

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

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- 1. From personal to global: Understandings of social accountability from stakeholders at four medical schools**
- 2. Teaching psychomotor skills in the twenty-first century: Revisiting and reviewing instructional approaches through the lens of contemporary literature**
- 3. Not all unprofessional behaviors are equal: The creation of a checklist of bad behaviors**
- 4. Towards a program of assessment for health professionals: from training into practice**  
(UBC first author)
- 5. Inter-rater variability as mutual disagreement: identifying raters' divergent points of view**  
(NMP first author)
- 6. 'Sometimes the work just needs to be done': socio-cultural influences on direct observation in medical training**
- 7. Motivation to learn: an overview of contemporary theories**
- 8. A Qualitative Study of the Experiences and Factors That Led Physicians to Be Lifelong Health Advocates**
- 9. When Assessment Data Are Words: Validity Evidence for Qualitative Educational Assessments**
- 10. Coaching From the Sidelines: Examining the Impact of Teledebriefing in Simulation-Based Training**

### **1. From personal to global: Understandings of social accountability from stakeholders at four medical schools**

Robyn Preston, Sarah Larkins, Judy Taylor & Jenni Judd

**Medical Teacher** vol 38 (10) p. 987-994 October, 2016

#### **Abstract**

**Aim:** This paper addresses the question of how social accountability is conceptualised by staff, students and community members associated with four medical schools aspiring to be socially accountable in two countries.

**Methods:** Using a multiple case study approach this research explored how contextual issues have influenced social accountability at four medical schools: two in Australia and two in the Philippines. This paper reports on how research participants understood social accountability. Seventy-five participants were interviewed including staff, students, health sector representatives and community members. Field notes were taken and a documentary analysis was completed.

**Results:** Overall there were three common understandings. Socially accountable medical education was about meeting workforce, community and health needs. Social accountability was also determined by the nature and content of programs the school implemented or how it operated. Finally, social

accountability was deemed a personal responsibility. The broad consensus masked the divergent perspectives people held within each school.

**Conclusion:** The assumption that social accountability is universally understood could not be confirmed from these data. To strengthen social accountability it is useful to learn from these institutions' experiences to contribute to the development of the theory and practice of activities within socially accountable medical schools.

**To read more:**

<http://www-tandfonline-com.ezproxy.library.uvic.ca/doi/full/10.3109/0142159X.2015.1114596>

<http://www-tandfonline-com.ezproxy.library.ubc.ca/doi/full/10.3109/0142159X.2015.1114596>

**2. Teaching psychomotor skills in the twenty-first century: Revisiting and reviewing instructional approaches through the lens of contemporary literature**

Delwyn Nicholls, Linda Sweet, Amanda Muller & Jon Hyett

**Medical Teacher** vol 38 (10) p. 1056-1063 October, 2016

**Abstract:**

A diverse range of health professionals use psychomotor skills as part of their professional practice roles. Most health disciplines use large or complex psychomotor skills. These skills are first taught by the educator then acquired, performed, and lastly learned. Psychomotor skills may be taught using a variety of widely-accepted and published teaching models. The number of teaching steps used in these models varies from two to seven. However, the utility of these models to teach skill acquisition and skill retention are disputable when teaching complex skills, in contrast to simple skills. Contemporary motor learning and cognition literature frames instructional practices which may assist the teaching and learning of complex task-based skills. This paper reports 11 steps to be considered when teaching psychomotor skills.

**To read more:**

<http://www-tandfonline-com.ezproxy.library.uvic.ca/doi/full/10.3109/0142159X.2016.1150984>

<http://www-tandfonline-com.ezproxy.library.ubc.ca/doi/full/10.3109/0142159X.2016.1150984>

**3. Not all unprofessional behaviors are equal: The creation of a checklist of bad behaviors**

Michael J. Cullen, Mojca R. Konia, Emily C. Borman-Shoap, et al

**Medical Teacher** published first on-line September 27, 2016

**Abstract**

Introduction: Professionalism is a key component of medical education and training. However, there are few tools to aid educators in diagnosing unprofessional behavior at an early stage. The purpose of this study was to employ policy capturing methodology to develop two empirically validated checklists for identifying professionalism issues in early-career physicians.

**Method:** In a series of workshops, a professionalism competency model containing 74 positive and 70 negative professionalism behaviors was developed and validated. Subsequently, 23 subject matter experts indicated their level of concern if each negative behavior occurred 1, 2, 3, 4, or 5 or more times during a six-month period. These ratings were used to create a “brief” and “extended” professionalism checklist for monitoring physician misconduct.

