



FROM THE LITERATURE

## Abstracts of Recent Papers

With thanks to the Editors and Publishers of *Academic Medicine*, *Medical Education*, *Medical Teacher*, and *Teaching and Learning in Medicine*, we regularly reproduce selected abstracts of recent papers from these journals that may be of interest to the readers of *Education for Health*.

These journals can be ordered at the following addresses:

*Academic Medicine*: Association of American Medical Colleges, 2450 N Street, NW, Washington, DC 20037, USA.

*Medical Education*: Blackwell Publishing Co., PO Box 87, Osney Mead, Oxford OX2 0DT, UK.

*Medical Teacher*: Carfax Publishing Co., PO Box 25, Abingdon OX14 3UE, UK.

*Teaching and Learning in Medicine*: Lawrence Erlbaum Associates, 365 Broadway, Hillsdale, NJ 07742, USA.

In addition, in this issue, we present an abstract from *Medical Education Online* (a free, internet-based journal). The full article is available at the URL given with the abstract. Back issues of this journal can be found at: <<http://www.utmb.edu/meo/>>

**Human doctoring: bringing authenticity to our care.** Cathy Risdon & Lori Edey  
*Academic Medicine*, 74, 896–899, 1999.

Increasingly, doctors are looking for ways to treat the whole patient—mind, body, and spirit, disease and illness. To accomplish this, doctors must establish authentic relationships with their patients—that is, relationships in which the life experiences and knowledge of both participants are acknowledged and respected. Physicians must be aware of everything they bring, both as persons and as professionals, to every clinical encounter. In this article, the authors discuss a hypothetical case of a teenaged girl suffering from recurrent coldsores and the possible ways her physician might handle her case. They analyze the differences among the three scenarios, using them to highlight ways physicians can work to achieve authentic and mutually beneficial relationships with the people in their care.

**The liberal arts physician.** Gerard N. Burrow  
*Academic Medicine*, 74, 1063–1066, 1999.

The United States is in the midst of the second revolution in American health care to occur during this century, as Kenneth Ludmerer makes clear in his book *Time to Heal; American Medical Education from the Turn of the Century to the Era of Managed Care*.

The ‘Flexnerian revolution’ eventually led to the closing of a third of the medical schools. Although such closures are not likely this time, familiar arrangements are collapsing, without a clear picture of the shape of things to come.

Whatever the outcome of the current revolution, well-trained physicians will be needed to care for the sick. Academic medical centers truly are at risk and increasingly require public support to flourish or even to survive, but medical schools and their teaching hospitals must demonstrate that they deserve this support. These institutions have responded by focusing on the business aspects of medicine, perhaps to the detriment of medical education. Lost in this focus is teaching time, and perhaps even more important, the time for mentoring. Often lacking too is a clear vision of the preparation needed by the student to practice medicine successfully in the future: different specialty mixes, interdisciplinary group practice, vastly increased use of information technologies, and overwhelming amounts of relevant and interrelated information.

Yet the answer is the same as it was 75 years ago when Yale introduced the first radical medical curricular reform – the ‘liberal arts physician,’ trained in science, he values of medicine, and particularly for uncertainty and with the capacity to adapt.

**Transformation of medical students’ education: work in progress and continuing challenges.** Michael E. Whitcomb & M. Brownell Anderson  
*Academic Medicine*, 74, 1076–1079, 1999.

In his book *Time to Heal; American Medical Education from the Turn of the Century to the Era of Managed Care*, Ludmerer expresses concern about the erosion of the environment in which medical students and residents learn the clinical skills, attitudes, and behaviors that they will need to practice high-quality medicine. Importantly, while he attributes the erosion of the clinical environment largely to the impact of managed care, he also places some responsibility within academic medicine itself, primarily the redirection of the clinical faculty’s efforts away from traditional academic pursuits to the generation of clinical revenues.

