SHARING TRAINING EXCELLENCE IN MEDICAL EDUCATION

STEME19

Annotated notes from Day Two of HEIW's STEME19 Conference - Oct 2nd 2019

This is an unauthorised & unofficial #FOAMed production by a catch-up delegate who has ploughed through the videos of all the plenary sessions that are available on the HEIW website.

Obviously, these notes reflect the bits that I found new, interesting or relevant: if you want to watch the videos yourself, and you're reading this in the PDF, you can find the sessions here. **- @DrLindaDykes**

JANE CANNON

Head of Approvals, GMC

For me, Jane's talk on "**Fair Training For all: Understanding and Responding to Differential Attainment"** - about BME doctors - was the talk of the event. I would highly recommend you watch it for yourself.

"There is an ethnic attainment gap, even if the doctor trained in the UK and even after socioeconomic status has been corrected for..."

Jane very carefully did ***not*** use the word "racism" or imply it in her presentation, but I found it difficult to escape the impression that many of our recruitment, training and placement norms in UK medicine might - potentially - be institutionally racist.

Although not specific to medicine, Jane signposted delegates to the 2012 HEFCE/ Paul Hamlyn Foundation report on BME student degree retention and attainment and highlighted the findings that it can be,
"*... difficult to adjust to a white-dominated culture different to that you grew up in*".

This is likely to apply to our postgraduate medical trainees just as to the undergraduates interviewed for the report: because BME students are at risk of under-attaining, they are also less likely to secure their first-choice locations for postgraduate training, potentially thrusting them out to parts of country far less multi-cultural than cities.

I was astonished to learn of the magnitude of the "preferred place" effect: there are more black students at the University of East London than at the "top" 20 UK HEIs *combined;* 50% of young black students choose to study in London; and students in general will prefer "*to pick institutions they feel reflect them... but medical students have less choice...*"

However, Jane also flagged up that in BME students in general, it is *"lack of preparedness for higher education, and not culture, ethnicity or racism"* where problems may occur.

But what if we, as trainers, are making things even worse, and excluding BME trainees from optimal feedback?

Jane revealed that a survey of trainers found that there was a *"reluctance to give feedback that may be construed as racist, especially if related to sensitive issues like language of inter-personal relationships."*

Thus, BME students are more likely to miss out on vital developmental feedback - which led me to the inescapable conclusion that we as trainers may actually be exacerbating the differential attainment problem, instead of helping to tackle it.

It also struck me that Jane's list of "What BME doctors need from their trainers" is exactly what brings out the best in *all* our trainees.

What BME doctors need from their trainers:

- ❖Trainers to show belief in them
- ❖Trainers to show interest in them
- ❖Understand barriers that may be occurring outside of work
- ❖Individualised feedback

Overall - an excellent talk, that gave me plenty to reflect on.

ALEX HOWELLS

CEO, HEIW

- This talk was mainly about the launch and development of Health Education & Improvement Wales, a descendant of the Wales Deanery that also incorporates workforce and development services for all NHS staff in Wales, and Pharmacy training.
- However, Alex did mention Michael West in his talk (Compassionate Leadership stuff - lots on the Kings Fund website) who in turn cites Amy C Edmondson's championing of psychological safety at work, whose 2014 TED talk about "Teaming" is well worth a watch.

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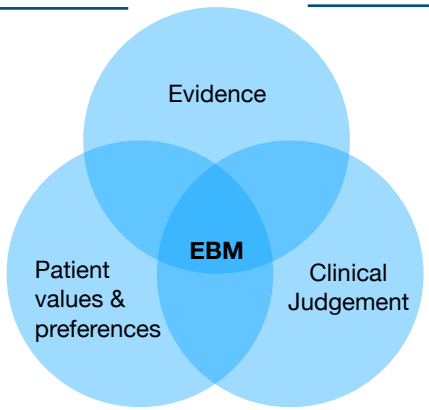
Day Two Continued

PROF PHIL NEWTON

DIRECTOR OF LEARNING & TEACHING, SWANSEA UNIVERSITY MEDICAL SCHOOL

Professor Newton's talk on "Evidence-based Approaches to Medical Education: Lessons from Pragmatism" was refreshingly honest in pointing out that the type - and quality - of "evidence" in the education literature is substantially different that that we are accustomed to in medicine - even though our efforts to practice EBM need to take into account *"more than just the evidence*"!

In terms of the education literature and resources, Phil recommended the BEME reviews (Best Evidence Medical & Health Professional Education) and ERIC (*"The Pubmed of Education"*) - although my browser gave a security warning when I tried to access ERIC.



Above: A reminder that Evidence-Based Medicine is not just about the evidence!

So what *does* work?

Well, forget "Learning Styles" (Auditory, Visual, Kinaesthetic), which *doesn't* hold, or at least not to the extent it has been touted in the past.

Plenty of strategies do work (see box, right), but the bottom line is that our working memory is still a rate-limiting step for learning…

and don't forget, when teaching undergraduates especially, that they are having to learn medical jargon at the same time as learning what it means… a bit like trying to memorise a list in a foreign language you don't know.

Educational Strategies That Do Work

- *Formative & Practice testing*
- *Reducing cognitive overload during teaching*
- *Peer teaching (appropriately facilitated and supervised)*
- *Spaced teaching*
- *use concrete examples to build on stuff your learners already know*
- *Feedback*

HELEN HOWSON

THE BEVAN COMMISSION

"Challenging Thinking & Practice in Wales" was the talk title, and Helen gave an overview of the work of the Bevan Commission, and the principles of Prudent Healthcare.

However the most useful moment of the talk for me was actually the Einstein quote: "*No problem can be solved from the same level of consciousness [kind of thinking] that created it*" - which seems to be a variant of the more common "insanity" quote.

JOHN BOULTON

INTERIM DIRECTOR OF NHS QI

"QI is the methodology to support the transformation"

John began by defining what he means by a culture of quality ("safe, effective, patient-centered, efficient, timely & equitable") - does this originate from the 2001 (US) Institute of Medicine Report "Crossing the Quality Chasm"?

He went on to discuss the history of the notion of "quality", which originated in 18/19C factories, moved through to Taylor's Principles (*"still taught on MBAs, but outlawed outside of this…"*) whose 1917 book was transformative - there's a digitised copy here, and then onto W Edwards Deming, who recognised the impact of management style on workers. Deming's System of Profound Knowledge advocates four "lenses" through which to view things simultaneously: appreciating a system, understanding variation, psychology, and epistemology (the theory of knowledge).

John completed his talk by talking about the chasms in the innovation cycle/Diffusion of Innovations/Chasm-Diffusion model, and the reliance on the 15% of so of the population (or, I presume, workforce) who are innovators and early adopters to talk and communicate the need for change to the remaining 85% "*who want proof first - the "chasm".* However John also shared that he feels there is another, less commonly-described chasm: that between innovators and early adopters.

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