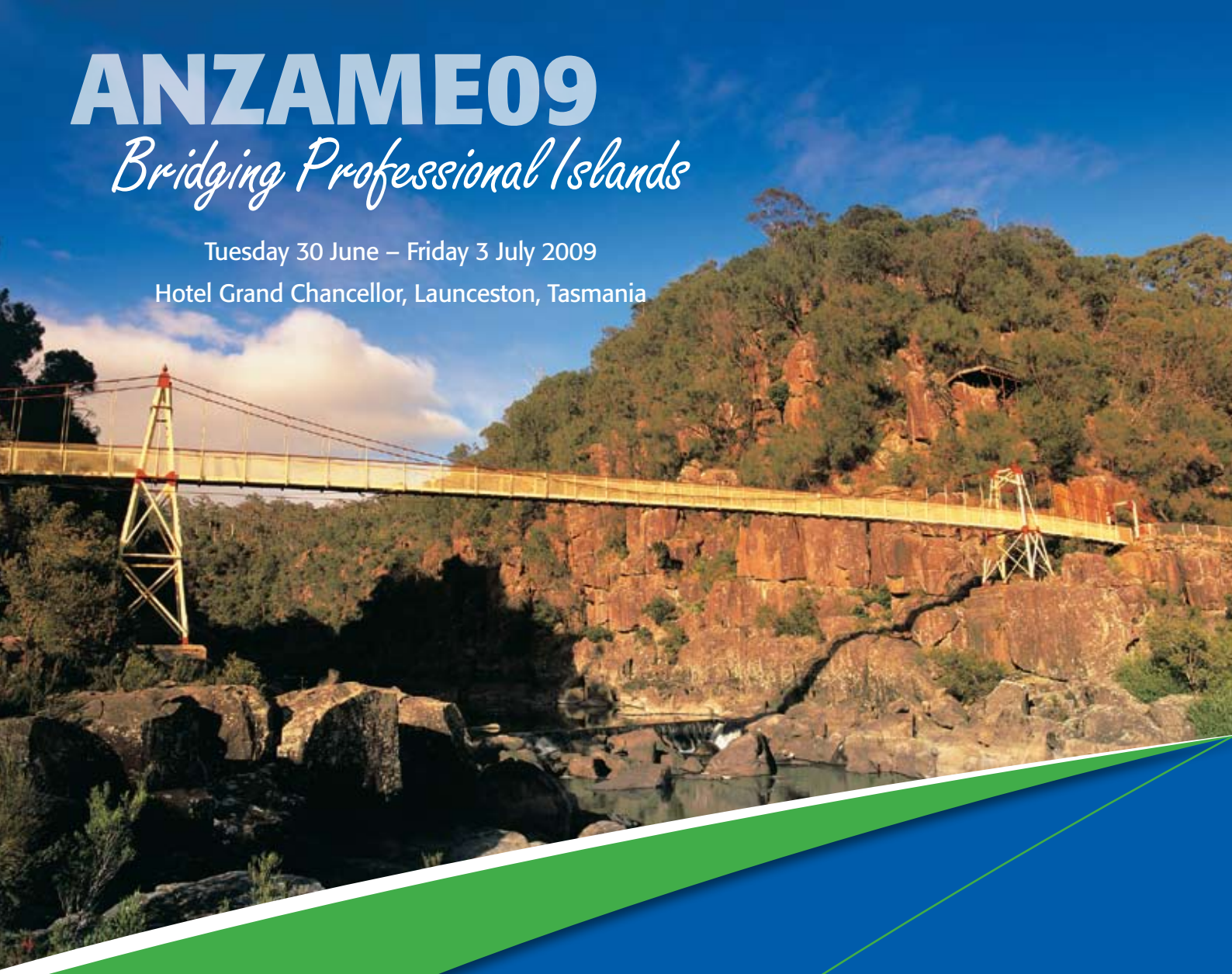
ANZAME09

Bridging Professional Islands

Tuesday 30 June – Friday 3 July 2009

Hotel Grand Chancellor, Launceston, Tasmania



UTAS

Handbook

www.cdesign.com.au/anzame2009

Welcome

This is the very first time that an ANZAME Conference has been held in Tasmania and on behalf of the Organising Committee I would like to welcome all delegates to Australia's beautiful island state. The Conference theme Bridging Professional Islands promotes a collaborative approach to significant changes in health workforce education and is intended to promote debate and discussion around the inter professional educational agenda, evidence and opportunities for simulation-based education, workplace-based learning, the impact of increased student numbers, and important issues related to professionalism.

Invited speakers will cover the theme from a variety of angles. Professor Allan Carmichael (President Australian and New Zealand Deans of Medicine) will set the scene by looking at changes in medical education over the past decade and challenges for the next. Professor Judy Searle, (Principal Medical Adviser, Workforce, Education and Training, Department of Health and Ageing) describes her new role as a 'cultural translator' between government and the key national and jurisdictional medical workforce stakeholders and is well placed to comment on implications of current workforce changes for health professional education. Peter Carver (Executive Director National Health Workforce Taskforce) is a key national player in health workforce reform and will focus on policy and processes for clinical placements which will change the nature of the relationships between education and training providers and health services. Associate Professor Merrilyn Walton designed and wrote the national patient safety educational framework and will answer the question – how far have we come in patient safety learning? Associate Professor John Clark (NHS UK Institute for Innovation and Improvement) will explore the drivers for greater engagement of health professionals in the management, leadership and transformation of services and the relationship with organisational performance and subsequent impact on education and training.