The Association of American Medical Colleges has information about the kinds of changes already occurring. In the preclinical curriculum, schools have introduced a wide range of new courses and topics, and there is more attention on professionalism and values. Schools are making fundamental changes in the design and conduct of the curriculum, primarily by adopting more integrated (non-departmental) approaches to course design and management. The clinical curriculum is changing primarily through the greatly expanded use of ambulatory care sites, and medical schools are developing new approaches to managing dispersed and varied instruction. Also, faculty are paying more attention to the role of residents as teachers and role models.

These changes speak well for medical education. Nonetheless, substantial and sustained work remains to be done despite the present uncertainty about the future of academic medical centers. This work is essential—a challenge that the leaders of academic medicine must not fail.

**Community-based training in family medicine—a different paradigm.** Bob Mash & Marietjie de Villiers

**Medical Education**, 33, 725–729, 1999.

**Introduction:** Community-based education is an important strategy for training students appropriately for delivering primary health care services. A community-based training rotation in Family Medicine and Primary Care was introduced at the University of Stellenbosch, South Africa, in January 1998.

**Objective:** The aim of this study was to explore the perceptions of final year medical students about the new rotation and to provide feedback on the value of this experience to the Faculty. In this article we explore the influence of differing world views held by biomedically oriented training institutions and the systems view of life adhered to by the discipline of Family Medicine on attempts to reform medical education.

**Method:** Quantitative and qualitative curriculum evaluation methods, including a questionnaire and focus groups discussions, were used. Students rated the value of the block as 7.8 out of 10.

**Results:** Eighty-eight percent of students felt that there should be an earlier exposure to Family Medicine and Primary Care in their training. The main themes identified from the qualitative results supported the literature findings and included the difference in type of practice between tertiary and primary levels of care and the value of learning a new approach to patient care. Despite the fact that the results emphasized the importance of including community-based training in Family Medicine and Primary Care at an early stage in the medical curriculum, resistance to implementation was encountered. This led to reflection on possible reasons why the recommendations of the study were not immediately adopted into the curriculum.

**Practical skills and valued community outcomes: the next step in community-based education.** Robert I. Williams, Stephen J. Reid, Cwengekile Myeni, Les Pitt & Geoff Solarsh

**Medical Education**, 33, 730–737, 1999.

**Objectives:** Community-based medical education (CBE) has clear value. However, there are aspects of CBE where improvement is possible. First, communities do not generally receive valued outcomes in exchange for participation in the CBE process. Secondly, students are usually not trained to influence health in the community using methods that are realistic in busy clinical practice.

**Design:** A CBE rotation was designed to address these problems. Rotation activities were structured to facilitate development of a health programme desired by the community while giving students practical skills for later use. Working with community residents and health staff, sequential groups of students carried out, in turn, problem analysis, resource identification, planning and implementation activities aimed at establishing a community tuberculosis (TB) control programme.

**Setting:** The University of Natal in Durban, South Africa.

**Subjects:** Final-year medical students.

into greater contact with community residents. The 'real-time' nature of planning the sequential student groups' work created logistical problems and, as an isolated activity, the rotation had little impact on student attitudes toward community-based careers.

**Conclusions:** Expanding the goals for CBE is both feasible and important. Further work should focus on refining designs for this next step in CBE.

**Patients as teachers: a qualitative study of patients' views on their role in a community-based undergraduate project.** Rosie Stacy & John Spencer  
**Medical Education**, 33, 688–694, 1999.

**Objectives:** Patients have been used in clinical medical education for many years with, traditionally, a relatively passive role. Following the General Medical Council recommendations for curricular change and the development of more community-based teaching, 'ordinary patients' in the community are increasingly being partnered with undergraduate students for particular projects. Very little research has been undertaken on patients' perceptions of this role.

**Design:** Semi-structured interviews were carried out with 20 people to explore the views of patients taking part in a community-based undergraduate medical student project (the 'patient study') at Newcastle Medical School about their role as teachers of medical students, what they felt they had gained from participating, any problems or concerns and suggestions for change or improvement.

