sadownik)
- Resuscitating the Dead Audience (a PowerPoint presentation by Dr. Leslie Sadownik)
- Interactive lecturing strategies (an article by Yvonne Steinert & Lindsay S. Snell)
- How do People Learn from Lecture? AMEE Medical Education Guide No.22
- The Art of Lecturing’ CD
- Guidelines for Multiple Choice Questions (A PowerPoint presentation)
- Writing Objectives
- Checklist for Videoconference Instructors
- Peer Review of Teaching - Lecture Format
- Basic Guide for Lecturing with Videoconferencing
- Great Internet site with 36 Formats for Interactive Lectures

Preceptors:
- Strategies for the Problem Resident
- Practical Prof: A fabulous teaching resource for clinical preceptors has been developed by the Rural Program in Alberta and is available for use by all our preceptors.
  http://www.practicalprof.ab.ca/
- Practical Prof’s CD

Postgraduate Program Directors:
- Strategies for the Learner with Problems
- Teacher Evaluation Forms: OR, Clinical or Bedside, Lecture, Seminar and PBL
- Assessment Tools:
  - ACGME Toolbox of Assessment Methods: ACGME Competencies: Suggested Best Methods of Evaluation, Mini-CEX and UBC Internal Medicine Clerkship Encounter Card

Graduates of the ABC Educational Program for the last 17 years and it continues to grow and develop as we attempt to balance in the experience of our students. It incorporates and links with history, art, literature, music, philosophy, narrative, ethics, poetry, and other humanities as they relate to medicine.

It is both a privilege and challenge to introduce Dr. Jock Murray to deliver the 5th Webber Education Lecture. It is a privilege – indeed and very inspiring – to have the opportunity to review a career as rich as Dr. Murray’s. However, it is also a challenge in that his CV runs to more than 80 pages; He has published more than 280 scholarly papers and has had leadership roles in many national and international organizations.* He was Dean of Medicine from 1985 – 1992 at Dalhousie University and it was in this role that he met my father. He is a clinical neurologist and his principal clinical research focus has been on multiple sclerosis.

He also has an interest in the humanities and art as applied to medicine. During my postgraduate medical training at Dalhousie, I recall Dr. Murray’s promotion and support of the paintings of Robert Pope. Robert Pope was a young man afflicted with lymphoma; his paintings presented his experience as a patient. These paintings were shared with medical students and physicians to provide a remarkable perspective on a patient’s experience with a life-threatening illness. A third area of interest, somewhat linked to the second, is Dr. Murray’s interest in the history of medicine; in particular, he has studied and written about illnesses and afflictions that have affected historical leaders.

Today we are clearly in the company of a great man of medicine. We are also in the company of a great Canadian. He has been recognized with our nation’s top honor, the Order of Canada. I think it is important to recognize that he is also a great citizen of Nova Scotia. In addition to his worldly accomplishments, he remains rooted in and committed to the Maritimes, which is understandable to anyone who has visited this special region of Canada. He is a devoted husband, father and grandfather. He serves on many volunteer boards in Halifax and Nova Scotia. In closing, I will take this opportunity to thank Dr. Murray for joining us today to share his thoughts on medical education.

- Dr. Eric M. Webber, Assistant Dean, Postgrad Education

* (See Faculty Development website for full biography)
Teaching Essential Lessons in Medicine through Art

Professionalism is a major topic for medical education today. To live and defend professionalism, physicians must first understand the definition, roles and responsibilities, and the impact on professional conduct. Medical educators must be aware of the importance of these factors in the medical profession. It is also not difficult to engage students in a discussion of an art work. I have also given these discussions of medical history and medical professionalism to public groups and they are also easily engaged in the discussion. (Editorial comment: To illustrate how he uses art to teach about professionalism, he presented a series of paintings of physicians. He analyzed what the physicians wore, the instruments they used, and their interaction with patients. See the example below.)

We began an artist in residence program with the assistance of the Canada Council in 1992 and these talented people have been very successful engaging the medical students. There have been artists, a muralist, a poet, an actor, a novelist, and a playwright, an interpretive dancer. All of these can bring something to the understanding of medicine and examination of the human condition, emotions and experience.

