



EURACT Newsletter

What can family medicine offer in education today for tomorrow's patient care?

By Janko Kersnik

Two things bother my mind when thinking about education in family medicine.

Firstly, family medicine is a unique discipline as discussions are ongoing while the definitions of the discipline are being developed, boundaries to other specialities and against health care profiles are being set, public health issues, health promotion and prevention, cost-containment, equity, quality and accessibility are being addressed (1, 2). Communication skills - among others the breaking of bad news - are introduced as a core of curricula. Medically unexplained symptoms, somatoform problems, diagnostic and decision uncertainty and wait-and-see strategy are captured as important topics of teaching (1-3).

Secondly, family medicine became captive of its enormous success and novelty in educational approaches (4). Almost each Medical School has a department of family medicine (5) and each country a kind of specialty training in family medicine (7-9). Evaluations of specialty trainings and undergraduate teaching are usually great, praising our extraordinary efforts in providing a bunch of new themes, topics and approaches, and foremost offering general practitioners

as role models in medical professionalism, cutting down traditional boundaries between teachers and students or trainees (4). Through these achievements family medicine acts also in education like practitioners - with goodwill to do what should be done - not asking either ourselves or

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educational authorities if there might be someone else in the educational gremmies who should devote time in their precious curricula to teach what family medicine education has taken on. Family medicine education keeps on repeating itself for the sake of the benefit of the students picturing a bright future for patients.

It seemed obvious that family medicine education had to take what was left from other Medical School disciplines to put its flag on the map of schooling if it did not want to become just a brief comprehensive repertorium of the "whole medi-

cine" taught in a Medical School before students would be dismissed as fully licensed doctors into the community. Claiming its own definitions and a growing body of academicians in the majority of European countries, family medicine has to start behaving as a classical medical discipline, equal to all other medical specialties. Instead of taking over the burden of filling in gaps in weak overall curricula of a Medical School, like family medicine does when filling in the gaps in poor health care systems in order to get the best available health care for patients, it should at least in teaching primarily focus on the provision of themes generic to family practice. The same is true in specialty training in those countries where family medicine education is split between training in family practice and hospital based training (6). Family medicine education should not take the whole responsibility of what other disciplines have been appointed to do.

Family medicine education has been recently faced with conflicting pressures from society, governments (tax payers) and health care related industries. As innovation based on the principles of the discipline of family medicine education is one of the driving forces in the

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constant development of family medicine (9), more and more colleagues have pointed out weaknesses in the modern health care industry. One of these is the medicalisation of all aspects of human life (10). Who else except family doctors have grasped this idea and have developed strategies to combat this perceived evil of modern society, mongering of liberal capitalism and ignorance of populations? Quaternary prevention can mean a big deal in avoiding unnecessary testing and treating for minor ailments or even non-diseases (11). Family medicine has - figuratively speaking - stepped on the throne of medical religion waving the flag of sacred medical principles. Personally I hope that family medicine has learnt the lesson of democracy. Democracy is a rule of numbers – masses do not necessarily mean a rule of wisdom. In a big world the medical society is outnumbered by non-medical people, who are driven by other forces than doctors are as medical professionals. How to stand this turmoil of not being recognised and praised even when you are right? Shall we give up or rebel? Neither of these acts is effective. We shall rely on what we do best – on education (3, 9, 12). It does not provide quick results but long lasting ones.

Family medicine education should apply core attributes of its discipline also in these cases and learn ourselves and teach others how patients can be managed comprehensively (1-3). It is not just about responding to actual complaints and/or managing chronic condition(s). Actually it is even more important to act beyond the payable contact diagnosis or consultation minutes. Family medicine has to take into account preventive aspects and influence future health care by seeking specific behaviours in our patients sitting in front of us in the consultation room. To keep general practitioners a bit above the common societal opinions regarding health care issues, doctors firstly need to learn ourselves by meeting colleagues, discussing issues, re-examining core principles and ethics of health care. Secondly, academicians and opinion leaders should be asked to participate in independent meetings, which will allow basic discussions and colleagues should be encouraged to take part.



Family medicine has to take into account preventive aspects and influence future health care by seeking specific behaviours in our patients sitting in front of us in the consultation room

Equipped with knowledge and skills on how to manage unjustified demands of patients and societal pressures against what general practitioners accept as medically justified, doctors can provide the best teaching experiences to students and trainees. It is not what we preach but how we behave that persuades patients and provides the best lesson for our learners.

