Style Matters

Improving medical meetings

IV—Evaluate for the future

D E RICHMOND, C J MERCER

Until five years ago, when formal evaluation procedures were introduced, meetings organised by the Royal Australasian College of Physicians in New Zealand had never been evaluated formally by the participants. Now, four types of evaluation are used: of learning achievements, of the effectiveness of the whole meeting, of individual sessions within the meeting, and of any extra learning or self assessment opportunities, such as computerised self evaluation or self learning facilities. The instruments of evaluation are being progressively improved.

We have four major objectives for wishing to evaluate a meeting: firstly, to ascertain its educational value in whole and in part; secondly, to obtain opinions about aspects of programming in the hope that future meetings may be improved; thirdly, to give the speakers the audience's opinions about their performance, and hence improve their future contributions; fourthly, to improve the quality and accuracy of our computerised and other extracurricular programmes. As a byproduct evaluation also enables people to participate more in any

meeting. This paper describes how evaluation of meetings as a whole and session by session increases the potential for improving the value of future meetings.

Evaluation methods

In all types of evaluation we have used questionnaires. In each case we have tried to minimise the time and effort required of participants in completing them.

WHOLE MEETING EVALUATION

The layout of the "quick tick" questionnaire may be judged from table 1, which doubles as a summary of the evaluation of the 1982 college meeting. Not included in that table are the sections for comments and personal and professional information about the respondent. The questionnaires are included in the satchel which participants receive as they register. Periodically during the meeting participants are reminded that they should complete the evaluation, preferably before they leave on the final day. Collection boxes, suitably marked, are placed at convenient locations.

After the conference the returns are amalgamated and evaluated, and the results are included in the postconference report to the organisers.

SESSION BY SESSION EVALUATION

For this form of evaluation special slips have been printed (see figure). They are distributed to each participant in the conference

TABLE 1—Excerpts from summarised results of the evaluation of the whole meeting based on opinions of the registrants (comments omitted)

	Excellent 5	Very good 4	Good 3	Fair 2	Poor 1
Organisation					
Advance details and publicity	5	11	12	4	2
Registration forms	7	10	14	2	
Format for printed programmes	9	13	10	2	
Site and facilities	21	10	1	1	1
Hostel accommodation (if used)	12	13	8		
Content and presentations					
Morning symposiums and panels					
Relevance of themes to your practice	5	14	10	2	
Relevance of individual session to practice	4	13	14	1	
Value as source of new information	3	7	15	7	
Value in confirming your existing ideas	2	12	17	1	
Value as a source of general interest material	3	11	15	2	1
Afternoon workshops and "meet the experts"					
Relevance of themes	8	5	4		
Value as source of new information	7	3	5	2	
Value in confirming existing ideas	2	3	10		
Opportunity to become acquainted with tutors	4	3	5	3	1
Value as forums for discussion	4	7	4		
Updates and vignettes					
Relevance of topics to your practice	5	9	12	3	1
Value as source of new information	3	8	9	7	
Value as forums for discussion	7	6	8	6	
Overall evaluation					
Extent to which attendance has been helpful in meeting your educational needs	5	11	13	2	1
Extent to which attendance has alerted you to knowledge deficiencies	0	12	14	6	1

Department of Medicine, Auckland Hospital, Auckland 1, New Zealand

D E RICHMOND, MD, FRACP, senior lecturer in medicine
C J MERCER, MB, FRACP, physician

Session-by-Session EVALUATION				
Code Number				LECTURE ☐ WORKSHOP ☐ SEMINAR ☐ PANEL ☐ OTHER
LECTURER'S 1	2	3		
Date	TOPIC			
CLARITY and INTEREST of PRESENTATION	LECTURER'S ABILITY as a SPEAKER	QUALITY of TEACHING AIDS USED	ADVANCEMENT in KNOWLEDGE	
1 2 3	1 2 3	1 2 3	1 2 3	
☐ Poor ☐ Fair ☐ Good ☐ Excellent	☐ Poor ☐ Fair ☐ Good ☐ Excellent	☐ Poor ☐ Fair ☐ Good ☐ Excellent	☐ Nil ☐ Some ☐ Moderate ☐ Considerable	
COMMENTS				

additional comments may be made on the reverse

Session by session evaluation form.

TABLE II—Example of personalised summaries of performance as a speaker derived from audience

	Speaker A				Speaker B			
	Poor	Fair	Good	Excellent	Poor	Fair	Good	Excellent
Clarity and interest of presentation	0	4	7	12	5	16	8	1
Lecturer's ability as speaker	0	2	9	12	6	19	4	1
Quality of teaching aids used	0	3	15	5	6	14	9	1
Advancement in knowledge	Nil 0	Some 6	Moderate 12	Considerable 4	Nil 6	Some 16	Moderate 6	Considerable 12
Comments:	(1) Presentation nicely spiced with humour but did not separate between soundly established feasible procedures and clinical research/evolving knowledge. (2) An excellent paper. (3) A very good session.				(1) Typed slides/graphs from published papers don't make good blue and white slides because of unevenness in the original typescript. (2) Rather jerky, non-smooth style of presentation. (3) Speaker didn't concentrate on current problems. (4) Tended to read his paper—lacked interest for that reason. (5) A good session.			

satchel. The registrants are reminded about these at the beginning of the conference and are told that this is their opportunity to contribute to the continuing education of the speakers by providing an evaluation of their performance. Chairmen of sessions are asked to remind the registrants to complete the slips at the end of each session and, if possible, to provide two or three minutes before the close to enable them to do so. The speakers are notified in advance that this type of evaluation will be performed and the reason for it.

