

## September 2016 Articles you may enjoy (abstracts and links)

[Links are included for both UVIC and UBC library websites as I understand it is easier for some of you to access the UBC site. When you click on a link, you will first be directed to either the UVIC or UBC library website; in both cases, your ID and password are identical to the one you use to access your email. For *Academic Medicine*, and *Simulation in Healthcare* (Ovid journals) you will need to log into the UVIC or UBC library website first. Please let me know if there are other issues.]

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1. **Writing competitive research abstracts- AMEE Guide no. 108** (title is a bit ambiguous; it is about writing abstracts for submission to conferences)  
Lara Varpio, Joannathan Amiel, and Boyd Richards  
**Medical Teacher** published on-line September 5, 2016

### Abstract

The ability to write a competitive research conference abstract is an important skill for medical educators. A compelling and concise abstract can convince peer reviewers, conference selection committee members, and conference attendees that the research described therein is worthy for inclusion in the conference program and/or for their attendance in the meeting. This AMEE Guide is designed to help medical educators write research conference abstracts that can achieve these outcomes. To do so, this Guide begins by examining the rhetorical context (i.e. the purpose, audience, and structure) of research conference abstracts and then moves on to describe the abstract selection processes common to many medical education conferences. Next, the Guide provides theory-based information and concrete suggestions on how to write persuasively. Finally, the Guide offers some writing tips and some proofreading techniques that all authors can use. By attending to the aspects of the research conference abstract addressed in this Guide, we hope to help medical educators enhance this important text in their writing repertoire.

**To read more:**

<http://www-tandfonline-com.ezproxy.library.uvic.ca/doi/full/10.1080/0142159X.2016.1211258>

<http://www-tandfonline-com.ezproxy.library.ubc.ca/doi/full/10.1080/0142159X.2016.1211258>

**2. Longitudinal cohort study on medical student retention of anatomical knowledge in an integrated problem-based curriculum**

Jennifer McBride and Richard Drake

**Medical Teacher** published online September 2, 2016

**Abstract**

**Background:** When modifying a curriculum to accommodate changes in the methods of subject matter presentation or fit within a shortened time frame, student retention of knowledge remains an important issue.

**Aim:** This study evaluates medical student retention of anatomical knowledge as they matriculate through an anatomy curriculum where the instruction hours are less than half of the current national average.

**Method:** Medical students completed an assessment tool developed to evaluate their baseline level of anatomical knowledge at the beginning of the first year. They then completed the instrument at the end of their 1st, 2nd, 3rd, and 4th years to assess their retention of anatomical knowledge during medical school. Data collection began in September 2010 and concluded in June 2015.

**Results:** Results demonstrate that students began medical school with a low level of anatomical knowledge (baseline), that knowledge increased during their first year ( $p < 0.001$ ), continued to increase during their second year ( $p < 0.001$ ), but was over 90% maintained through years 3 and 4.

**Conclusion:** In conclusion, an anatomy course with reduced hours (~60), using active learning methods, contextual learning, cadaver demonstrations, increased exposure to imaging, and longitudinal reinforcement can help students build a strong foundation of anatomical knowledge.

**To read more:**

<http://www-tandfonline-com.ezproxy.library.uvic.ca/doi/full/10.1080/0142159X.2016.1210113>

<http://www-tandfonline-com.ezproxy.library.ubc.ca/doi/full/10.1080/0142159X.2016.1210113>

**3. Dimensions of integration, continuity, and longitudinality in clinical clerkships.**

Rachel Ellaway, Lisa Graves and Beth-Ann Cummings

**Medical Education** vol 50 (9) pp. 912-921 September 2016

**Abstract**

**Context**

Over the past few decades, longitudinal integrated clerkships (LICs) have been proposed to address many perceived short-coming of traditional block clerkships. This growing interest in LICs has raised

broader questions regarding the role of integration, continuity and longitudinality in medical education. A study with complementary theoretical and empirical dimensions was conducted to derive a more precise way of defining these three underlying concepts within the design of medical education curricula.