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Country Report

Undergraduate general practice training in Norway – current status and challenges for the future

By Mette Brekke

A well-functioning primary health care system is known to lead to better health outcomes and greater equity in health at a lower cost, compared to more specialist-based health care systems (1).

Primary health care means the provision of first contact, person focused, ongoing care over time that meets the health related needs of people, referring only uncommon or serious conditions, and coordinating care when people receive treatment at other service levels.

The general practitioner (GP) has long been the cornerstone of the Norwegian health care system. At present we have a well-functioning list system, where 4100 list holding GPs provide service to a population of close to 5 Millions, and each inhabitant knows who is his/her personal doctor. Anyhow, there is still room for improvement, and the Government has recently launched a new health care reform (“The Coordination Reform”) as a “white paper”, which states that even more health problems should be solved in the community and by GPs (2). Not surprisingly, increasing health care expenditures have been a major drive behind this reform.

The question is, though: How does current education in medical schools secure that a sufficient share of young doctors will want to go into general practice in the future, to sustain a high quality and comprehensive primary health care (3)?

Medical schools

Medical school in Norway implies six years university studies, followed by 18 months of internship. A total of 580 students graduate each year, from the univer-



sities in Oslo (n = 210), Bergen (n = 150), Trondheim (n = 120) and Tromsø (n = 100). A similar number of Norwegian students graduate from universities abroad - in among others Poland, Czech Republic, Germany, and Denmark. What kind of general practice training these students are exposed to, is outside our control. The domestic medical schools, though, aim at providing a rather comprehensive general practice education. Variations exist between the four universities and reforms are constantly taking place – here I will focus on the main common issues and challenges.

Important elements of current general practice undergraduate education

- *Early patient exposure.* Students visit a general practice very soon after they enter medical school – in Oslo we see them on day two! During several scattered days they meet patients and try how it is to be in the doctor’s role.
- General practice is taught as *one of three main clinical subjects*, besides internal medicine and surgery. This comprises both a special general practice

term towards the end of the study period, but also that general practice lectures are provided throughout the six years. For example, I myself lecture on “Acute abdominal pain in general practice” in the sixth (gastro-enterological) term, and about “Gynecological problems in general practice” in the ninth (mother-and child) term. Some lectures are given together with a hospital doctor, for example regarding hypertension, acutely ill children etc.

- General practice curriculum is based upon our *comprehensive Norwegian textbook (4)*, of which we are proud and which will appear in a third edition in 2012. The textbook is the result of collaboration between academic GPs throughout Norway and a large number of working GPs, and is also used in undergraduate teaching in Sweden and Denmark.
- Towards the end of medical school the students spend *up to eight weeks doing clinical work in a GP’s office*. Here they are exposed to “master and apprentice” teaching – this is by far the closest contact they get with one single doctor throughout the whole medical school!
- The students’ knowledge and skills regarding general practice are assessed in various *examinations*. In Oslo, we give a special general practice examination at the end of the 5th year, and general practice is also a major part of the final theoretical and practical examination. This means that at the practical assessment, each student examines three hospital bound patients and one patient brought in from a general practice in the city.

Challenges

- “*The hidden curriculum*”. Regardless of general practice training, the students spend most of their time in highly specialized university hospitals. It can easily occur that teachers in the

hospital based disciplines discard general practice, for example by telling stories of how the family doctor failed to make the correct (and very special) diagnosis of the current patient. Or they may let it shine through that general practice as a career choice is of less value, compared to their own specialty. Of course such input will influence the students' point of view over time. My personal impression as a teacher is that this "hidden curriculum" – although still existing - has become less influential over the years, and certainly since I myself was a student!

- *Budgets.* Even if Norway is an affluent country, universities constantly fight budgetary cuts and limitations. "The hidden curriculum" may easily influence deans and other decision makers, and lead to reductions in general practice teaching. Early patient exposure and clinical rotation in GPs' offices have been under special threat, as these are relatively expensive teaching methods. It is very positive that the deans at the four universities at their last annual meeting agreed to work towards a stronger focus on general practice in their curricula. Probably, the recent "Coordination reform" will have put some pressure on them.
- *Quality assurance.* Norwegian medical schools lack systems for a comprehensive

and universal quality assessment and assurance for their theoretic curricula as well as for the teaching taking place in GPs' offices. The latter has by large been left open to the single GP teacher, trusting that he/she will provide a valuable "master and apprentice" experience. Lately, some attempts of standardisation of this particular teaching have been implemented (5) – but there is ample room for improvement. By large, it is a challenge to assure that the undergraduate general practice teaching is in line with changes and demands in the society.



