



FROM THE LITERATURE

Selected 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 produce 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 2UE, UK.

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

Health promotion in the medical curriculum: enhancing its potential. Jennie Naidoo & Judy Orme

Medical Teacher, 22, 282–287, 2000.

The medical profession has a central role in contributing to public health. An expanding role for doctors in terms of health is clearly indicated by their anticipated contributions to health improvement programmes, primary care groups, healthy living centres and health-action zones. These initiatives all require doctors to contribute to planning health promotion activities for local populations. It is timely with the recent publication of the Government's public health strategy Saving Lives—Our Healthier Nation to consider how best to integrate health promotion into medical education. This paper outlines key issues that underpin sound health promotion practice. These areas are equity, effectiveness and collaborative working. Evidence from the literature, research, policy and practice is used to demonstrate how these areas could be integrated appropriately into the medical curriculum. A series of vignettes is presented for teachers to use to enhance the effective delivery of health promotion for medical students.

The need for evidence in education. C.P.M. Van Der Vleuten, D.H.J.M. Dolmans & A.J.J.A. Scherpbier

Medical Teacher, 22, 246–250, 2000.

In this article a plea is made to use evidence in education. A remarkable difference in attitude is noted between university staff in their role as scientists in their discipline and in their role as teachers. Whereas evidence is the key to guide scientists in the development of their discipline, evidence on teaching and learning hardly affects their

role as teachers. Teaching is, rather, dominated by intuition and tradition. However, particularly in education, intuitions and traditions are not always correct when they are submitted to empirical verification. It even often turns out that our intuitions are not justified or that assumed relations are far more complex. To illustrate the fallacy of our (implicit) intuitions and beliefs, a few of these assumptions are held against the available evidence. Two assumptions related to the learning of students and two assumptions related to the assessment of student achievement are discussed. The illustrations make clear that we do need to use evidence in education, just as we do in any other professional area. Being a professional teacher requires more than being an expert in a content area; it also requires familiarity, use, and perhaps production of educational evidence and theory.

Task-based learning: the answer to integration and problem-based learning in the clinical years. R.M. Harden, T. Crosby, M.H. Davis, R.W. Howie & A.D. Struthers *Medical Education*, 34, 391–397, 2000.

Introduction: Integrated teaching and problem-based learning (PBL) are powerful educational strategies. Difficulties arise, however, in their application in the later years of the undergraduate medical curriculum, particularly in clinical attachments. Two solutions have been proposed—the use of integrated clinical teaching teams and time allocated during the week for PBL separate from the clinical work. Both approaches have significant disadvantages. Task-based learning (TBL) is a preferred strategy. In TBL, a range of tasks undertaken by a doctor are identified, e.g. management of a patient with abdominal pain, and these are used as the focus for learning. Students have responsibility for integrating their learning round the tasks as they move through a range of clinical attachments in different disciplines. They are assisted in this process by study guides.

Method: The implementation of TBL is described in one medical school. One hundred and thirteen tasks, arranged in 16 groups, serve to integrate the student learning as they rotate through 10 clinical attachments.

Results: This trans-disciplinary approach to integration, which incorporates the principles of PBL offers advantages to both teachers and students. It recognizes that clinical attachments in individual disciplines can offer rich learning opportunities and that such attachments can play a role in an integrated, as well as in a traditional, curriculum. In TBL, the contributions of the clinical attachments to the curriculum learning outcomes must be clearly defined and tasks selected which will serve as a focus for the integration of the students' learning over the range of attachments.

A conceptual framework to guide the development of self-directed, lifelong learning in problem-based medical curricula. B.M. Miffin, C.B. Campbell & D.A. Price *Medical Education*, 34, 299–306, 2000.

Context: The information explosion and continual changes in the means of accessing information have reinforced the importance of preparing graduates to direct their own learning throughout their careers. Increasingly, medical schools are turning to problem-based curricula to develop in graduates the capacity to “self-direct” further learning.

Problem: Experience shows that, to achieve this goal, there needs to be consistency in interpretation of the goal and faculty-wide agreement about the way the problem-based curriculum fosters self-direction.

Suggested solution: This paper describes the conceptual framework developed by the Graduate School of Medicine, The University of Queensland, to guide the achievement of self-directed, lifelong learning in a graduate entry, problem-based curriculum.

Implications: It may be useful for others who are experiencing difficulties with implementing problem-based curricula, and for those who are contemplating changing to problem-based models.

Curricular change in medical schools: how to succeed. Carole J. Bland, PhD, Sandra Starnaman, PhD, Lisa Wersal, MA, Lenn Moorhead-Rosenberg, PhD, Susan Zonia, PhD & Rebecca Henry, PhD

Academic Medicine, 75, 575–594, 2000.

