What the educators are saying

One-minute model for clinical teaching

Some terms don't travel. Preceptor (meaning tutor) is one that has barely gained a foothold in Britain, but the growing popularity of the one-minute preceptor (OMP) model may change things. In a series of experiments across North American universities, Irby and colleagues from the University of California showed that the new method of teaching is more effective and more efficient than lengthier traditional teaching. They also showed that the new method changed what clinicians teach: they became more specific and more disease focused in their teaching. The five OMP microskills are to

- Ask the learner to commit to what he/she thinks is going on with the patient
- Probe for underlying reasoning
- Teach general rules
- Provide positive feedback
- Correct errors.

Academic Medicine 2004;79:42-55

Adjusting the seat of learning

Just because they are bright doesn't mean that medical students are any better prepared than other students for university learning. How much support for learning is built into their curriculum by design? The university administrators' journal, *Perspectives*, recently carried an article on managing support for learning within the curriculum. It says that support for learning needs to be inclusive rather than remedial, and should be integrated into the curriculum by design. Holistic support consists of various interconnected elements, including pre-course preparation linked to an induction programme about developing approaches to learning. Both the e-learning environment of the university and the tutorial system can continue the emphasis on helping students learn to work effectively.

Perspectives 2004;8:11-7

Call yourself a teacher?

Are clinicians so smart that they don't need to learn anything about education? An international group of medical educators explored the notion that clinical teachers have a sound grasp of basic teaching principles. They set a 50 item multiple choice paper on aspects of assessment, adult learning, and curriculum for three groups of clinicians: clinicians with advanced training in education; internal medicine specialists; and surgical specialists. Relief all round at the findings: despite little formal training in teaching, all the experienced clinical educators possessed a "reasonable tacit knowledge" of the basic principles (with no significant difference between physicians and surgeons). However, those with advanced training had greater knowledge of pedagogic principles. We wonder if metastudy on the stress reactions of experienced clinician educators sitting 50-question MCQ papers will follow?

Medical Teacher 2004;26:23-7

Helping students to see the bigger picture

With education focusing more and more on outcomes, bolstered by the achievement of defined competencies, there is a danger of concentrating on where we want students to get to and losing sight of how they get there. The Enhancing Teaching-Learning Environments in Undergraduate Courses project (www.ed.ac.uk/etl) is looking, in part, into the idea of threshold concepts and troublesome knowledge. The notion here is that all subject areas have "threshold concepts," key concepts that, once understood, allow learners to understand, interpret or view something in a different way. Until the threshold is crossed, the student will struggle to progress. Medical educators often struggle to get students to see beyond the detail (for instance, of a case or of a physiological principle) to the wider picture, and to start using their knowledge and skills to solve problems. Perhaps medicine is full of such thresholds and in future we should consider how we help students to cross them when we plan curriculums.

Let medical students teach each other

Is peer tutoring just medical education on the cheap or does it offer something more? A study on learning surface anatomy is memorable for the opening of the abstract: "With opportunities for dissection and examination of sick patients decreasing." Peninsula Medical School (Exeter and Plymouth) explored how comfortable its medical students feel about being examined by their peers of the same and opposite gender. No surprises here—not much enthusiasm for having their genitals examined by student colleagues of the opposite sex. However, the survey results help define what is acceptable for the majority of students. In a separate study, the medical education unit at Glasgow University invested in a peer assisted learning programme, whereby senior students are taught how to tutor junior colleagues. Subsequently, fourth and fifth year student trainers were highly rated by their first and second year student trainees.

Medical Teacher 2004;26:86-8; *Lancet* 2004;363:490-1

Do patients understand their doctor's level of training?

No, according to a study of patients in a North American emergency department. Only 58% knew the level of training of the doctor looking after them, and the survey showed widespread ignorance about the implications of different training levels and supervision by senior doctors. On the other hand, 80% felt it was very important to know their doctor's level of training. The article talks about the "conspiracy of silence" that may exist when we avoid offering patients the opportunity to refuse permission for a doctor in training to participate in care. Does informed consent mean that we should not only have training grades visible on name badges, but also offer explanations about what these grades mean in terms of experience and supervision? Even more disturbing are the reflections of the same Tennessee group on their patient surveys about allowing junior doctors to practise medical procedures at all.

Academic Medicine 2004;79:139-47

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