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- *The closing down of internship.* Until now the six years at medical school have been followed by 18 months of mandatory internship, where six months have been in general practice. This has secured that all doctors – regardless where

they subsequently chose to work – gain a rather substantial knowledge of general practice. Because of EU workforce regulations, this system is no longer possible to run, and it seems that it will shortly be closed down. This will imply a serious loss of general practice competence and insight among young doctors, and we will inevitably need to rethink on the contents and extent of general practice education in medical schools.

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Physician know thyself... Really?

By Valérie Dory

As a profession, medicine has been granted wide-ranging autonomy and privilege in exchange for providing competent and compassionate care. The autonomy of the profession is broadly transferred to each individual doctor both in terms of his/her practice and in terms of his/her learning. As self-regulated professionals and life-long learners, doctors are admonished to self-assess their competence and medical schools aim to prepare their stu-

dents for this task. There have however been several voices casting doubt on the relevance and feasibility of this widespread dictate (1-4).

What does the term self-assessment mean?

Self-assessment is very much an umbrella term and can mean different things to different people. Broadly speaking, self-assessment is a judgement one makes about oneself. Different authors have put forth

different categories of self-assessment. Eva et al have proposed to distinguish broad self-assessment (e.g. do I have a good sense of humour? am I good enough in managing congestive heart failure?) from self-monitoring which is a more specific moment-to-moment evaluation of how one is doing during an activity (1,2). They suggest that broad self-assessment is mainly relevant to continuing professional development which often relies on doctors to assess their learning needs and select appropriate activities, whereas self-monitoring is

mainly relevant to autonomous practice (e.g. knowing when to look something up or refer a patient to someone else). We have proposed a 4 category classification which distinguishes further between each of the two levels proposed by Eva et al, with the most general level referring to sweeping evaluations such as self-concept and self-esteem, and the most specific referring solely to metacognitive monitoring, i.e. monitoring of one's mental processes (5). Although some use the term self-assessment to refer to taking a test on one's own, it has been suggested that this should be called self-testing rather than self-assessment (2).

The inaccuracy of self-assessment

It is as hard to see one's self as to look backwards without turning around. Henry David Thoreau

Several reviews of the literature have shown that individuals' (including doctors' and medical students') self-assessments are poorly correlated with external assessments (correlation coefficients typically around 0.3) (3, 6, 7). There are a number of difficulties inherent with the task of self-assessment. Self-assessment like any assessment involves 1) collecting data, 2) comparing this data to some reference standard, in order to 3) reach a judgement (8, 9).

Data collection

The first hurdle is to collect valid data reliably. This can be more or less difficult depending on the what and when of the self-assessment task (2, 9). It is for instance easier to self-assess when there are data available from one's senses requiring little if any interpretation. It is quite straightforward to determine whether one can lift a 30 kg weight with one's left hand. Try it and the answer will be self-evident. In the same way it is a relatively simple matter to ascertain how one is doing while taking a blood sample: if blood is flowing into the tube and the patient seems happy, it's going well. Not everything a doctor does however is that readily observable. Much of a doctor's job is of a cognitive nature (i.e. clinical reasoning). The mental processes involved are gene-

We propose a 4 category classification of self-assessment and self-monitoring with the most general level referring to sweeping evaluations such as self-concept and self-esteem, and the most specific referring solely to metacognitive monitoring, i.e. monitoring of one's mental processes

rally not directly accessible to one's own mind. Indeed metacognition (the monitoring and control of one's mental processes) often uses heuristics, shortcuts as it were, to get a ballpark idea of how they are proceeding (10). Even the consequences of clinical reasoning do not always provide clear-cut data. How much is a patient's state the result of the actions of a single team-member? How much is in fact the result of the specifics of the pathophysiology of the individual case? Will the consequences even appear while the patient is under the care of the doctor whose actions may or may not have impacted on his/her state? Another important obstacle to accessing valid data reliably is memory. This is especially true when self-assessment concerns a general ability. This is where the distinction between broad self-assessment and self-monitoring becomes more than a semantic exercise. Self-assessment of a general ability (e.g. is my management of dermatological complaints adequate?) requires delving into one's memory of successive events and combining them to obtain an overall estimation of one's proficiency. Such a task is subject to the documented biases inherent to the processes of selection, interpretation, reconstruction and aggregation involved in memory. Eva & Regehr have argued, and indeed found some evidence to support their claim, that self-monitoring is more accurate than the data on self-assessment, which relies more often than not on studies of broad self-assessments, suggest (11, 12).