All medical schools recognize, but often pay inadequate attention to, the diverse and highly developed talents and backgrounds of our students. We sometimes select them because of their academic performance, but fail to recognize that these could enhance their medical learning and life experiences as physicians. All we had to do was to legitimize involvement and activity in the humanities while they were learning and that it would make them better physicians. When we communicated clearly that we valued the interest and involvement in the humanities, the students became very creative and initiated many amazing activities and projects. One was a new way of doing a student art exhibit. Two students started this over a decade ago, calling on the other students to meet about an art show. They discussed a theme and then brought in many people to teach them about the topic (over the years, they have selected Alzheimer’s disease, violence, sexual dysfunction, ADHD/hyperactivity syndrome, transplantation among others). Following these education sessions, they each went off to create a work of art that reflected some aspect of the theme that was particularly meaningful to them. Each year they raise funds to support the costs and then hold a well attended public opening, with a very professional looking brochure about the art works. Just as impressive is the writing by the student alongside the picture of their creation. The art work might be a painting, photograph, sculpture, stained glass, weaving or other medium. It has become a major annual event, displaying each student’s talent, but also their deep feelings and understanding of the medical condition being examined.

There are other activities in the arts in the medical school, including a faculty-student exhibit in the university, a student project to add art to the walls of the medical school, a specific display of the history of anatomy in art, elective projects in art and medicine, an art exhibit in the foyer of the medical school.

First operation performed under ether (anesthesia) in 1846, a painting by Robert C. Hinkley (Cambridge Illustrated History of Medicine, 1996)

Preparing Future Physicians for the CanMEDS Health Advocate Role

Shafik Dharamsi (Assistant Professor, Family Practice)

The CanMEDS Health Advocate role relates to the physician’s responsibility to identify and respond appropriately to the social determinants of health, health care disparities and the needs of vulnerable or marginalized populations. In essence, in their role as health advocates, physicians are expected to attend to “the ethical and professional issues inherent in health advocacy, including altruism, social justice, autonomy, integrity and idealism.” However, reference to these concepts among educators is made usually without a clear sense of how these concepts can be taught, integrated into medical curricula and subsequent clinical practice and evaluated. Health advocacy is regarded by educators as one of the more difficult CanMEDS roles to integrate into medical education. FDIG funding will support the development of a Health Advocate Training Guide that will:

a) profile the health advocate related work of BC physicians from various medical disciplines and ways that demonstrate the relevance of health advocacy in health care;

b) provide medical educators with educational strategies for integrating HA competencies into their teaching in various areas of medicine; and

c) make the Guide freely available to medical educators through the UBC FoM website.

Faculty Development Initiatives Grant Recipients 2009

Dr. Shafik Dharamsi

Upcoming Conferences

2009 American Association of Medical Colleges Annual Meeting
November 6 - 11, 2009
Hynes Convention Center - Sheraton Boston - Marriott Copley Place – Boston

2009 Association for the Study of Medical Education “Researching Medical Education” Conference
November 16, 2009
RIBA, 66 Portland Place, London

2009 American Educational Research Association Annual Meeting
April 30 - May 4, 2010
Denver, Colorado

2010 Canadian Conference on Medical Education
May 1 - 5, 2010
St. John’s, Newfoundland and Labrador

Development of an Inter-professional Preceptor Orientation Manual

Donna Drynan (Clinical Associate Professor, OS & OT) & Sue Murphy (Instructor, PT)

Factors that often influence professionals’ decision to provide a clinical learning experience to a student may include self confidence in preceptor skills and finding the time to teach in a busy clinical setting. Add in the concept of facilitating the learning of students from other professions to this scenario and preceptors are faced with increased pressure and may question their ability and competence to act as preceptors. Academic education programs must consider how to support clinicians who want to educate a student in an inter-professional model. Traditional clinical education activities can be costly to deliver, require staff to be away from practice, may not reach those practicing in remote areas and are often discipline specific. The development of an inter-professional handbook will provide clinicians with tools to build their confidence in the area of inter-professional mentorship and collaboration. It will be a comprehensive guide that reviews the importance of IP education as reviewed in the literature and as it relates to patient safety; orient them to the current status of IP education in the FoM; provide examples of suggested IP learning activities that can take place in the clinical setting and strategies on how best to evaluate IP learning, including the use of the inter-professional competencies developed by the College of Health Disciplines.