There is a full program with over 140 concurrent PeArLS, small group presentations and workshops and a new feature of continuous poster presentations.

Welcome – we look forward to walking the bridge together!

Professor Judi Walker
Conference Convenor
ANZAME09

Launceston

Launceston, Tasmania's second oldest and second largest city, sits at the junction of the North and South Esk rivers. The city is compact and pretty with colourful Victorian and Edwardian homes lining the hillsides along the river banks.

The Cataract Gorge Reserve, which includes the first Basin and the Cliff Grounds, form extensive recreation spots just 15 minutes walk from the heart of Launceston. The reserve is ideal for walking, viewing historic gardens and exotic plants or simply relaxing in the restaurant or tearooms.

Launceston is a good base for exploring the vineyards of the Tamar Valley and from Launceston you can also explore national parks such as Narawntapu (known for wildlife spotting) and Cradle Mountain-Lake St Clair, or the historic colonial villages of Evandale and Longford.

It is also worth spending time in the Queen Victoria Museum and Art Gallery, and Launceston's first-class arts and crafts outlets, including the Design Centre and the Ritchies Mill complex.

Conference Aims

The aims of ANZAME09 *Bridging Professional Islands* is to highlight both the need for and the current focus on a collaborative approach to health professional education. What is already happening? What are the plans for the future? Is an interprofessional agenda needed? What is the relationship between discipline areas? How do we cope with increased student numbers and changing dynamics?

Conference Organising Committee

- Judi Walker, Conference Convenor
- Gaye Clark
- Shelagh Lowe
- Justin Walls
- Juliana Ahmad
- Rosalind Bull
- Dominic Geraghty
- Jo Osborne
- Craig Zimitat

Conference Secretariat

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CONFERENCE DESIGN

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Social Functions

Welcome Reception

When:	Tuesday 30 June 2009
Where:	Hotel Grand Chancellor
Time:	5.30 – 7pm
Cost:	Inclusive for full registrations
Additional Tickets:	$30
Dress:	Smart casual

Welcome to Launceston! Join us for a drink and casual get-together. The Welcome Reception is an ideal opportunity to catch up with your interstate colleagues and exhibitors, and is a great time to meet delegates who are attending the ANZAME conference for the first time.

Conference Dinner

When:	Thursday 2 July 2009
Where:	The Boathouse
Time:	7 – 11pm
Cost:	Inclusive for full registrations
Additional Tickets:	$95
Dress:	Smart casual

The Conference Dinner will be a casual night of great food, wine and entertainment. Help us celebrate the 2009 ANZAME Conference with a wonderful evening.

Coaches will depart from the Hotel Grand Chancellor front entrance at 6.45pm sharp and return to city hotels after the dinner.

About ANZAME

ANZAME: The Association for Health Professional Education

- Aims to promote, support and advance education in the health professionals.
- Aims to facilitate communication between educators in the health professions.
- Is about undergraduate and postgraduate training and continuing education.
- Aims to recognise facilitate and disseminate high quality educational research in health professions education.
- Offers seeding grants and awards to encourage educators, researchers and students
- Is the focal point for health professions education in western Pacific region.
- Publishes a peer-reviewed journal, *Focus on Health Professional Education* and a news bulletin.
- Holds an annual conference.
- Is managed by an elected Committee of Management.

For more information go to **www.anzame.unsw.edu.au**

The ANZAME Annual Awards

ANZAME invites nominations for their awards, which are presented yearly at the annual Conference. Please refer to the ANZAME website for the submission criteria, conditions of Awards and nomination procedures **www.anzame.unsw.edu.au**

- The ANZAME Award
- The Fred Katz Memorial Medal
- The ANZAME Undergraduate Student Prize
- The ANZAME Postgraduate Student Prize
- ANZAME Honorary Membership

2009 Annual General Meeting

As an incorporated body, ANZAME is legally required to hold an annual general meeting to enable members to review performance during the previous financial year.

The Annual General Meeting is called by the Committee and is held in association with the annual conference held in early July. It is essential that members of ANZAME attend the AGM so that the following matters can be considered and discussed.

The business of the Annual General Meeting is to include the following:

- to confirm the minutes of the previous annual general meeting or any special general meeting held since then;
- to receive reports from the Committee on the activities of the association during the year;
- to elect the members of the Committee;
- to receive and consider the annual Treasurer's report and financial statements of the association;
- to approve the budget of the association;
- to direct and review the general affairs of the association;
- to review the actions taken by the Committee between annual general meetings;
- to consider any other business.