Comparing data to a reference standard

To reach a decision based on the collected data, a threshold must be determined. This threshold can be criterion-based (e.g. competence in procedure X means an y% success rate; measuring blood pressure correctly means following certain steps), or norm-based (am I a above-average driver?). Both require that the individual have a good grasp of what the standard represents. It has for instance been shown that self-assessments are more highly correlated with external assessments when the criteria are explicit (7, 13). This may also provide part of the explanation for the frequent finding that the poorest performers are also the most grossly unaware of their actual ability. If one knows little about a domain, one may have little understanding about what there is to know (as Eva et al pointed out "How can I know what I don't know?" (14)). Kruger and Dunning tested the effect of an intervention designed to improve logical reasoning in poor performers and found that not only did the intervention improve their actual performance on a test of logical reasoning but that it also led to more accurate self-assessment (15). It appears that gaining understanding into the domain tested helps individuals calibrate their self-assessment. Both require a good grasp of the reference standard.

Judgement

Human judgement has been shown to suffer from many biases, the description of which is beyond the remit of this piece. Self-assessment has been found to be subject to a particular bias called the "above-average effect", i.e. most people believe that they are above average in a wide variety of domains, which of course cannot be the case (15). Some have argued that this optimistic view of oneself is adaptive. The literature on self-efficacy in particular has shown that individuals who believe in their ability to perform a task even in difficult circumstances end up performing better overall thanks to several mediating processes

such as increased motivation and perseverance (16).

Is acquiring the ability to self-assess the cornerstone of self-regulated learning and practice?

Can it be acquired? Can it be taught?

Certain of the obstacles inherent to self-assessment, such as the limits of memory and introspection, cannot be lifted whereas others can. The quality of data collection can be improved by encouraging students and practitioners to document their self-assessment. Reflection-on-action is one way to do that. According to Schön, reflection-on-action is a deliberate analysis of a specific prior event, aiming to

sional development activities have frequently provided practitioners with objective tests to help them gauge their competence in a non-threatening way. Some portfolios also include the requirement to document external feedback.

The next step in the process, namely comparing data to a reference standard, is probably the area in which improvements can be most easily gained in self-assessment accuracy. Using explicit marking criteria or showing students video benchmarks have been shown to work (7,13,21). Communicating learning objectives and evaluation criteria to students should not only help self-assessment but could also play an important part in the assimilation of professional norms and indeed in the development of professional identity.

which can sometimes lead to the feedback being simply disregarded. They suggest that facilitation may improve the assimilation of external feedback. Such facilitation would need to take into account the individual's self-assessment, whether accurate or not, to guide the reflection process in a sensitive manner.

Do we actually mean to develop metacognitive skills rather than just self-assessment?

Self-assessment has been the focus of much attention because as autonomous professionals, doctors are frequently left to their own devices in practice and certainly in their learning (although some countries have more stringent controls). The adult learning model has also proposed that much of continued learning must be self-directed (23). Even in the classroom, the emphasis on helping learners to learn has increased (24). Self-assessment and metacognition should not however be confused. Metacognition, i.e. "thinking about thinking", refers to the monitoring and control processes involved in regulating our mental processes. Clearly these processes are important for self-regulated learning. However monitoring should not be narrowly construed as purely introspective self-assessment. Using self-testing, seeking and reflecting on external feedback are highly valuable metacognitive strategies. Perhaps it is metacognition more generally that we should seek to develop rather than simply self-assessment.