**Setting:** Newcastle Medical School, UK.

**Subjects:** Second-year medical students.

**Results:** Two major themes emerged. First, patients saw themselves in active roles as teachers: as experts in their medical condition; as exemplars of their condition; and as facilitators of the development of students' professional skills and attitudes. Secondly, patients felt they had benefited from participation, through talking about their problems; learning more about themselves; the satisfaction of helping; and from receiving gifts. In addition, a number of other issues were identified including interpersonal dynamics, gender and ethnic differences, inadequate briefing of participants and whether such community-based patient involvement might, in some situations, be felt to be exploitative.

**Conclusions:** The study has shown that patients see themselves clearly as having specific contributions to make to medical students' education and training. This has implications for the further development of community-based teaching.

**Attitudes towards community medicine: a comparison of students from traditional and community-oriented medical schools.** Isobel F. Rolfe, Sallie-Anne Pearson, Edward G. Cleary & Carole Gannon  
**Medical Education**, 33, 606–611, 1999.

**Objective:** To compare the attitudes towards community medicine of first and final year students from two Australian medical schools.

**Method:** In 1995, medical students from Newcastle University (a problem-based,

community-oriented curriculum) and Adelaide University (a more traditional lecture-based curriculum) were asked to complete the Attitudes to Community Medicine questionnaire. This is a valid and reliable 35 item survey assessing six key domains of community medicine. The two medical schools differ in their methods of selection and curriculum delivery, and also in curriculum content.

**Results:** Response rates averaged 95% for first year and 81% for final year students. Students selected into both medical schools were found to have positive attitudes with respect to most aspects of community medicine. However, those entering Newcastle had more positive attitudes toward community medicine overall than their Adelaide counterparts. They also scored more positively on subscales relating to holistic care and evaluation of health care interventions. Students who were older and female scored more positively on some subscales, but correction for age and gender did not change the conclusions about medical school differences.

**Conclusion:** This study suggests that selection criteria, and probably curriculum style and emphasis, have an influence on the attitudes that medical students possess and later develop toward community medicine.

**Assessment in problem-based learning medical schools: a literature review** Mathieu R. Nendaz & Ara Tekian

**Teaching and Learning in Medicine**, 11, 232–243, 1999.

**Background:** Despite widespread use of problem-based learning (PBL) in medical schools, no review currently exists on its assessment. Given the importance of assessment for any curriculum, a critical review of the literature was conducted to explore whether the assessment methods match the philosophical tenets of PBL.

**Summary:** Articles from MEDLINE and other databases on the assessment of PBL were reviewed. The following areas require special attention by PBL medical schools: enhancement of formal continuous formative assessment; use of the context of a working problem to assess knowledge and problem-solving skills; prevention of negative steering effects by a judicious choice of assessment content, instruments, and timing; and implementation of a longitudinal and centralized student profile.

**Conclusion:** Despite the existence of general practical recommendations on assessment in PBL settings, this review reveals a lack of uniformity and consensus on the practical application of general principles. Topics for future research are highlighted.

**A strategy for the detection and evaluation of unprofessional behavior in medical students.** Maxine A. Papadakis, Emilie H. S. Osborn, Molly Cooke, Kathleen Healy & the University of California, San Francisco School of Medicine Clinical Clerkships Operation Committee

**Academic Medicine**, 74, 980–990, 1999.

The authors describe the first four years (1995–1998) in which the University of California, San Francisco School of Medicine operated an evaluation system to monitor

students professional behaviors longitudinally through their clinical rotations. The goals of this system are to help ‘turn around’ students found to have behaved unprofessionally, to demonstrate the priority placed by the school on the attainment of professional behavior, and to give the school ‘muscle’ to deal with issues of professionalism. A student whose professional skills are rated less than solid at the end of the clerkship receives a ‘physicianship report’ of unprofessional behavior. If the student receives such a report from two or more clerkships, he or she is placed on academic probation that can lead to dismissal even if passing grades are attained in all rotations. Counseling services and mentoring by faculty are provided to such students to improve their professional behaviors.