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UBC Centre for Health Education Scholarship

What are the characteristics of medical students who are drawn to work in rural and remote areas? How could PBL tutors improve the learning experience for students? Do third year students completing integrated clerkships have better outcomes on national clinical exams than their rotational counterparts?

These are some of the questions being answered by UBC faculty involved in health professions education scholarship.

Educational scholarship is now a well-recognized and supported discipline in major medical schools. Changes in teaching, technology, and workforce issues have emphasized the need for research into and evaluation of health professions education. The UBC Faculty of Medicine, a well-recognized educational innovator, has responded to this need by creating the Centre for Health Education Scholarship (CHES).

CHES’s mission is to promote scholarship that supports, challenges, and improves health professions education. Our primary functions are to:

- Facilitate collaborative educational research, evaluation and development;
- Translate and disseminate new knowledge related to educational practices;
- Support faculty focusing their academic work on an educational track;
- Provide a safe and supportive environment for the generation of ideas and possibilities related to educational research, evaluation and development.

In December 2008, 70 faculty members came to a Town Hall meeting to advise CHES on how to address these functions. Since then, we have assisted over 30 faculty members and nine residents. We have supported ten grant applications and research projects in health professions education. Our primary functions are to:

- In addition to his research interests in cognitive psychology, Dr. Regehr has researched and published in a variety of content domains including: teaching and testing of technical skills in surgery, refinement of tools for assessing clinical skills in the testing context and in the field and the refinement of our understanding of professionalism as it relates to medical practice. His recent research is heavily focused on the development of new theories and methodologies for understanding self-assessment in practice. He has co-authored over 100 publications in peer reviewed journals, over 150 peer reviewed presentations in international scientific conferences, over 40 invited presentations around the world and over 50 peer reviewed grants in the health professional education domain.

Dr. Glenn Regehr has joined CHES as the incoming Associate Director, Research, effective July 1, 2009. Dr. Regehr comes from the University of Toronto where he was the Associate Director of the Wilson Centre and a Professor in the Departments of Surgery and Psychiatry. In his role as an educator, he has supervised over 50 masters, doctoral students, post-doctoral and research fellows. He has developed and taught masters and doctoral level courses on topics such as Cognitive and Educational Psychology, Research Methods in Health Professions Education and Statistics for the Social Sciences.

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Clinicians vs. Basic Scientists: Teaching Perspectives of Problem-Based Learning Tutors
Pawel Kindler, Dan Pratt & John Collins

Teaching perspectives describe how teaching is guided by beliefs and intentions that justify actions of teachers. Our aim was to contrast clinician tutors against basic scientist tutors to investigate views about the purpose of PBL, strategies for effective PBL tutoring and the relationship between teaching perspective(s) and PBL tutoring.

Among 49 participants, 27 were clinicians and 22 were basic scientists. Each had tutored at least three PBL blocks and was consistently ranked as “meets” or “exceeds requirements” on student evaluations.

Participants ranked summary descriptions of five perspectives on PBL tutoring. Each also completed the Teaching Perspectives Inventory (TPI) survey at www.TeachingPerspectives.com.

All concurred that the Developmental Perspective was the most appropriate perspective for tutoring PBL and Social Reform the least appropriate. Transmission and Apprenticeship paragraphs were ranked higher by clinicians; Nurturing was ranked higher by basic scientists. TPI profiles (web-based) showed clinicians scored higher on Apprenticeship than did basic scientists. Remaining differences were non-significant.

Participants agreed that the Developmental Perspective was most congruent with the foundations of PBL. No single view emerged as dominant from tutors’ own TPI surveys indicating that facilitation provided by exemplary tutors relies on key features of developmental, apprenticeship and nurturing perspectives.

Contact: pawel.kindler@ubc.ca

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Mask-Making as a Teaching Tool in Medicine: How Medical Students Can Address and Reflect on the Topic of Violence
Jane Gair, John Anderson & Trudi Smith

“Doctor, Patient and Society” (DPAS) explores the social, ethical and moral issues related to being a physician. During this course, medical students learn about the topic of violence - domestic violence, elderly abuse, international violence and war, and child abuse. In order to allow students the opportunity to reflect on and express their thoughts and feelings about this topic, a workshop was designed around mask-making. Creating the masks, decorating them and discussions using them occurred over the four week period. This way of learning and discussing was piloted at the Island Medical Program in order to see what the impact on learning was for the students who participated. A focus group was conducted immediately following the final week of the violence block where students could discuss their views about the way the block was delivered, the effectiveness of the mask-making exercise and their satisfaction with their learning.