**Results:** This study confirmed the subjective impression that some unprofessional behaviors are more egregious than others. Fourteen negative behaviors (e.g. displaying obvious signs of substance abuse) were judged to be concerning if they occurred only once, whereas many others (e.g. arriving late for conferences) were judged to be concerning only when they occurred repeatedly.

**Discussion:** Medical educators can use the professionalism checklists developed in this study to aid in the early identification and subsequent remediation of unprofessional behavior in medical students and residents.

**To read more:**

<http://www-tandfonline-com.ezproxy.library.uvic.ca/doi/full/10.1080/0142159X.2016.1231917>

<http://www-tandfonline-com.ezproxy.library.ubc.ca/doi/full/10.1080/0142159X.2016.1231917>

**4. Towards a program of assessment for health professionals: from training into practice**

Kevin Eva, Georges Bordage, Craig Campbell, Robert Galbraith, Shiphra Ginsberg, Eric Holmboe, and Glenn Regehr.

**Advances in Health Sciences Education; Theory and Practice** October 2016, Volume 21, [Issue 4](#), pp 897–913

**Abstract:**

Despite multifaceted attempts to “protect the public,” including the implementation of various assessment practices designed to identify individuals at all stages of training and practice who underperform, profound deficiencies in quality and safety continue to plague the healthcare system. The purpose of this reflections paper is to cast a critical lens on current assessment practices and to offer insights into ways in which they might be adapted to ensure alignment with modern conceptions of health professional education for the ultimate goal of improved healthcare. Three dominant themes will be addressed: (1) The need to redress unintended consequences of competency-based assessment; (2) The potential to design assessment systems that facilitate performance improvement; and (3) The importance of ensuring authentic linkage between assessment and practice. Several principles cut across each of these themes and represent the foundational goals we would put forward as signposts for decision making about the continued evolution of assessment practices in the health professions: (1) Increasing opportunities to promote learning rather than simply measuring performance; (2) Enabling integration across stages of training and practice; and (3) Reinforcing point-in-time assessments with continuous professional development in a way that enhances shared responsibility and accountability between practitioners, educational programs, and testing organizations. Many of the ideas generated represent suggestions for strategies to pilot test, for infrastructure to build, and for harmonization across groups to be enabled. These include

novel strategies for OSCE station development, formative (diagnostic) assessment protocols tailored to shed light on the practices of individual clinicians, the use of continuous workplace-based assessment, and broadening the focus of high-stakes decision making beyond determining who passes and who fails. We conclude with reflections on systemic (i.e., cultural) barriers that may need to be overcome to move towards a more integrated, efficient, and effective system of assessment.

**To read more:**

<http://link.springer.com.ezproxy.library.uvic.ca/article/10.1007/s10459-015-9653-6>

<http://link.springer.com.ezproxy.library.ubc.ca/article/10.1007/s10459-015-9653-6>

**5. Inter-rater variability as mutual disagreement: identifying raters' divergent points of view**

Andrea Gingerich, Susan Ramio, et al

**Advances in Health Sciences Education; Theory and Practice** First Online: 20 September 2016

**Abstract:**

Whenever multiple observers provide ratings, even of the same performance, inter-rater variation is prevalent. The resulting 'idiosyncratic rater variance' is considered to be unusable error of measurement in psychometric models and is a threat to the defensibility of our assessments. Prior studies of inter-rater variation in clinical assessments have used open response formats to gather raters' comments and justifications. This design choice allows participants to use idiosyncratic response styles that could result in a distorted representation of the underlying rater cognition and skew subsequent analyses. In this study we explored rater variability using the structured response format of Q methodology. Physician raters viewed video-recorded clinical performances and provided Mini Clinical Evaluation Exercise (Mini-CEX) assessment ratings through a web-based system. They then shared their assessment impressions by sorting statements that described the most salient aspects of the clinical performance onto a forced quasi-normal distribution ranging from "most consistent with my impression" to "most contrary to my impression". Analysis of the resulting Q-sorts revealed distinct points of view for each performance shared by multiple physicians. The points of view corresponded with the ratings physicians assigned to the performance. Each point of view emphasized different aspects of the performance with either rapport-building and/or medical expertise skills being most salient. It was rare for the points of view to diverge based on disagreements regarding the interpretation of a specific aspect of the performance. As a result, physicians' divergent points of view on a given clinical performance cannot be easily reconciled into a single coherent assessment judgment that is impacted by measurement error. If inter-rater variability does not wholly reflect error of measurement, it is problematic for our current measurement models and poses challenges for how we are to adequately analyze performance assessment ratings.