Conclusion

Individuals, including doctors, regularly engage in self-assessment at some level and use this data to inform many of their personal and professional decisions. Overall self-assessment has been shown to be inaccurate, especially when it relies on memory of multiple events and especially in the least proficient. Accuracy can be improved to some extent by encouraging deliberate reflection on specific events using data from internal and external sources. Medical curricula should strive to encourage students to be critical about their self-assessment and should

Step	Obstacles	Avenues for improvement
Data collection	Non observable data Limitations of introspection Limitations of memory Aggregating memories of multiple events	Seek data from external sources Refer to a specific event
Comparison to a reference standard	Criteria unknown or misunderstood	Increase competence Communicate criteria (marking grids, video benchmarking...)
Judgement	Bias e.g.: "above-average effect"	

Obstacles to accurate self-assessment and avenues for improvement

increase one's understanding of the event and to learn from it (17). Karen Mann et al reviewed the literature on reflection in the health sciences (18). They found some indications that reflection ability can be fostered in students and practitioners. Portfolios are one example of an intervention designed to encourage and facilitate reflection. Mann et al found that educational or professional climate was an important factor (18). Another important avenue is to encourage individuals to seek data from external sources to inform self-assessment, what Eva et al refer to as "self-directed assessment seeking" (2) and Sargeant et al "directed self-assessment" (19). "Multisource feedback" has been developed to do just that, providing practitioners with assessments from co-workers and patients which can then be combined with self-assessment to stimulate reflection (20). Continuing profes-

Should it be taught?

Despite these suggested ways to improve self-assessment accuracy, some of its limitations cannot be overcome. This has led some to argue that the focus should shift from improving self-assessment accuracy to educating about its limitations and indeed abandoning it altogether (2). One of the problems with this approach is that it fails to take into account that self-assessment occurs anyway and has a significant impact on the way that assessment data from external sources, i.e. feedback, is assimilated. Sargeant et al have examined how doctors use data from multisource feedback and have found that the degree of dissonance between external data and self-assessment impacts the reflection process (19, 22). Feedback that is inconsistent with self-assessment appears to trigger reflection together with strong emotional responses

equip them with more comprehensive metacognitive strategies such as self-directed assessment seeking and reflection. Autonomy is not synonymous with isolation. Indeed practice and learning can benefit greatly from social interactions including constructive feedback and facilitated reflection.

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INTERMEZZO

On the way to be a 'good teacher'

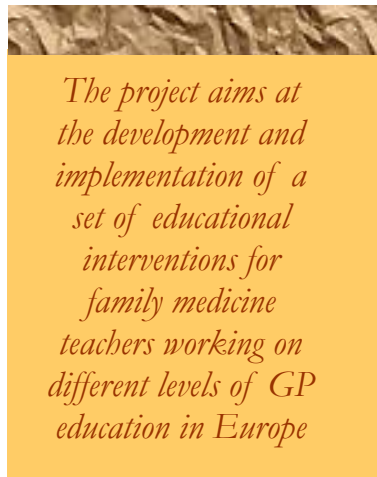
By Ozlem Tanriover

The Leonardo EURACT Level 1 course for trainers in family medicine/general practice was held in Cesme, Izmir Turkey between 27 to 30th of June 2011. This was the first of a series of courses developed within a two year project titled "Framework for Continuing Educational Development of Trainers in General Practice in Europe (CED in GP)". The project, co-funded by the European Union within the framework of Leonardo da Vinci Programme, aims at development and implementation of a set of educational interventions for family medicine teachers working on different levels of GP education in Europe. There are three course levels : Level 1 (from novice to competent educator) - level 2 (from competent to proficient educator) and finally level 3 (from proficient to educational expert). I had the opportunity to attend the course of level 1, and I would like to share this experience with you.

First of all, we had two great hosts: Professor Dilek Guldal and Professor Okay Basak who organized everything in detail, (sometimes they seemed to be a little bit tired, but their warm smiles never faded away), and also participated in the training programme to show us how a teacher can be outstanding in the primary care just like the other faculty in the course.

On the first day, we met our 'trainers'; professors from Turkey, Poland, UK and Denmark and we introduced ourselves. From all over Europe there were both experienced teachers as well as novice ones, but I saw a very enthusiastic group of people ready to learn, eager to work and stay indoors for hours despite beautiful weather and a nice beach located in the coastline of the Aegean coastline. At the beginning of the course, it was a little bit strange for me because I needed to take off my teacher-hat and sit there as a student which made me think of what sort of teacher behaviors, or teacher characteristics, including personal attributes, are perceived by students to be associated

with quality instruction and effective learning? How would I rate myself as a teacher through the perspectives of my students. While I was thinking like that our first assignment came; we had to write down 7 items on how a good teacher should be. After being divided into 3 groups, we discussed about a good teachers' qualifications. Communication skills were in number one as needed to be a good teacher in fact it is needed to be a good GP also; my group also voted that a good teacher should also be a good clinician, confident, life long learner, and be empathic. After describing 'Good teachers qualifications', we worked on to find out our own learning needs. How good teachers we were? What were our learning needs? How could we improve ourselves? Maybe this was the main idea of the course: to improve yourself through education, so that you could improve your students and as an outcome improve your practice.