### **Methods**

The theoretical dimension involved a thematic review of the literature on integration, continuity and longitudinality in medical education. The empirical dimension surveyed all 17 Canadian medical schools on how they have operationalised integration, continuity and longitudinality in their undergraduate programmes. The two dimensions were iteratively synthesised to explore the meaning and expression of integration, continuity and longitudinality in medical education curriculum design.

### **Results**

Integration, continuity and longitudinality were expressed in many ways and forms, including: integration of clinical disciplines, combined horizontal integration and vertical integration, and programme-level integration. Types of continuity included: continuity of patients, continuity of teaching, continuity of location and peer continuity. Longitudinality focused on connected or repeating episodes of training or on connecting activities, such as encounter logging across educational episodes. Twelve of the 17 schools were running an LIC of some kind, although only one school had a mandatory LIC experience. An ordinal scale of uses of integration, continuity and longitudinality during clerkships was developed, and new definitions of these concepts in the clerkship context were generated.

### **Conclusions**

Different clerkship designs embodied different forms and levels of integration, continuity and longitudinality. A dichotomous view of LICs and rotation-based clerkships was found not to represent current practices in Canada, which instead tended to fall along a continuum of integration, continuity and longitudinality.

### **To read more:**

<http://onlinelibrary.wiley.com.ezproxy.library.uvic.ca/doi/10.1111/medu.13038/full>

<http://onlinelibrary.wiley.com.ezproxy.library.ubc.ca/doi/10.1111/medu.13038/full>

and the commentary (no abstract):

### **Integration, continuity and longitudinality: the 'what' that makes patient-centred learning in clinical clerkships**

Lucie Walters and Kathleen Brooks

**Medical Education** vol 50 (9) pp. 889-891 September 2016

<http://onlinelibrary.wiley.com.ezproxy.library.uvic.ca/doi/10.1111/medu.13118/full>

<http://onlinelibrary.wiley.com.ezproxy.library.ubc.ca/doi/10.1111/medu.13118/full>

#### **4. Investigating conditions for meaningful feedback in the context of an evidence-based feedback programme (There is also another UBC study on feedback in this issue)**

Stephane Voyer, Cary Cuncic, Deborah Butler, Kimberley MacNeil and Chris Watling  
**Medical Education** vol 50 (9) pp. 943-954 September 2016

##### **Abstract:**

##### **Context**

We developed, implemented and evaluated an evidence-based programme of feedback designed to address limitations identified in the current literature.

##### **Objectives**

We sought to advance understanding about how and why feedback processes might be more effective in clinical education.

##### **Methods**

Three faculty members and nine first-year internal medicine residents participated in the pilot programme. To counter challenges identified in the literature, feedback was based on direct observation, grounded in longitudinal faculty–resident relationships, and devoid of summative assessment. We used a qualitative case study design to address three research questions: (i) What benefits did the participants describe? (ii) What elements of the programme facilitated these benefits? (iii) What were the limitations and challenges of the programme? Collected data included audiotapes of interactions between faculty members and residents, field notes written during observations, and semi-structured interviews and focus groups with resident participants. Data analysis moved cyclically and iteratively through inductive and deductive analysis.

##### **Results**

Residents described benefits relating to their ways of working (clinical skills), ways of learning (accountability for learning) and ways of feeling (emotional well-being). According to participants, specific elements of the programme that achieved these benefits included the direct observation of authentic clinical work, the longitudinal relationship with a faculty member and the emergence of feedback as a conversation between the faculty member and learner.

##### **Conclusions**

We conclude that the conditions established within our pilot feedback programme influenced the learning culture for first-year internal medicine residents by grounding direct observation in authentic clinical work and setting the observations in the context of a longitudinal, non-assessment-based relationship between a faculty member and resident. These conditions appeared to influence residents' participation in the feedback process, their ways of approaching their daily clinical work, their emotional well-being and their engagement in their own learning.