**To read more:**

<http://link.springer.com.ezproxy.library.uvic.ca/article/10.1007/s10459-016-9711-8>

<http://link.springer.com.ezproxy.library.ubc.ca/article/10.1007/s10459-016-9711-8>

## **6. 'Sometimes the work just needs to be done': socio-cultural influences on direct observation in medical training**

Chris Watling, Kori LaDonna, Lorelei Lingard et al

**Medical Education** vol 50 (10) pp. 1054-1064 October 2016

### **Abstract:**

### **Context**

Direct observation promises to strengthen both coaching and assessment, and calls for its increased use in medical training abound. Despite its apparent potential, the uptake of direct observation in medical training remains surprisingly limited outside the formal assessment setting. The limited uptake of observation raises questions about cultural barriers to its use. In this study, we explore the influence of professional culture on the use of direct observation within medical training.

### **Methods**

Using a constructivist grounded theory approach, we interviewed 22 residents or fellows (10 male, 12 female) about their experiences of being observed during training. Participants represented a range of specialties and training levels. Data collection and analysis were conducted iteratively. Themes were identified using constant comparative analysis.

### **Results**

Observation was used selectively; specialties tended to observe the clinical acts that they valued most. Despite these differences, we found two cultural values that consistently challenged the ready implementation of direct observation across specialties: (i) autonomy in learning and (ii) efficiency in health care provision. Furthermore, we found that direct observation was a primarily learner-driven activity, which left learners caught in the middle, wanting observation but also wanting to appear independent and efficient.

### **Conclusions**

The cultural values of autonomy in learning and practice and efficiency in health care provision challenge the integration of direct observation into clinical training. Medical learners are often expected to ask for observation, but such requests are socially and culturally fraught, and likely to constrain the wider uptake of direct observation.

### **To read more:**

<http://onlinelibrary.wiley.com.ezproxy.library.uvic.ca/doi/10.1111/medu.13062/full>

<http://onlinelibrary.wiley.com.ezproxy.library.ubc.ca/doi/10.1111/medu.13062/full>

and the commentary (no abstract) **Elevating the value of direct observation for learning the limits of autonomy.**

<http://onlinelibrary.wiley.com.ezproxy.library.uvic.ca/doi/10.1111/medu.13141/full>

<http://onlinelibrary.wiley.com.ezproxy.library.ubc.ca/doi/10.1111/medu.13141/full>

## **7. Motivation to learn: an overview of contemporary theories**

David Cook and Anthony Artino Jr.

**Medical Education** vol 50 (10) pp. 997-1014 October 2016

### **Abstract:**

#### **Objective**

To succinctly summarise five contemporary theories about motivation to learn, articulate key intersections and distinctions among these theories, and identify important considerations for future research.

#### **Results**

Motivation has been defined as the process whereby goal-directed activities are initiated and sustained. In expectancy-value theory, motivation is a function of the expectation of success and perceived value. Attribution theory focuses on the causal attributions learners create to explain the results of an activity, and classifies these in terms of their locus, stability and controllability. Social-cognitive theory emphasises self-efficacy as the primary driver of motivated action, and also identifies cues that influence future self-efficacy and support self-regulated learning. Goal orientation theory suggests that learners tend to engage in tasks with concerns about mastering the content (mastery goal, arising from a 'growth' mindset regarding intelligence and learning) or about doing better than others or avoiding failure (performance goals, arising from a 'fixed' mindset). Finally, self-determination theory proposes that optimal performance results from actions motivated by intrinsic interests or by extrinsic values that have become integrated and internalised. Satisfying basic psychosocial needs of autonomy, competence and relatedness promotes such motivation. Looking across all five theories, we note recurrent themes of competence, value, attributions, and interactions between individuals and the learning context.

#### **Conclusions**

To avoid conceptual confusion, and perhaps more importantly to maximise the theory-building potential of their work, researchers must be careful (and precise) in how they define, operationalise and measure different motivational constructs. We suggest that motivation research continue to build theory and extend it to health professions domains, identify key outcomes and outcome measures, and test practical educational applications of the principles thus derived.