The project aims at the development and implementation of a set of educational interventions for family medicine teachers working on different levels of GP education in Europe

We continued to explore how adults learn. Unlike children, adults have unique experiences and values and learn with expectations. We learned the Kolb's and Fleming's VARK method of learning and we prepared a poster presentation about this.

On the second day, we gathered to find out which teaching methods we used and which methods we liked best and in terms of

knowledge, skills and attitudes which methods served best to teach. We did a brainstorming about the methods we used. We have seen that we have been using quite different methods, without knowing our trainees' learning styles, but we learned about it later. After that, we watched a very short video showing a patient and a resident doing the consultation. Each group prepared a dramatization, representing the patient, trainee doctor and the trainer. And we tried to discover what the patient felt, how was the trainee doctor's attitude and as a trainer how could we give feedback to our trainee. Giving feedback, was one of the most important, yet challenging task for relatively inexperienced trainers because our goal is to improve our trainees, without hurting their feelings and we have to be specific and constructive. We worked on some scenarios by role playing and saw that it was not easy at all.

For me, one of the most interesting part was to learn my own learning style. We filled out a questionnaire to find out about our learning style. We mainly focused on 4 learning styles: Activists, Reflectors, Pragmatists, and Theorists. In each of these styles, people learn in different ways. For example, I had reflector style; this group of people liked to watch, think and review and liked to use journals and brainstorming. Lectures were helpful if they provided expert explanations and analysis. So, of course our students have their own style, and it would be most beneficial if we could organize our teaching style according to needs of our students.

On the third day, we discussed about role-playing and actually wrote and played difficult situations that we encounter during our consultations with our patients, which guided us to feel how to be in someone else's shoes. And finally we worked on how to develop a teaching plan. Planning ahead, time management,

being organized, and enthusiasm are essential for a teaching plan. I started to plan for the next year with a great motivation.

From this level 1 course, I have learned that in order to be a good teacher; we should use some strategies. First of all, we should communicate well and open to any criticism. We should clearly indicate our expectations for students' behavior and performance in the beginning and then explain concepts and techniques at the students' level confirming their understanding. We should provide feedback in a

non-humiliating manner, and understand students' learning needs at different levels of training and adjust our teaching accordingly. Of course, this is just the beginning and there are still many issues to be addressed like how to facilitate learning in work place or how to do the assessments.

As family physicians, we approach our patients as one of our family members. The same is true for our students. We like to see them grow as competent doctors as well as role models in our community. So, we need to work harder for our own educational needs.

In my opinion, we all had 'take home messages' from this level 1 course. Some of us started to plan for the next year, while some others thought about more educational needs.

We were all from different countries and cultures but we shared some common goals and dreams: to be good physicians and good educators. In order to reach our goals and dreams we need more education and motivation because learning as well as teaching is a life long journey.

Literature Reviews



Who are the judges? Or nanotechnology of teaching?

Reviewer Elena Frolova

M. J. B. Govaerts, L. W. T. Schuwirth, C. P. M. Van der Vleuten, A. M. M. Muijtjens. *Workplace-based assessment: effects of rater expertise. Adv in Health Sci Educ (2011) 16:151-65.*

Summary

The possibility of assessing performance has lately been the subject of discussions in EURACT for many years. The most appropriate and popular methodology is workplace-based assessment (WBA). Many other professional domains (not only medicine) try to use this method. Research into WBA typically takes the psychometric perspective, focusing on quality of measurement. Workplace-based assessment relies on judgments by professionals, who typically have to perform their rating tasks in a context of time pressure, non-standardized assessment tasks and ill-defined or competing goals. Raters are thus continuously challenged to

sample performance data, interpret findings, identify and define assessment criteria and translate private judgments into sound (acceptable) decisions.

Therefore a better understanding of raters' reasoning and decision making strategies can really improve WBA outcomes. Interestingly, expertise is a complex cognitive process. Compared with non-experts for example, experts see things differently and see different things. So the behavior of raters and cognitive processes can be studied in order to come to a better choice of experts and better WBA outcomes.