##### **To read more:**

<http://onlinelibrary.wiley.com.ezproxy.library.uvic.ca/doi/10.1111/medu.13067/full>

<http://onlinelibrary.wiley.com.ezproxy.library.ubc.ca/doi/10.1111/medu.13067/full>

and the commentary (no abstract):

**Context, time, and building relationships: bringing in situ feedback into the conversation**

Shelley Ross, Nancy Dudek, Samantha Halman and Susan Humphrey-Murto

**Medical Education** vol 50 (9) pp. 893-895 September 2016

<http://onlinelibrary.wiley.com.ezproxy.library.uvic.ca/doi/10.1111/medu.13138/full>

<http://onlinelibrary.wiley.com.ezproxy.library.ubc.ca/doi/10.1111/medu.13138/full>

**5. Simulated Disaster Day: Benefit From Lessons Learned Through Years of Transformation From Silos to Interprofessional Education**

Livingston, Laura L. MA; West, Courtney A. PhD; Livingston, Jerry L. PhD, RN; Landry, Karen A. PhD, RN; Watzak, Bree C. PharmD; Graham, Lori L. PhD

**Simulation in Healthcare: The Journal of the Society for Simulation in Healthcare** Volume 11 (4) August 2016, p. 293-298

**Abstract:**

Summary Statement: Disaster Day is a simulation event that began in the College of Nursing and has increased exponentially in size and popularity for the last 8 years. The evolution has been the direct result of reflective practice and dedicated leadership in the form of students, faculty, and administration. Its development and expansion into a robust interprofessional education activity are noteworthy because it gives health care professions students an opportunity to work in teams to provide care in a disaster setting. The “authentic” learning situation has enhanced student knowledge of roles and responsibilities and seems to increase collaborative efforts with other disciplines. The lessons learned and modifications made in our Disaster Day planning, implementation, and evaluation processes are shared in an effort to facilitate best practices for other institutions interested in a similar activity.

**To read more: (You may need to log into Uvic library for this one (Ovid Journals))**

[http://ovidsp.tx.ovid.com.ezproxy.library.uvic.ca/sp-3.22.0a/ovidweb.cgi?&S=LJHAFPLCKHDDJBMINCIKGDCCNPHKAA00&Link+Set=S.sh.22.23.26%7c12%7csl\\_10](http://ovidsp.tx.ovid.com.ezproxy.library.uvic.ca/sp-3.22.0a/ovidweb.cgi?&S=LJHAFPLCKHDDJBMINCIKGDCCNPHKAA00&Link+Set=S.sh.22.23.26%7c12%7csl_10)

**6. The attributes of an effective teacher differ between the classroom and the clinical setting**

Jolene Haws, Luke Rannelli, Kevin McLaughlin et al

**Advances in Health Sciences Education** (2016) 21: 833-840

**Abstract:**

Most training programs use learners’ subjective ratings of their teachers as the primary measure of teaching effectiveness. In a recent study we found that preclinical medical students’ ratings of classroom teachers were associated with perceived charisma and physical attractiveness of the teacher, but not intellect. Here we explored whether the relationship between these variables and teaching effectiveness ratings holds in the clinical setting. We asked 27 Internal Medicine residents to rate teaching effectiveness of ten teachers with whom they had worked on a clinical rotation, in addition to rating each teacher’s *clinical skills*, *physical attractiveness*, and *charisma*. We used linear regression to study the association between these explanatory variables and teaching effectiveness ratings. We found no association between rating of physical attractiveness and teaching effectiveness.

Clinical skill and charisma were independently associated with rating of teaching effectiveness (regression coefficients [95 % confidence interval] 0.73 [0.60, 0.85],  $p < 0.001$  and 0.12 [0.01, 0.23],  $p = 0.03$ , respectively). The variables associated with effectiveness of classroom and clinical teachers differ, suggesting context specificity in teaching effectiveness ratings. Context specificity may be explained by differences in the exposure that learners have to teachers in the classroom versus clinical setting—so that raters in the clinical setting may base ratings upon observed behaviours rather than stereotype data. Alternatively, since subjective ratings of teaching effectiveness inevitably incorporate learners' context-specific needs, the attributes that make a teacher effective in one context may not meet the needs of learners in a different context.