Society's changing needs, advancing knowledge, and innovations in education require constant changes of medical school curricula. But successful curricular change occurs only through the dedicated efforts of effective change agents. This study systematically searched and synthesized the literature on educational curricular change (at all levels of instruction), as well as organizational change, to provide guidance for those who direct curricular change initiatives in medical schools. The focus was on the process of planning, implementing, and institutionalizing curricular change efforts; thus, only those articles that dealt with examining the change process and articulating the factors that promote or inhibit change efforts were included. In spite of the highly diverse literature reviewed, a consistent set of characteristics emerged as being associated with successful curricular change. The frequent reappearance of the same characteristics in the varied fields and settings suggests they are robust contributors to successful change. Specifically, the characteristics are in the areas of the organization's mission and goals, history of change in the organization, politics (internal networking, resource allocation, relationship with the external environment), organizational structure, need for change, scope and complexity of the innovation, cooperative climate, participation by the organization's members, communication, human resource development (training, incorporating new members, reward structure), evaluation, performance dip (i.e., the temporary decrease in an organization's performance as a new program is implemented), and leadership. These characteristics are discussed in detail and related specifically to curricular change in medical school settings.

The development of professionalism: curriculum matters. Delese Wear, PhD & Brian, Castellani, PhD

Academic Medicine, 75, 602–611, 2000.

The authors propose that professionalism, rather than being left to the chance that students will model themselves on ideal physicians or somehow be permeable to other elements of professionalism, is fostered by students' engagement with significant, integrated experiences with certain kinds of content. Like clinical reasoning, which cannot occur in a vacuum but must be built on particular knowledge, methods, and the development of skills, professionalism cannot flourish without its necessary basis of

knowledge, methods, and skills. The authors present the need for an intellectual widening of the medical curriculum, so that students acquire not only the necessary tools of scientific and clinical knowledge, methods, and skills but also other relevant tools for professional development that can be provided only by particular knowledge, methods, and skills outside bioscience domains. Medical students have little opportunity to engage any body of knowledge not gained through bioscientific/empirical methods. Yet other bodies of knowledge—philosophy, sociology, literature, spirituality, and aesthetics—are often the ones where compassion, communication, and social responsibility are addressed, illuminated, practiced, and learned. To educate broadly educated physicians who develop professionalism throughout their education and their careers requires a full-spectrum curriculum and the processes to support it. The authors sketch the ways in which admission, the curriculum (particularly promoting a sociologic consciousness, interdisciplinary thinking, and understanding of the economic/political dimensions of health care), and assessment and licensure would function.

Toward a normative definition of medical professionalism. Herbert M. Swick, MD *Academic Medicine*, 75, 612–616, 2000.

In recent years, professionalism in medicine has gained increasing attention. Many have called for a return to medical professionalism as a way to respond to the corporate transformation of the U.S. health care system. Yet there is no common understanding of what is meant by the word professionalism. To encourage dialog and to arrive eventually at some consensus, one needs a normative definition. The author proposes such a definition and asserts that the concept of medical professionalism must be grounded both in the nature of a profession and in the nature of physicians' work. Attributes of medical professionalism reflect societal expectations as they relate to physicians' responsibilities, not only to individual patients but to wider communities as well. The author identifies nine behaviors that constitute medical professionalism and that physicians must exhibit if they are to meet their obligations to their patients, their communities, and their profession. (For example, "Physicians subordinate their own interests to the interests of others.") He argues that physicians must fully comprehend what medical professionalism entails. Serious negative consequences will ensue if physicians cease to exemplify the behaviors that constitute medical professionalism and hence abrogate their responsibilities both to their patients and to their chosen calling.

Using a standardized family to teach clinical skills to medical students. Maria C. Clay, Heidi Lane, Stephen E. Willis, Margaret Peal, Seshadri Chakravarthi, George Poehlman

Teaching and Learning in Medicine, 12, 145–149, 2000.

Background: The use of standardized patients has been an accepted instructional methodology in medical education for many years. A logical evolution of this methodology is the creation of a standardized patient family.

Description: This paper describes on such standardized family, the Jones Family and how the family is used to teach interpersonal skills, interviewing, communication, counseling, and history-taking skills to medical students.

Evaluation: After several years of using the Jones family, the authors have found that more comprehensive scripts need to be developed, that recruitment and retention of

standardized patients for a year-long program does not seem to be a problem, and that the value-added of a standardized family greatly enhances the educational experience for students. A standardized family seems a logical educational vehicle for teaching continuity of care, confidentiality, contextual placement of medical information within family dynamics, cultural beliefs, community orientation and generalist.

Conclusion: A standardized family is a viable instructional methodology that deserves greater use in medical education.

The collaborative health care team: the role of individual and group expertise.

Vimla L. Patel, Kayla N. Cytryn, Edward H. Shortliffe & Charles Safran

Teaching and Learning in Medicine, 12, 117–132, 2000.

Background: Increasing costs of health care and rapid knowledge growth have led to collaboration of health care professionals to share knowledge and skills.

Purposes: To characterize the qualitative nature of team interaction and its relationship to training health professionals, drawing on theoretical and analytical frameworks from socio-cognitive sciences.

Methods: Activities in a primary care unit were monitored using observational field notes, hospital documents, and audiorecordings of interviews and clinical interactions.

Results: The demarcation of responsibilities and roles of personnel within the team became fuzzy in practice. Continuous care was provided by primary care providers and specialized care by intermittent consultants. The nature of individual expertise required was a function of the patient problem and the interaction goal. These team characteristics contributed to reduction of unnecessary and redundant interactions.

Conclusions: Distributed responsibilities allow the team to process massive amounts of patient information, reducing cognitive load on individuals. The uniqueness of individual professional expertise as it contributes to the accomplishment of team goals is highlighted, suggesting emphasis on conceptual competence in the development of individual professional education programs.