Style Matters

Improving medical meetings

III—Diversify the format of conference sessions

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Participants in most medical conferences do not confer. Bremner's disappointment at the passivity of conference audiences and reliance on lecturing as the chief mode of communication¹ is shared by a few but probably not by most of those who believe that the main purpose of medical meetings is efficient dissemination of information.

In the belief that medical conferences can be efficient yet provide opportunities for the participants to talk and share ideas and experiences, the Royal Australasian College of Physicians in New Zealand has evolved a structure for its annual clinical and scientific meetings over the past five years, which is conducive to both these ends. This paper describes our experience with diversified session forms and other aspects of conference design which have taken us well away from the succession of 20 minute presentations followed by five minutes of discussion which formerly characterised our meetings and still characterise many others.

Overall design for a three day conference

The considerations we have taken into account in the overall design are as follows. Firstly, we have timetabled the most intensive sessions in the morning, when audience concentration is at its peak. Thus the mornings are given over to keynote speakers and major symposiums with the audience meeting in large groups for all or most of the time. Secondly, we have changed the pace in the afternoons by scheduling small group sessions and shorter presentations emphasising shared experience, thus enabling tiring minds to cope. Thirdly, we have catered for the desire of participants to choose content and type of session by running a limited number concurrently. Fourthly, we have encouraged informal exchanges among participants by avoiding scientific sessions at meal times and after 5.30 pm. Finally, we have increased the educational content of our meetings by moving away from a high proportion of original papers to a greater emphasis on updating and review of important medical themes.

Types of conference session

Major symposiums—Although current methods of using multiple speakers addressing aspects of a topic followed by discussion are efficient, and we continue to use them, we have introduced some variations. These include the use of panel discussions, formal debates, and sessions built around patient management problems. A successful way

to introduce patient management problems is as short case histories based on diagnostic and management problems encountered in real life practice, which are first commented on by a member of the audience who has studied the problem in advance and then by one or more of a panel of experts. Questions and comments from the audience follow.

Clinical updates—These comprise 15 minute presentations on some aspect of the growing edge of medicine, followed by five minutes' discussion. We usually schedule these as an afternoon activity, one of two or three concurrent sessions using different formats.

Clinical vignettes—These five minute case presentations designed to illustrate one point about diagnosis or management are followed by five minutes of discussion and shared opinion. Clinicians who are not necessarily recognised experts in any subject enjoy presenting their cases. They may be used in a block of time or infiltrated into the programme, at any stage, to provide some light but practical relief.

Miniworkshops—These are usually scheduled for two to two-and-a-half hours in the afternoon concurrent with other types of session. Two or three tutors run each workshop. Themes are chosen so that there will be a high degree of audience participation. Popular topics have included: bedside diagnosis in cardiology, neurology, etc; tuition in diagnostic techniques, such as echocardiography; interpretation of radiographs and other laboratory tests. The audience is limited to a maximum of 20, but some work is often done in smaller groups. Thus a workshop on "bedside diagnosis" would usually be limited to six participants per tutor.

Meet the expert—This type of session (also known as "kerbside consultations") is based on the American College of Physicians' "meet the professor" session. The audience is limited to roughly 16 people and the duration to one hour. A range of topics on which the expert is prepared to give an opinion is advertised in advance of the meeting and the audience presents its problems, both theoretical and practical, for elucidation and group discussion.

Computerised self assessment—The college's bank of computerised multiple choice questions with answers and commentary for main-frame and desk top computers is made available for self assessment.

Self learning—A quiet room is set aside to enable those who wish to do so to browse through the continuing education unit's library of audiotapes, microfiche, and slide-tape programmes.

Presentation of original research—Although we have moved away from a major commitment to the presentation of original research papers, we think that it is important to maintain a place in one of the morning programmes for the presentation of a selection of original papers. The introduction of a substantial prize for the best presentation of original work by a trainee of the college, as judged by a panel of experts, has proved popular.

Discussion

The college lays no claim to be the originator or even to be the first body to use a diversity of sessions in its meetings. The American College of Physicians' annual meeting incorporates some diversity of sessions, and other types of format have been described. For example, a novel yet effective way of handling original papers has been described by Dobbing.^{2,3}

We are aware, however, that many medical meetings are still

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programmed along traditional lines. Learning ought to be pleasurable, and there are sound theoretical reasons why a format of diversified sessions increases the pleasure and effectiveness of learning. A key feature of modern theories of adult education and learning is that people actively seek information which will provide a better understanding of events which are relevant to them at a particular time. Thus the focus of learning is "relevance." Hence in any educational setting each adult participant will view the setting differently and take from it only items of relevance. The "teacher" thus becomes not only a dispenser of facts but a provider of learning opportunities and a facilitator of an actual learning process for each participant.