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The Multiple Mini Interview and Northern Suitability
Carol-Anne Courneya, George Pachev, Maria Corral, Geoffrey Payne, David Snudden & Michael Fabian

In 2008, UBC Admissions instigated the Multiple Mini Interview (MMI) as part of the selection process. In addition to the 10 standard MMI scenarios, we included two northern scenarios based on information submitted in paper by applicants. In the first iteration of the course two years ago, a number of the invited speakers struggled to specifically address their assigned topic, for example, speaking at a too basic level for fourth year, or focusing on more detail than the students were ready to absorb. As the speakers deviated from their invited topics, sessions tended to overlap others within the course or in previous years.

Participants ranked summary descriptions of five perspectives on PBL tutoring. Each also completed the Teaching Perspectives Inventory (TPI) survey at www.TeachingPerspectives.com. All teachers and students are now required to complete a template form documenting objectives, learning outcomes, and an abstract of the material to be taught prior to their session. This makes those who present in the course start planning and defining their teaching early and explicitly. The course committee and student representatives review the templates. Student rep and committee feedback is fed to the teachers to influence the upcoming sessions.

Student evaluations of the course improved substantially post implementation of this system and we present their ratings.

The system developed and here described proved to be an effective communication tool for improving a complex course.

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UBC Medical Education Research Abstracts

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UBC Medical Education Research Abstracts

New References on Longitudinal Integrated Clerkships


The authors discuss the unique benefits of longitudinal, integrated clerkship experiences.

Hemmer P. Longitudinal, integrated clerkship education: Is different better? Acad Med 2009; 84:821. Is longitudinal clerkship education the best way to ensure students’ sense of belonging, commitment, and ownership of patients during medical school?


UBC Medical Education Research Abstracts

Use of a Lesson Plan/Abstract System Improves Direction of an Integrated Multi-Themed Course in the Geographically Distributed UBC Medical School
Linlea Armstrong, PMP committee & Angela Towle

The Preparation for Medical Practice (PMP) course is one month in fourth year of non-clinical teaching. The content is diverse and taught by about 40 guest lecturers, many small group tutors and the 250 students. In the first iteration of the course two years ago, a number of the invited speakers struggled to specifically address their assigned topic, for example, speaking at a too basic level for fourth year, or focusing on more detail than the students were ready to absorb. As the speakers deviated from their invited topics, sessions tended to overlap others within the course or in previous years.

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UBC Medical Education Research Abstracts

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UBC Medical Education Research Abstracts
Background:
The ICC program was given the impetus by the overall UBC expansion plan for a distributed medical education model in which the concepts of community-based learning and longitudinal experiences would be explored. The goals of the program were aimed at physician supply in rural and remote areas and creating alternative models of clerkships. The planning began in 2003 and the first program was implemented in Sept 2004 in Chilliwack. A northern rural site, Terrace, was implemented in 2008 and a further site, Peace-Liard will start in Sept 2009. We based the initial model on the Flinders’ program. We planned the initial program using the same overall objectives, assessments and examination process as our traditional clerkship programs. So far, 27 UBC students have participated in this program.

Initial results included:
• No significant differences across examinations and clinical skills assessments in the two groups of students;
• The students located in Chilliwack performed far more technical skills and procedures;
• All students have consistently matched to their first choices in the CaRMS match in both Royal College and Family Practice programs.

See below a sample schedule of a typical student’s week in Terrace, BC highlighting the exposure to multiple specialties in one week.

<table>
<thead>
<tr>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital rounds with FP Preceptor</td>
<td>Time will be flexible to suit off hours and FP clinic start</td>
<td>7:00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8:00</td>
<td>On call monitor ER and work during day on call with FP after 1700</td>
<td>9:00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9:00</td>
<td>OR Surgery - General</td>
<td>10:00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10:00</td>
<td>OR - Ob GYR</td>
<td>11:00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11:00</td>
<td>OR Surgery - General</td>
<td>12:00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12:00</td>
<td>OR - Ob GYR</td>
<td>13:00</td>
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<td></td>
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<tr>
<td>13:00</td>
<td>Academic Half Day</td>
<td>14:00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14:00</td>
<td>Half day study</td>
<td>15:00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15:00</td>
<td>On call evening</td>
<td>16:00</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Future plans:
In keeping with other schools running ICC programs, we have proven that these clerkships are as educationally effective as a traditional rotational clerkship. Our focus is now shifting to examining the qualities that make these programs both different and successful. One theme that is emerging is the continuity aspect – continuity of the preceptor/student relationship and patient continuity experience. The development of these programs has enabled the school to accept innovative changes and move ahead with further curricular revisions. Planning continues for other sites including an urban model.