**To read more:**

<http://link.springer.com.ezproxy.library.uvic.ca/article/10.1007/s10459-016-9669-6>

<http://link.springer.com.ezproxy.library.ubc.ca/article/10.1007/s10459-016-9669-6>

**7. Interprofessional rhetoric and operational realities: an ethnographic study of rounds in four intensive care units**

Elise Paradis, Myles Leslie and Michael Gropper

*Advances in Health Sciences Education* (2016) 21: 735-748

**Abstract:**

Morning interprofessional rounds (MIRs) are used in critical care medicine to improve team-based care and patient outcomes. Given existing evidence of conflict between and dissatisfaction among rounds participants, this study sought to better understand how the operational realities of care delivery in the intensive care unit (ICU) impact the success of MIRs. We conducted a year-long comparative ethnographic study of interprofessional collaboration and patient and family involvement in four ICUs in tertiary academic hospitals in two American cities. The study included 576 h of observation of team interactions, 47 shadowing sessions and 40 clinician interviews. In line with best practices in ethnographic research, data collection and analysis were done iteratively using the constant comparative method. Member check was conducted regularly throughout the project. MIRs were implemented on all units with the explicit goals of improving team-based and patient-centered care. Operational conditions on the units, despite interprofessional commitment and engagement, appeared to thwart ICU teams from achieving these goals. Specifically, time constraints, struggles over space, and conflicts between MIRs' educational and care-plan-development functions all prevented teams from achieving collaboration and patient-involvement. Moreover, physicians' de facto control of rounds often meant that they resembled medical rounds (their historical predecessors), and sidelined other providers' contributions. This study suggests that the MIRs model, as presently practiced, might not be well suited to the provision of team-based, patient-centered care. In the interest of interprofessional collaboration, of the optimization of clinicians' time, of high-quality medical education and of patient-centered care, further research on interprofessional rounds models is needed.

**To read more:**

<http://link.springer.com.ezproxy.library.uvic.ca/article/10.1007/s10459-015-9662-5>

<http://link.springer.com.ezproxy.library.ubc.ca/article/10.1007/s10459-015-9662-5>

### **8. Lessons from Rocket Science: Reframing the Concept of Physician Health Advocate**

Maria Hubinette, Glenn Rrgehr and Sayra Christancho

**Academic Medicine** published ahead of print September 2016 DOI:

10.1097/ACM.0000000000001299

#### **Abstract:**

Health advocacy is a prominent component of health professionals' training internationally and is frequently discussed in the medical education literature. Despite this, it continues to be a problematic and challenging topic for medical educators, health professionals, and trainees alike. Borrowing from the field of systems engineering, the authors suggest a need to reconceptualize health advocacy using a systems mind-set rather than a physician-centric perspective. Conceptualizing health advocacy as a systemic, collective effort requires educators, practitioners, and trainees to challenge the assumption that the role of a competent physician health advocate can be fully defined without regard to the larger system or collective within which physicians function. Further, this implies a substantially more dynamic understanding of physicians' and other participants' parts in the collective activity. Of course, this new way of conceptualizing physicians' practices is not limited to health advocacy. The current education paradigm trains physicians for individual competency but expects them to practice collectively. Defining physician competencies, or the competencies of any health care provider, in isolation from the particular system of which that individual is an integral part implicitly places that health care provider as the central focus of that system. Thus, academic medicine needs to move its educational and research efforts forward in a manner that recognizes that a systems engineering approach to health improvement will allow the various players to maximize their individual efforts to more effectively support the collective activity. (C) 2016 by the Association of American Medical Colleges

#### **To read more:**

<http://ovidsp.tx.ovid.com.ezproxy.library.uvic.ca/sp-3.22.1b/ovidweb.cgi>

<http://ovidsp.tx.ovid.com.ezproxy.library.ubc.ca/sp-3.22.1b/ovidweb.cgi>

### **9. Feedback to Supervisors: Is anonymity really so important?**

Dudek, Nancy L. MD, MEd; Dojeiji, Suzan MD, MEd; Day, Kathleen MA; Varpio, Lara PhD