The 34 participants in this study were GP-supervisors who were actively involved as supervisor-assessor in general practice residency training. The level of expertise was defined as the number of years of task-relevant experience as a supervisor-rater. All experts watched the same two DVDs and filled in special protocols; the duration of all steps was recorded and then analyzed. As results showed, experienced raters generated significantly more inferences or interpretations

of student behavior, whereas non-experts provided more descriptions. The experts-raters generated significantly more interpretations when filling out the six-dimensional global rating scale. The results also show non-significant differences between the two groups in the rating scores.

Comments

In spite of the importance of the goal of such studies, this one demonstrates all expectable results. We know that experts are better than novices, but many novices become experts.

The participants of the study were all volunteers, and therefore may have been more motivated to carefully assess trainees' performance. This may limit the generalization of the results to raters in 'real life' general practice. We all know, that real life in general practice is much more hectic and complicated, time is really limited.

The methodology of the research design does not allow making objective conclusions:

Literature Reviews

the sample is not random; the choice of material for expertise (DVD with cases where GPs act) also is arbitrary.

So what do we have? Free choice of cases, voluntary and paid participation in research – far removed from real-life-setting conditions of research, and in general the conclusion that experienced raters are better than novices.

In my opinion these results cannot help improve the results of WBA as we will choose the expertise of more experienced raters anyway if we have such opportunity and we will train new experts to reach the level of experienced ones.

But from a scientific point of view this article gives us the possibility to look at the mystery of cognitive processes in the brain, to understand decision making better. Maybe in the future we will choose experts for any examination using special procedures, and they will also rate trainees with special procedures, elaborated on the base of such experiments...

Implications for training

For training of raters this research can be useful – as well for experienced ones as for novices.



Who cares about reading papers in an era of PSR outreach?

Reviewer Janko Kersnik

Harris J, Kearley K, Heneghan C, Meats E, et al. *Are journal clubs effective in supporting evidence-based decision making? A systematic review.* BEME Guide No. 16. *Medical Teacher* 2011;33:9–23.

Summary

Background: This paper presents a systematic review on research on journal clubs (JCs) and provides an overview of this teaching method. Surprisingly, many studies tackled this relatively old phenomenon. The aim of JCs is to promote the taking up of research evidence into medical practice.

Objective: This systematic review aims to determine whether the JC is an effective intervention in supporting clinical decision making.

Methods: Undergraduate, post-graduate and practice JCs that evaluated whether clubs promote changes in learner reaction, attitudes, knowledge skills, behaviour or patient outcomes. Over 200 papers were found describing JCs. Eighteen studies were included. Interventions were too heterogeneous to allow pooling.

Results: JCs were used for several purposes with making use of critical appraisal of published data among the most prominent ones. Studies reported improvements in reading behaviour (N=5/11), confidence in critical appraisal (N=7/7), critical appraisal test scores (N=5/7) and ability to use findings (N=5/7). No studies reported on patient outcomes. Sixteen studies used self

-reported measures, but only four studies used validated tests. Realist synthesis identified potentially 'active educational ingredients', including mentoring, brief training in clinical epidemiology, structured critical appraisal tools, adult-learning principles, multifaceted teaching approaches and integration of the JC with other clinical and academic activities.

Conclusion: The effectiveness of JCs in supporting evidence-based decision making is not clear. Better reporting of the intervention and a mixed methods approach to evaluating active ingredients are needed in order to understand how JCs may support evidence-based practice. The aims of JCs should be stated. The authors recommend to thoroughly describe the educational models and teaching and learning principles underpinning the intervention, to develop valid and reliable tools to evaluate how the learning environment supports the process of learning, to use logic models to evaluate how different elements of JCs promote decision making about using research in practice and to evaluate the relative success of the intervention by different levels of learner – medical student, intern, research fellow, faculty and practitioner.

Comments

I enjoyed reading this paper from two perspectives.

Firstly, the authors were - thanks to journal policy - able to provide a good background on adult education, which makes the paper interesting from a point of a short repertorium of important educational concepts. Secondly, the paper showed all the meticu-



lous problems in educational research and the authors made all the efforts to enlighten the readers how to avoid problems and flaws in future educational research.