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

<http://onlinelibrary.wiley.com.ezproxy.library.uvic.ca/doi/10.1111/medu.13074/full>

<http://onlinelibrary.wiley.com.ezproxy.library.ubc.ca/doi/10.1111/medu.13074/full>

**8. A Qualitative Study of the Experiences and Factors That Led Physicians to Be Lifelong Health Advocates** Law, Marcus MD, MBA, MEd; Leung, Pearl MD; Veinot, Paula MHSc; Miller, Daniel MPH; Mylopoulos, Maria PhD  
**Academic Medicine** Volume 91(10), October 2016, p 1392–1397

**Abstract:**

**Purpose:** Given the public’s trust and the opportunities to observe and address social determinants of health, physicians are well suited to be health advocates, a key role in the CanMEDS physician competency framework. As some physicians find it difficult to fulfill this role, the authors explored the experiences and influences that led established physicians to be health advocates.

**Method:** The authors used a phenomenological approach to explore this topic. From March to August 2014, they interviewed 15 established physician health advocates, using a broad definition of health advocacy—that it extends beyond individual patient advocacy to address the root causes of systemic differences in health. Interviews were audio recorded and transcribed verbatim. The transcripts were coded and the data categorized into clusters of meaning, then into themes. Data analysis was conducted iteratively, with data collection continuing until no new information was gathered.

**Results:** Participants described the factors that contributed to the development of their health advocate identity (i.e., exposure to social injustice, upbringing, schooling, specific formative experiences) and those that facilitated their engagement in health advocacy work (i.e., mentors, training, systemic and organizational supports). They also highlighted how they continue in their role as lifelong advocates (i.e., continuous learning and improvement, self-reflection and self-reflexivity, collaboration, intrinsic satisfaction in the work).

**Conclusions:** Many factors allow physician health advocates to establish and sustain a commitment to improve the health of their patients and the broader population. Medical schools could use these findings to guide curriculum development related to teaching this physician competency.

**To read more:**

[http://ovidsp.tx.ovid.com.ezproxy.library.uvic.ca/sp-3.22.1b/ovidweb.cgi?&S=EHBOFPCEIIDDAABFNCKFAMCDHBDAA00&Link+Set=S.sh.22.23.26%7c23%7csl\\_10](http://ovidsp.tx.ovid.com.ezproxy.library.uvic.ca/sp-3.22.1b/ovidweb.cgi?&S=EHBOFPCEIIDDAABFNCKFAMCDHBDAA00&Link+Set=S.sh.22.23.26%7c23%7csl_10)

[http://ovidsp.tx.ovid.com.ezproxy.library.ubc.ca/sp-3.22.1b/ovidweb.cgi?&S=EHBOFPCEIIDDAABFNCKFAMCDHBDAA00&Link+Set=S.sh.22.23.26%7c23%7csl\\_10](http://ovidsp.tx.ovid.com.ezproxy.library.ubc.ca/sp-3.22.1b/ovidweb.cgi?&S=EHBOFPCEIIDDAABFNCKFAMCDHBDAA00&Link+Set=S.sh.22.23.26%7c23%7csl_10)

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## 9. When Assessment Data Are Words: Validity Evidence for Qualitative Educational Assessments

Cook, David A. MD, MHPE; Kuper, Ayelet MD, DPhil; Hatala, Rose MD, MSc; Ginsburg, Shiphra MD, Med  
**Academic Medicine** Volume 91(10), October 2016, p 1392–1397

### Abstract

Quantitative scores fail to capture all important features of learner performance. This awareness has led to increased use of qualitative data when assessing health professionals. Yet the use of qualitative assessments is hampered by incomplete understanding of their role in forming judgments, and lack of consensus in how to appraise the rigor of judgments therein derived. The authors articulate the role of qualitative assessment as part of a comprehensive program of assessment, and translate the concept of *validity* to apply to judgments arising from qualitative assessments. They first identify standards for rigor in qualitative research, and then use two contemporary assessment validity frameworks to reorganize these standards for application to qualitative assessment.

Standards for rigor in qualitative research include responsiveness, reflexivity, purposive sampling, thick description, triangulation, transparency, and transferability. These standards can be reframed using Messick's five sources of validity evidence (content, response process, internal structure, relationships with other variables, and consequences) and Kane's four inferences in validation (scoring, generalization, extrapolation, and implications). Evidence can be collected and evaluated for each evidence source or inference. The authors illustrate this approach using published research on learning portfolios.