The slips are deposited in marked collection boxes placed near the exit of the lecture hall. At the end of the conference these are sorted and a report prepared for each speaker, which is sent with the formal letter of thanks each receives for his or her contribution to the meeting.

Results and discussion

The results reported here are those obtained at the 1982 annual clinical and scientific meeting of the Royal Australasian College of Physicians and are given in the form in which they are presented to the scientific subcommittee of the college in New Zealand.

WHOLE MEETING EVALUATION

The results (table I) are based on a total of 38 returns, representing about a third of the registrants—a proportion typical of the responses obtained over the past five years. The conference lasted three days, during which four special societies met concurrently with the main body of fellows. As is our custom, each of the three days was devoted to a separate subspecialty of medicine—in this case cardiology, chest medicine, and nephrology. The mornings were given over to symposiums and panel discussions, and the afternoons to miniworkshops, meet the expert sessions, clinical updates, and clinical vignettes.

Because this was the first occasion in which the college had met on a residential basis, using university halls of residence, there was particular interest in the reaction to this innovation. On the whole opinions were so favourable that the college has decided to make most future meetings residential. The main criticisms noted related to the tardy publication of some of the premeeting promotional material. The programme committee was reasonably happy with the level of satisfaction on the relevance of themes and the value of the various sessions.

SESSION BY SESSION EVALUATION

Our interest in this concept was initiated by Shephard's paper describing the "speaker" index.¹ This index, developed as an instructional aid for a course in communication, proved too complex for our session by session evaluation, in which the investigator must compromise between obtaining enough detail to make the evaluation worth while and having the form sufficiently simple that participants will actually complete it. Table II compares the evaluation of two speakers, chosen to illustrate that audiences do not uniformly "mark down the

middle" but can discriminate between performances. The results are returned to each speaker in this form without further editing. Overall, about one third of each audience completes a speaker by speaker evaluation slip for each session.

This type of evaluation always suffers from a reduction in returns on the last day—especially for sessions on the final afternoon. Registrants need to be constantly reminded to make their returns before they leave. Few bother to post them back afterwards.

We believe that session by session evaluation gives an audience the satisfaction of knowing that it can contribute something to the speaker. It encourages an attitude of evaluation instead of uncritical receptivity. It is another way in which audiences can be encouraged actively to participate in a meeting and hence have a more positive perspective on it. We think that it has also contributed to improved standards of speaking and chairmanship, aspects of our meetings which are attracting much less audience criticism than in the past.²

References

- Shephard DAE. How to evaluate papers given at medical meetings: use of the speaker index. *Br Med J* 1979;ii:1403-4.
- Richmond DE. Improving medical meetings: I—Educate speakers and chairmen of sessions in advance. *Br Med J* 1983;287:1201-2.

We have been having considerable clinical success with the treatment and prophylaxis of sunburn by using an oral vitamin A supplement. Is this a recognised form of treatment, and if so is it a responsible one in view of the side effect?

The suggestion that oral vitamin A may be useful in the treatment and prophylaxis of sunburn has been around for 20 years or more. But there seems to be no scientific evidence supporting this in properly controlled trials. About 18 years ago Findlay noted: "The suppliers [of such therapeutic agents] wisely prefer that all trials are done by tractable investigators using natural sunlight under natural conditions. The subjects undergoing the test, having been alerted to what the drug is supposed to do, are encouraged to give their friendly personal testimony, using their memories of earlier sun effects as the standard of comparison."¹ This seems to be the case with oral vitamin A preparations and sunburn prevention. Investigations without control subjects such as that of Turner *et al*² on British Airways cabin crew, who were asked to compare their sunburn while taking vitamin A with what they recollected of previous years when they were not, suggested that the treatment helped. Nevertheless, double blind therapeutic trials have shown it to be without action.³ So there still seems to be no scientific evidence that vitamin A has any therapeutic effect on sunburn.—I A MAGNUS, professor of photobiology, London.

¹ Findlay GH. Oral interceptives that do not work. In: Urbach F, ed. *The biologic effects of ultraviolet radiation (with emphasis on the skin)*. 1st ed. Oxford: Pergamon Press, 1969.

² Turner AC, Barnes RM, Green RL. The effect of a preparation of vitamin A and calcium carbonate on sunburn. *Practitioner* 1971;206:662.

³ Furman KI. Sylvasun and prevention of sun-trauma. *S Afr Med J* 1972;46:1670-3.