From 1995 to 1998, 29 reports of unprofessional behavior on the part of 24 students were submitted to the dean’s office; five students received two reports. The clerkship that submitted the most reports was obstetrics – gynecology. The most common complaint for the five students who received two reports was a poor relationship with the health care team. Four of these students had their difficulties cited in their dean’s letters and went on to residency; the fifth voluntarily withdrew from medical school.

The authors describe the students’ and faculty members’ responses to the system discuss lessons learned difficulties and continuing issues review future plans (e.g., the system will be expanded to the first two years of medical school) and reflect on dealing with issues of professionalism in medical school and the importance of a longitudinal (i.e., not course-by-course) approach to monitoring students’ behaviors. The authors plan to compare the long-range performances of students identified by the evaluation system with those of their classmates.

**BEME guide no. 1: best evidence medical education** R. M. Harden, Janet Grant, Graham Buckley & I. R. Hart  
*Medical Teacher*, 21, 553–562, 1999.

There is a need to move from opinion-based education to evidence-based education. Best evidence medical education (BEME) is the implementation, by teachers in their practice, of methods and approaches to education based on the best evidence available. It involves a professional judgement by the teacher about his/her teaching taking into account a number of factors—the QUESTS dimensions. The quality of the research evidence available—now reliable is the evidence? the Utility of the evidence—can the methods be transferred and adopted without modification, the Extent of the evidence, the Strength of the evidence, the Target or outcomes measured—how valid is the evidence? and the Setting or context—how relevant is the evidence? The evidence available can be graded on each of the six dimensions. In the ideal situation the evidence is high on all six dimensions, but this is rarely found. Usually the evidence may be good in some respects, but poor in others. The teacher has to balance the different dimensions and come to a decision on a course of action based on his or her professional judgement. The QUESTS dimensions highlight a number of tensions with regard to the evidence in medical education: quality vs. relevance; quality vs. validity; and utility vs. the setting or context. The different dimensions reflect the nature of research and innovation. Best Evidence Medical Education encourages a culture or ethos in which decision making takes place in this context.

**BEME Guide no. 2: teaching and learning communication skills in medicine—a review with quality grading of articles.** Knut Aspegren  
*Medical Teacher*, 21, 563–570, 1999.

A literature search for articles concerning communication skills teaching and learning in medicine was done. The search yielded 180 pertinent articles, which were quality graded into the three categories of high, medium and low quality, using established criteria. Only those of high and medium quality were used for the review, which thus is based on 31 randomized studies, 38 open effect studies and 14 descriptive studies. Communication skills can be taught in courses, are learnt, but are easily forgotten if not maintained by practice. The most effective point in time to learn these at medical school is probably during the clinical clerkships, but there is no study that has specifically addressed this question. After a short period of training, doctors can be effective as teachers. The teaching method should be experiential as it has been shown conclusively that instructional methods do not give the desired results. The contents of communication skills courses should primarily be problem defining. All students should have communication skills training since those with the lowest pre-course scores gain the most from such courses. Men are slower learners of communication skills than women, which should be taken into account by course organizers. As there is only one really long-term follow up into the residency phase of communication skills training at medical school, those who have done randomized studies in the field should if possible carry out further follow-up studies.

**A system of recognition for excellence in medical teaching.** D. W. R. Gray  
*Medical Teacher*, 21, 497–499, 1999.

Many activities compete for the time of the busy academic clinician. Patient care naturally comes first, but the priority given to other activities depends upon incentives and at present teaching is losing ground to research. A major advantage that research has over teaching is the ability to put an internationally identifiable mark of ability into the CV, in the form of a publication list. Teaching activity lacks an internationally recognized method of assessment, other than recommendations by referees, which are not reliable. A simple scheme is suggested, which seeks to redress the balance by creating an internationally recognized measurement of teaching ability, for which the term International Medical Education Credits (IMECs) is proposed. The scheme has the following three main components: first, a measure of the true amount of time devoted to teaching; second, a measure of the quality of teaching as perceived by the recipients; third, a system for ensuring international comparability by enhancing the role of the external examiner and the formation of an International Association of External Examiners to oversee the scheme is proposed.