Regarding the topic of the paper I got the - in a way - expected answer that ill-defined intervention produces ambiguous results. The phenomena of JCs preceded the emerge of EBM and seemed to be quite popular in many academically aware doctor groups for many decades. So, from my point of view, JCs can only serve as one of the EBM tools for the uptake of new knowledge. Also, several side interventions in terms of mentoring, didactic support, use of structured review instruments, adhering to principles of adult learning, using multifaceted approaches to learning, and integrating learning with other academic and clinical activities might have enhanced the effectiveness of JCs. To be trained in the method may play a crucial role. We should not neglect the investment of time and other resources in a mixed group of early adopters and laggards. From my point of view a personal learning plan developed with a facilitator might identify those who can benefit in behavioural change using EBM supported by this group technique. Do we know exactly how many colleagues care about reading papers in an era of PSR outreach pressure?

Implications for training

On the basis of this systematic overview I am not able to recommend use of JCs on great scale for participants not trained in principles of EBM and in small group. Students and trainees, who should take part in JCs, should have classes on JCs as a learning method if JCs are about to be promoted on a larger scale in a country, otherwise JCs are just one EBM variation of extracting information from a scientific paper selected by someone else.

Shedding more confusion on feedback

Reviewer Brendan O' Shea

Eva KW, Armson H, Holmboe E, Lockyer J, Loney E, Mann K, Sargent J. Factors influencing responsiveness to feedback: on the interplay between fear, confidence and reasoning processes. Adv in Health Sci Education DOI 10.1007/s10459-011-9290-7, published online 06 April 2011. Open access at Springerlink.com

This article includes an overview on historical and current theories of feedback in the context of medical teaching, together with results of a qualitative study conducted on 8 learning groups across 5 countries, involving 134 participants. Participants included undergraduate learners, post-graduate learners, and practicing physicians.

The overview provided appeared comprehensive, discursive and inconclusive. The qualitative data from the Focus Groups was reassuringly familiar, and could be considered as good evidence that the participants were at least as confused as most of us are, on this important but difficult and poorly understood topic.

In the conclusion, it is aptly noted that 'there is no simple recipe for the delivery of feedback.'

Comments

If you have a strong academic interest in the theory and practice of feedback in your teaching, or if you were considering a research piece on feedback, this article is likely to be of use and of interest. There is an extensive and relevant reference section.

With respect to the methodology of the focus group, overall it appears clear, sequential and logical; one uncertainty relates to the selection of the partici-

pants, and the authors omit to indicate the number of individuals invited.

If you are looking for a clear set of key points, and you are chiefly driven by a need to obtain a practical grasp on giving effective feedback in your own teaching, there may be better articles or sources to consider.

If you are (as most of us) in a clinical role and actively engaged in ongoing continuing medical education, you will find the data presented and the reportage from the focus groups most reassuring, moderately provocative, and indeed enjoyable.

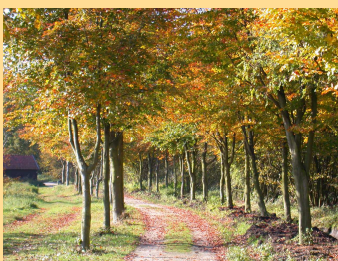
Selective use of these qualitative elements might also be of interest in stimulating and informing discussion among any group of learners you have a teaching responsibility for, and particularly so if you were considering the introduction of more or of different feedback process as part of your programme.

Implications for training

Even in the context of a careful, discursive and comprehensive article such as this, it is clear that consistent and reliable feedback in many respects remains a desirable rather than reliable or uniformly feasible objective.

At present, and in the context of this article, reliable effective feedback may be more of an art than a science. It may perhaps be more complex than our current research methodologies can easily or reliably elucidate.

Therein lies both the confusion and the challenge.....



Agenda

EURACT

11-13 November 2011

Euract Council meeting
Faro, Portugal

21-23 March 2012

Euract Council Meeting
Jerusalem, Israel

WONCA – Europe

8-11 September 2011

Europe Regional Conference
2011 Warsaw, Poland
“Family medicine, practice, science
and art”.

EGPRN

10-13 May 2012

Ljubljana, Slovenia
Quality improvement in the
care of chronic disease in
family practice : the contribu-
tion of education and re-
search

18-21 October 2012

Antwerp Belgium
The theme for this meeting is:
“Research on patient-centred
interprofessional collabora-
tion in primary care”.

OTTAWA CONFERENCE

9-13 March 2012

Kuala Lumpur, Malaysia
OTTAWA conference on
assessment of medical
competence

AMEE

25-29 August 2012

Lyon, France
The theme for this meeting is
« *The Continuum of Education in
the Healthcare Profession* »



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