Lessons learnt:
• Students and faculty in “new” programs have a lot of initial anxiety.
• Program development and implementation must be pursued as a partnership with the community’s health service, health authorities and in liaison with postgraduate programs. Ultimately, each program design needs to be tailored to the unique nature of the community.
• The design of the student assessment system must match the integrated longitudinal program design. The traditional “end of rotation” exams are disruptive in an integrated system.
• Faculty development and ongoing program evaluation and feedback are essential to program quality and students are invaluable in the process.

Conclusion:
Medical students and residents have expressed a meaningful sense of what it means to be vulnerable and marginalized, a heightened level of awareness of the social determinants of health and the related importance of community engagement, and a deeper appreciation of the Health Advocate Role and the key concepts embedded within it.

Conclusions: Social justice-oriented approaches to service-learning coupled with critical reflection provide potentially viable pedagogical approaches for learning the Health Advocate Role, but how this will affect the students’ future medical practice is yet unknown.

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Predictors of Choosing a Career at the CaRMS Match
Ian Scott, Wright, Brenneis, Gowans, Boone & Banner

Background: Given that student career interest is a major determinant of the final mix of providers, it is important to understand what characteristics at medical school entry predict a student’s ultimate career choice.

What we did: We matched over 1500 medical students and their entry characteristics with their CaRMS match. Our focus is now shifting to examining the qualities that make these programs both different and successful. One theme that is emerging is the

Conclusions: There are a number of medical student attributes that predict what career a student will choose on their CaRMSmatch. These models we have created have good accuracy.

Take home message: These attributes can be used to target medical students for recruitment to various careers.

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Improving Feedback and Skill Acquisition in Undergraduate Clinical Skills
Steve Martin & Jane Gair

Hypothesis: In the setting of clinical skills education, feedback refers to information describing students’ performance in a given activity. It is a key step in the acquisition of clinical skills, yet feedback is often omitted or handled improperly in a clinical training. This can result in negative consequences, some of which may extend beyond the training period.

Intervention: A literature search was performed and confined to:
1. Enhancing basic clinical skills acquisition and mastery
2. Feedback in Medical Education
3. Apprenticeship Mentorship/Modeling in Medical Education

A faculty development intervention was designed to prepare tutors to provide effective feedback to students.

Outcome: Unstructured or informal discussion, structured “exit-interviews” and feedback forms were used to collect data. Informal feedback was collected from the students, standardized patients, tutors and faculty development staff. Formal or questionnaire based feedback was received by the FD staff from the tutors. The common theme of all sources of feedback was that these sessions were effective in facilitating change and improvement of skill.

Conclusion: Just in time faculty development focused on providing feedback in clinical encounters was effective in improving the skill level of the student and tutor.

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Building Virtual Patient Cases: An Introduction to the Process of Case Development
John Masterson, Linda Peterson, Bryn Runkle & Jed Shimizu

Virtual patient cases are “interactive computer simulations of real-life clinical scenarios for the purpose of health professions training, education, or assessment, used by learners, teachers, or examiners” (Ellsward, Candler, Smolthers & Greene, 2006). They provide medical educators with rich, multi-layered and dynamic e-teaching strategies and encourage medical problem solving at variable levels of complexity. They also facilitate assessment and learning outcomes measurement. While there is growing recognition of the utility of virtual patient cases, the process of case development is still relatively undefined and can be challenging.

This presentation is based on the lessons learned during a year-long collaboration between the University of British Columbia and McGill University, which resulted in 62 Urology cases for medical students, accessible from all three UBC distributed teaching sites. Four cases, selected as optimal learning resources, were completed by approximately 130 first year students during the Fluids, Electrolytes, Renal, and Genito-Urinary Block of the PBL Skills course. These cases were written by students, with collaboration from residents and faculty.

