



Postgraduate clinical teaching

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from Taiwanese students in terms of both their cumulative and first-year GPAs.

As there is currently a significantly larger percentage of male medical students than female medical students at our institution, international students serve to balance this gender disparity. In addition, research has shown that students of low socioeconomic status are underrepresented in medical schools, leading medical educators to warn that a medical education is becoming something that is exclusively for students from rich families. Our results imply that the admission of international medical students to our university can increase the range of students' socioeconomic backgrounds.

The admission of international students to our medical school has not only brought unique perspectives to our campus, but has also led to less gender inequality and more socioeconomic diversity. Further, these students have shown themselves to be just as academically competent as Taiwanese medical students. Thus our results show that in Taiwan, international students can greatly increase diversity with limited drawbacks.

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A new spin on vertical integration

Dear Sir

Over recent years, medical schools have incorporated Vertical Integration (VI) into their curricula. Bradley and Mattick (2008) defined VI as a '*... combination of basic and clinical sciences in such a way that the traditional divide between pre-clinical and clinical studies is broken down*'. There is growing evidence that VI provides a more contextualised approach to learning, eases the transition to post-graduate training and facilitates earlier career choices. Recently, there has been a drive towards integrating basic sciences with clinical sciences within specific teaching sessions. There is little research, however, into the benefits of using VI within small-group teaching sessions and in evaluating the perceptions of medical students of this style.

For the first time at Northwick Park Hospital, we organised junior-doctor led interactive sessions for first-year clinical students. The sessions integrated biomedical sciences with cases relating to common topics encountered in daily clinical practice. For example, a session on arterial blood gases involved a series of clinical scenarios with real-life blood-gas results followed by a detailed discussion on the physiology of

gaseous exchange and the biochemistry of plasma acid-base balance, relating these back to the clinical presentations.

25 students with a mean age of 20.8 years (20–23) who attended >6 sessions, filled out feedback questionnaires. 92% of the students expressed a preference for more vertically integrated small-group teaching throughout their medical curricula. All students preferred VI sessions to either basic science or bedside teaching alone.

There is growing awareness of VI and its usefulness in medical training. The results of our questionnaire-based study concur with the overall positive outlook on student perception of VI in medical education today. We also demonstrate that students show a preference for the use of VI within individual teaching sessions.

It is interesting to note that almost all the studies assessing VI that have been published so far are questionnaire-based analyses, including our study. This indicates that the evidence of perceived benefits of VI is based on study participants' opinion. To date, studies looking specifically at comparing set end-points between students undergoing training with traditional versus vertically integrated medical curricula are lacking.

Medical education is constantly changing. The search for the optimal teaching style continues. Our study demonstrates a preference for the use of VI within small-group teaching sessions. Exactly where this particular teaching style lies among the other proposed styles on the backdrop of an evolving medical system is yet to be determined.

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Dear Sir

Two recent 'Twelve Tips' in the same issue of *Medical Teacher* provide an interesting contrast and the positions from which they are written identify a key issue for those learning and teaching in postgraduate medicine. Dennick (2012) considers three aspects of learning theory and from them draws conclusions about how learning opportunities might be best constructed. Of particular importance is a learner-centred approach, identifying and building upon previous knowledge,

of relating learning to context and of reflecting upon experience.

Kirkham and Baker (2012) come from a different perspective. While acknowledging the importance of experience they are concerned that in practice, routine clinical work always takes precedence over anything else and may not itself be accompanied by much learning. They find themselves at odds with their colleagues who feel that trainees are best kept in the clinical environment. They may also be worried about being able to measure whatever learning that does take place. Based on a requirement for a formal generic teaching programme their proposals are for teaching sessions, which should be in protected time and compulsory. They outline a model syllabus around a number of common patient presentations and some more general topics.

I find a disconnect here. Is day-to-day clinical experience an opportunity or a threat? Or, if it is both how can we make it more of one and less of the other? Many years ago, I was an enthusiast for protected time for teaching but now I am not so sure. The risk I see is an attitude that protected sessions become the only teaching that matters and the rest of the time can all be devoted to uninterrupted service work without needing to worry about the much more complex and messy task of experiential learning that Dennick implies. We should not undermine the use of experience because the clinical environment appears too unfriendly for teaching. We should strive for better learning and teaching opportunities within the clinical encounter, recognising that every patient is different, every encounter a potential learning opportunity. Osler got this right more than a century ago. It may not always be measurable but then not everything that counts can be counted.

For example, for most doctors the consultation is their primary activity but how many hospital consultants (GPs do it better) watch our trainees conduct a ward round or an outpatient session, at least outside a formal assessment, and perhaps not even then? The one-minute preceptor idea has not yet crossed the Atlantic.

As a possible way forward, the General Medical Council (2012) has recently proposed the concept of Supervised Learning Events (SLE). Detail is thin and it needs to be seen if these will be more than a new bit of jargon for formative assessment. Nevertheless perhaps there is a valuable opportunity now to use the authority of the regulator to devise innovative ways of capturing the 'teachable moment' within the stochastic environment of clinical work which will satisfy everyone that necessary learning is being achieved without undue disruption to clinical work.

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Workplace-based assessments in surgery: Are we heading in the wrong direction?

Dear Sir

Workplace-based assessments were intended to be used in a formative manner as tools to guide learning. Bindal et al. (2011) expressed concern that these assessments are being used in a summative way and this limits the educational value. They reported that finding available assessors and time pressures were major obstacles for successfully completing workplace-based assessments. These concerns were supported by Pereira and Dean (2009), who reported that only 6% of surgical trainees felt the inter-surgical curriculum project, which trainees use for workplace-based assessments, had a positive impact on training. Many trainees were filling in assessments in batches in one sitting, as a tick-box exercise further compromising the educational value.

I am pleased that the General Medical Council, UK, has responded to these concerns and has recommended that supervised learning events supersede workplace-based assessments. Supervised learning events should be used to help doctors progress by identifying strengths and areas for development. Performance descriptors are removed and outcomes of supervised learning events are not used as evidence in making formative assessments.

The national foundation programme for doctors has adopted these proposals, which seems to be a positive step in changing the cultural perception of workplace-based assessments. However, at odds to this, the joint committee on surgical training in the UK, this year, decided to increase the number of annual workplace-based assessments for surgical trainees to 40 per year. London deanery has taken this further, requiring a minimum number of 80 per year for their core trainees. It seems that this is a backward step. Bindal et al. (2011) have highlighted that trainees are already having difficulty in completing workplace-based assessments. In order to enhance educational quality, adequate time is needed for feedback, not an increase in quantity of assessments.

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