This concept must be central to any model of adult education and incorporated into methods and techniques. Learning in small groups is a process of shared facilitation of learning. Consultation is a process of helping the client discover strategies of management for himself. Self directed learning, workshops, discovery learning, etc, all operate on this key cognitive model.⁴ Tough's educational research has shown for adults the importance of self education through reading and experiment.⁵ It seems obvious that any learning experience which incorporates opportunities for one to one participation and self inquiry may also be usefully incorporated into medical conferences. In Bremner's words, "The membership ought to be the conference and not simply witness to it."¹

Guidelines for leaders of the various types of session have been developed and published.⁶ The appropriate guidelines are sent to the leaders several months before the meeting so that they may have an opportunity to use them in planning their sessions. We think that it is important to change the conference format slightly from year to year so that there is an opportunity to try out new ideas, reincorporate old ones, and generally avoid being tied rigidly to one format.

In evaluating each year's conference participants have shown a high degree of acceptance of the diversified format and in particular of the small group afternoon sessions. One participant wrote in response to the question asking about the acceptability of the sessions: "This is how all medical meetings ought to be."

References

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MATERIA NON MEDICA

The ringing grooves of change

A contributor to the *BMJ* recently introduced his paper in the "Practice Observed" section with the quotation from Tennyson's *Locksley Hall*:

Let the great world spin for ever down the ringing grooves of change.

I used to wonder why Tennyson chose grooves as suitable pathways of change, and why they should ring, until I read many years ago E F Benson's *As We Were*. This was a very readable account of Victorian England—or at least of those aspects that presented themselves to the author, a rather privileged observer since he was a son of an Archbishop of Canterbury who inevitably moved among the eminent people of his day. According to Benson, Tennyson was very short sighted and mistook the first railway lines he saw laid above the ground for parallel grooves sunk into it. The poet retained this mistaken image in his mind and in due course it inspired one of his sonorous lines. "But," says Benson, "what does that matter? A fine line of poetry was worth more than the truth about the railway line." This is a point of view that admirers of Keats's poetry will thoroughly agree with. What does it matter if it was Balboa, not stout Cortez, who stood with his men, "Silent upon a peak in Darien"?

Incidentally, we Adelaideans can claim some association with the Tennyson family. Alfred's only surviving son, Hallam (who has no bespectacled evidence of his father's myopia in any photographs I have seen of him), was the governor of South Australia from 1899 to 1902. Although his training for this viceregal colonial position had merely been his experience as his father's private secretary (and subsequently his posthumous biographer), he was popular in the Antipodes, and Adelaide now has a suburb, as well as sundry streets, named after the family. Moreover, we owe the establishment of our first public maternity hospital—now the biggest obstetric teaching institution here—to the initiative of his dynamic wife, Audrey. It would have been called the "Lady Tennyson Home" but she graciously declined the honour so that it could be named as a memorial to Queen Victoria, who had just died. Like Tennyson's "great world" this hospital has spun down the ringing grooves of change ever since, but it is still a fine monument to the Tennyson family as well as to the queen whose name it commemorates.—ERIC SIMS, paediatrician, Adelaide.

Men and spirits

The urge to touch them is irresistible—great smooth curves of gleaming stone. It comes almost as a surprise when the Njuzu, the Water Spirit, does not feel wet to the hand, so fluid is its shape. There was recently at the Commonwealth Institute in London an exhibition of the work of Nicholas Mukomberanwa, perhaps the best known of the new school of Shona sculptors from Zimbabwe. The recorded history of stone sculpture in Zimbabwe is not long. In the Great Zimbabwe Ruins there were found several carvings of the Zimbabwe Bird. Who the sculptors were, and when the ruins were built, has never been clearly established. The contemporary art schools came into being in the late 1940s, at the Serima and Cyrene missions. There African sculptors were taught to work in wood and soapstone, and in ceramics.

The National Gallery, of what was then Rhodesia, was opened in 1957, under the directorship of Frank McEwen. He set up a workshop where he encouraged sculptors (many of whom earned a living at the gallery as porters and attendants) to extend their work beyond what passes for "native art"—the ubiquitous airport kitsch. The sculptors began to work in hard rock—serpentine, steatite, and the beautiful bright green verdite. There is now an established group of Shona sculptors whose work is exhibited internationally and widely acclaimed.

When I grew up in preindependence Rhodesia white children were little encouraged to learn about black culture. Certainly we were taught African history and geography, but not much else. The local African language was learnt in the streets and kitchens, if at all. We knew that there was a world of lore and legend, of spirits and ancestral powers, but it was totally inaccessible. The barrier was absolute—no crossing the cultural divide.

At the Commonwealth Institute I wandered among these magical sculptures. The craftsmanship is superb. There are wrinkled old men, suggested in a few lines on a block of stone. There is an enormously self satisfied "Rich Man." There is a "Chief" who is the very image of Arthur Scargill. These figures are universal. But, in addition, there are the spirits. More often suggested in the work than graphically portrayed, they are omnipresent. Their power and significance are almost tangible. Through the genius of one man for the very first time I felt as if the barrier had been lifted, just a little.—A-M ROLLIN, consultant anaesthetist, London.