**Academic Medicine** vol 91 (9) September 2016 p1305-1312

#### **Abstract:**

**Purpose:** Research demonstrates that physicians benefit from regular feedback on their clinical supervision from their trainees. Several features of effective feedback are enabled by nonanonymous processes (i.e., open feedback). However, most resident-to-faculty feedback processes are anonymous given concerns of power differentials and possible reprisals. This exploratory study investigated resident experiences of giving faculty open feedback, advantages, and disadvantages.

**Method:** Between January and August 2014, nine graduates of a Canadian Psychiatry residency program that uses open resident-to-faculty feedback participated in semistructured interviews in which they described their experiences of this system. Three members of the research team analyzed transcripts for

emergent themes using conventional content analysis. In June 2014, semistructured group interviews were held with six residents who were actively enrolled in the program as a member-checking activity. Themes were refined on the basis of these data.

**Results:** Advantages of the open feedback system included giving timely feedback that was acted upon (thus enhancing residents' educational experiences), and improved ability to receive feedback (thanks to observing modeled behavior). Although some disadvantages were noted, they were often speculative (e.g., "I think others might have felt [horizontal ellipsis]") and were described as outweighed by advantages. Participants emphasized the program's "feedback culture" as an open feedback enabler.

**Conclusions:** The relationship between the feedback giver and recipient has been described as influencing the uptake of feedback. Findings suggest that nonanonymous practices can enable a positive relationship in resident-to-faculty feedback. The benefits of an open system for resident-to-faculty feedback can be reaped if a "feedback culture" exists. (C) 2016 by the Association of American Medical Colleges

**To read more:**

[http://ovidsp.tx.ovid.com.ezproxy.library.uvic.ca/sp-3.22.1b/ovidweb.cgi?&S=DFDNFPOBMMDDGBLNNCIKIBIBJBPAA00&Link+Set=S.sh.24.25.28.34%7c33%7csl\\_10](http://ovidsp.tx.ovid.com.ezproxy.library.uvic.ca/sp-3.22.1b/ovidweb.cgi?&S=DFDNFPOBMMDDGBLNNCIKIBIBJBPAA00&Link+Set=S.sh.24.25.28.34%7c33%7csl_10)

[http://ovidsp.tx.ovid.com.ezproxy.library.ubc.ca/sp-3.22.1b/ovidweb.cgi?&S=DFDNFPOBMMDDGBLNNCIKIBIBJBPAA00&Link+Set=S.sh.24.25.28.34%7c33%7csl\\_10](http://ovidsp.tx.ovid.com.ezproxy.library.ubc.ca/sp-3.22.1b/ovidweb.cgi?&S=DFDNFPOBMMDDGBLNNCIKIBIBJBPAA00&Link+Set=S.sh.24.25.28.34%7c33%7csl_10)

**10. Use of a Simulation-Based Capstone Course to Teach and Assess Entrustable Professional Activities to Graduating Medical Students**

David Salzman, William McGaghie et al

**Medical Science Educator** September 2016 vol 26 (3) 453-456

**Abstract:**

A 3-day simulation-based capstone course was developed and pilot tested for a cohort of graduating medical students to assess their readiness for residency. The intervention taught and assessed individual performance on specific components of the 13 core entrustable professional activities (EPAs) that all medical school graduates should perform independently. Two 6-station clinical skills examinations (CSE) were developed to assess performance before and after a simulation-based educational intervention. Graduating medical students could not reliably perform selected EPAs at baseline. However, a focused 3-day simulation-based capstone experience produced significant improvement in core clinical skills.

**To read more:**

<http://link.springer.com.ezproxy.library.uvic.ca/article/10.1007%2Fs40670-016-0267-2>

<http://link.springer.com.ezproxy.library.ubc.ca/article/10.1007%2Fs40670-016-0267-2>