Developing a library of virtual patient cases is a challenging undertaking, requiring planning and forethought in numerous asp[...]

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Cary Cuncic, Sharon Marr, Tim Wood & Rose Hatala

Background: The “gold standard” for assessment of clinical performance has been the OSCE, consisting of multiple brief stations that assess narrow aspects of clinical performance. This format has the limitation in that it may not be representative of complex, multi-system patients regularly assessed by many physicians. We developed a modified long-case OSCE format having single patients with several issues to be addressed and examined its psychometric properties.

Methods: Twenty internal medicine residents and sixteen examiners were recruited. All candidates rotated through two stations, each having three distinct components with two examiners per station. Pearson correlations between components were calculated and reliability was assessed by the generalizability coefficient. Face validity and acceptability were assessed qualitatively.

Results: The generalizability coefficient of the pilot two station OSCE format was 0.71 and four stations (two hours of testing time) would be needed for a generalizability coefficient of >0.8. Both examiners and residents found the examination acceptable and felt it was more representative of a real patient encounter.

Conclusion: The modified long-case OSCE was found to have similar reliability as the multi-short-station OSCE while maintaining acceptable and having increased face validity. However, a limitation was that we could not rule out a “halo” effect.

Contact: hatala@imac.com

Steve Martin & Jane Gair

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Contact: hatala@imac.com

The Australian Experience
Dr. Paul Worley (Dean of Medicine, Flinders University)

In 1997 Flinders University’s Medical School introduced an integrated clerkship in small rural areas. The initiative was so successful that they significantly expanded the program. The following is an excerpt from Dr. Worley’s presentation at the Medical Education Research Day on April 24, 2009.

There were a number of triggers in Australia for implementing an integrated clerkship model. The first is in the need to distribute the medical workforce to underserved areas. If you take students from an underserved origin and you give them positive undergraduate experiences in underserved areas, they are more likely to work in those areas. Most of those underserved areas don’t have a tertiary hospital with the standard rotational capacity for their traditional model of medical school clerkship education, so it was necessary to develop an alternative model of education in order to place medical students into these rural and remote settings.

In Flinders, we have data from 1999-2008 medical school graduates. We have found that 70% of the students who trained in an integrated clerkship model are now practicing in rural communities. That compares with 10% of students who trained in the tertiary sector. Importantly, those 70% are not all family physicians.

Even though the program is based on a continuity model where the family physicians are the principal supervisors, 30% of the students do not take up family medicine as their preferred practice. They are internists, surgeons and psychiatrists. We eventually had two anatomical pathologists that graduated from our international integrated clerkship. We thought we had failed! But what had we done wrong? On reflection we thought, an integrated clerkship is actually a preparation for medicine, as a whole, as a career. It’s not a preparation for a certain type of medicine just as a rotational clerkship in a hospital is not just a preparation for a hospital-type of practice.

Interestingly, I mentioned to a number of you that we have a longitudinal integrated clerkship model.30% of the students do not take up family medicine just as a rotational clerkship in a hospital is not just a preparation for a hospital-type of practice.

The third trigger is that patients with common diseases are no longer being taken of in tertiary hospital settings. If you look at White’s evidence, he will show you that out of a 1000 patients in a community, 750 get unwell, 250 see a doctor, and one goes to a tertiary centre. We need to bring the patients out into the community so that they can see the 250 that present to the doctor vs. the one who presents to the hospital. The community-based medical education has very much used an integrated model in order to be able to cover a broader curriculum.

Finally, the fourth trigger is that medical research is context specific. In other words, where the evidence is collected, it means that it is evidence for that context. But it doesn’t necessarily mean that it is evidence that should be used for another context. And it’s particularly evident when you look at how we distribute the medical workforce. For example, there is evidence that suggests that MRIs should be the first intervention with a patient with head trauma. If you are out in the prairies, in a small town, having that as your evidence base is useless. In fact, it is worse than useless. It’s actually discouraging to people who even start practicing there because they say “I cannot practice evidence-based medicine”. You can, but you have to construct the evidence relevant to that community. By getting academics involved in teaching in those environments, those academics can also be involved in research in those environments. We can then build upon that evidence base that is far more relevant to the 1000 rather than to the one in White’s evidence.