The authors advocate a "methods-neutral" approach to assessment, in which a clearly stated purpose determines the nature of and approach to data collection and analysis. Increased use of qualitative assessments will necessitate more rigorous judgments of the defensibility (validity) of inferences and decisions. Evidence should be strategically sought to inform a coherent validity argument.

### To read more:

[http://ovidsp.tx.ovid.com.ezproxy.library.uvic.ca/sp-3.22.1b/ovidweb.cgi?&S=EHBOFPCEIIDDAABFNCFAMCDHBDAA00&Link+Set=S.sh.59.60.63%7c16%7csl\\_10](http://ovidsp.tx.ovid.com.ezproxy.library.uvic.ca/sp-3.22.1b/ovidweb.cgi?&S=EHBOFPCEIIDDAABFNCFAMCDHBDAA00&Link+Set=S.sh.59.60.63%7c16%7csl_10)

[http://ovidsp.tx.ovid.com.ezproxy.library.ubc.ca/sp-3.22.1b/ovidweb.cgi?&S=EHBOFPCEIIDDAABFNCFAMCDHBDAA00&Link+Set=S.sh.59.60.63%7c16%7csl\\_10](http://ovidsp.tx.ovid.com.ezproxy.library.ubc.ca/sp-3.22.1b/ovidweb.cgi?&S=EHBOFPCEIIDDAABFNCFAMCDHBDAA00&Link+Set=S.sh.59.60.63%7c16%7csl_10)

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## 10. Coaching From the Sidelines: Examining the Impact of Teledebriefing in Simulation-Based Training

Ahmed, Rami A.; Atkinson, Steven Scott; Gable, Brad et al

**Simulation in Healthcare: The Journal of the Society for Simulation in Healthcare**

Volume 11(5), October 2016, p 334–339

### Abstract:

**Introduction:** Although simulation facilities are available at most teaching institutions, the number of qualified instructors and/or content experts that facilitate postsimulation debriefing is inadequate at many institutions. There remains a paucity of evidence-based data regarding several aspects of debriefing, including debriefing with a facilitator present versus teledebriefing, in which participants undergo debriefing with a facilitator providing instruction and direction from an off-site location while they observe the simulation in real-time. We conducted this study to identify the effectiveness and feasibility of teledebriefing as an alternative form of instruction.

**Methods:** This study was conducted with emergency medicine residents randomized into either a teledebriefing or on-site debriefing group during 11 simulation training sessions implemented for a 9-month period. The primary outcome of interest was resident perception of debriefing effectiveness, as measured by the Debriefing Assessment for Simulation in Healthcare-Student Version (See Appendix, Supplemental Digital Content 1, <http://links.lww.com/SIH/A282>) completed at the end of every simulation session.

**Results:** A total of 44 debriefings occurred during the study period with a total number of 246 Debriefing Assessment for Simulation in Healthcare-Student Version completed. The data revealed a statistically significant difference between the effectiveness of on-site debriefing [6.64 (0.45)] and teledebriefing [6.08 (0.57),  $P < 0.001$ ]. Residents regularly evaluated both traditional debriefing and teledebriefing as “consistently effective/very good.”

**Conclusions:** Teledebriefing was found to be rated lower than in-person debriefing but was still consistently effective. Further research is necessary to evaluate the effectiveness of teledebriefing in comparison with other alternatives. Teledebriefing potentially provides an alternative form of instruction within simulation environments for programs lacking access to expert faculty.

### To read more:

[http://ovidsp.tx.ovid.com.ezproxy.library.uvic.ca/sp-3.22.1b/ovidweb.cgi?&S=EHBOFPCEIIDDAABFNCKFAMCDHBDAA00&Link+Set=S.sh.110.111.114%7c6%7csl\\_10](http://ovidsp.tx.ovid.com.ezproxy.library.uvic.ca/sp-3.22.1b/ovidweb.cgi?&S=EHBOFPCEIIDDAABFNCKFAMCDHBDAA00&Link+Set=S.sh.110.111.114%7c6%7csl_10)

[http://ovidsp.tx.ovid.com.ezproxy.library.ubc.ca/sp-3.22.1b/ovidweb.cgi?&S=EHBOFPCEIIDDAABFNCKFAMCDHBDAA00&Link+Set=S.sh.110.111.114%7c6%7csl\\_10](http://ovidsp.tx.ovid.com.ezproxy.library.ubc.ca/sp-3.22.1b/ovidweb.cgi?&S=EHBOFPCEIIDDAABFNCKFAMCDHBDAA00&Link+Set=S.sh.110.111.114%7c6%7csl_10)