2009 Annual General Meeting – Tasmania

A name change for ANZAME has been formally and informally debated for some time. For several years there has been a disparity between our acronym and the longhand Association name. It has been suggested that our name should reflect our interprofessional and multidisciplinary health professional education membership. The ANZAME March Bulletin, as well as a recent email, was distributed to all members containing the suggested names. The three or four top runners will be selected and the new name will be finalised and motioned at the 2009 AGM, which will be held during our 2009 conference in Tasmania. If you would like to be included in this decision, it is vital that you attend the Annual General Meeting in Launceston, Tasmania 2009.

For further information, please contact Lee-Anne Munro at the ANZAME Office Ph: 0405 123 599 OR Email: anzame@flinders.edu.au).

Invited Speakers

John Clark

Director of Medical Leadership and International Relations, NHS Institute for Innovation and Improvement, UK; Director of Institute for Healthy Leadership, Department of Health, Western Australia; Honorary Associate Professor Institute of Clinical Leadership, University of Warwick Medical School, UK

John Clark is responsible for developing medical leadership capacity within the NHS. He joined the predecessor body – NHS Leadership Centre – in 2003 having previously been Director and Senior Fellow at the Health Services Management Centre (HSMC) at the University of Birmingham. He is currently leading, in conjunction with The Academy of Medical Royal Colleges and a range of health and medical professional and regulatory organisations, a national project to enhance the engagement of doctors in leadership. This also includes the development of an integrated leadership competency framework for doctors from undergraduate and postgraduate education through to the most senior medical roles.

John is currently seconded from the NHS Institute to the Department of Health, Western Australia to establish the Institute for Healthy Leadership. He has previously been heavily engaged in developing the Healthy Leadership Strategic Framework and has been involved in a wide number of different activities within the health and higher education systems in WA over the past 12 years. John will conduct his secondment through regular visits to Perth and from his base at the NHS Institute for Innovation and Improvement at the University of Warwick Campus in the UK.

Leadership Training for Health Professionals – no longer an optional extra

Historically, in many countries, the health professions have not been particularly encouraged to attain competency in management and leadership. It has generally been left to individuals to voluntarily seek management and leadership training and development.

The presentation will use a case study approach by drawing on a major project jointly led by the NHS Institute for Innovation and Improvement (UK) and the Academy of Medical Royal Colleges and involving all the medical professional, regulatory, educational and service bodies that will now require all doctors at all levels of their training and careers to attain an agreed set of management and leadership competences. The presentation will explore the drivers for greater engagement of health professionals in the management, leadership and transformation of services and the relationship with organisational performance.

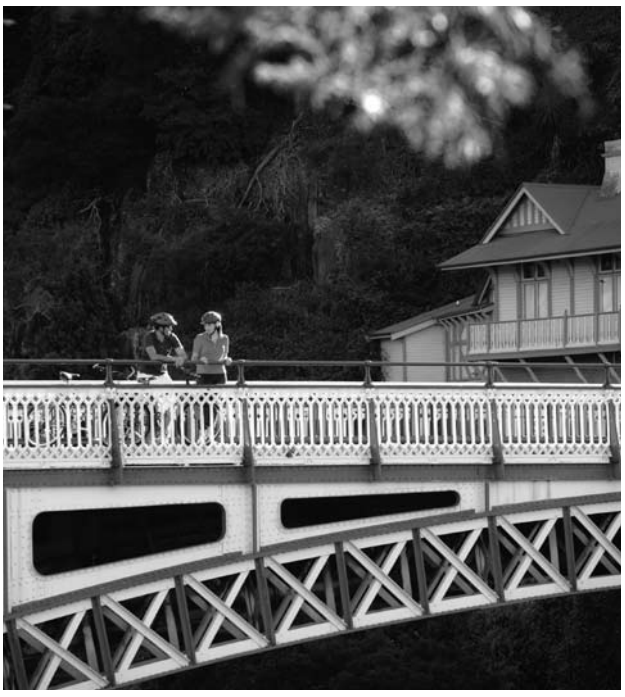
Allan Carmichael

OAM MBBS (Monash) MD (Melb) FRACP

Head, School of Medicine Dean, Faculty of Health Sciences, University of Tasmania, Australia; State Adviser Health Services, Department of Health & Human Services, Tasmania; President, Medical Deans Australia New Zealand.

Professor Carmichael graduated from Monash University, subsequently trained as a paediatrician and worked at Royal Children's Hospital, Melbourne over a 20-year period in clinical, teaching, research and administrative roles. In 1992, Professor Carmichael moved to Tasmania as Professor of Paediatrics & Child Health at the University of Tasmania and since 1997 has been Head of the School of Medicine and Dean of the Faculty of Health Science. He has served on numerous National and State Government Committees including NHMRC and Child Health advisory committees. He has been a member of the Australian Medical Council Medical School Committees and Assessment Teams, and a number of committees on prevocational and postgraduate medical training.

During his keynote presentation, Allan intends to cover changes in medical education, training and workforce over the past decade and the challenges and opportunities facing the medical and health professional workforces over the next decade. The implications for education and training will be discussed.



Merrilyn Walton

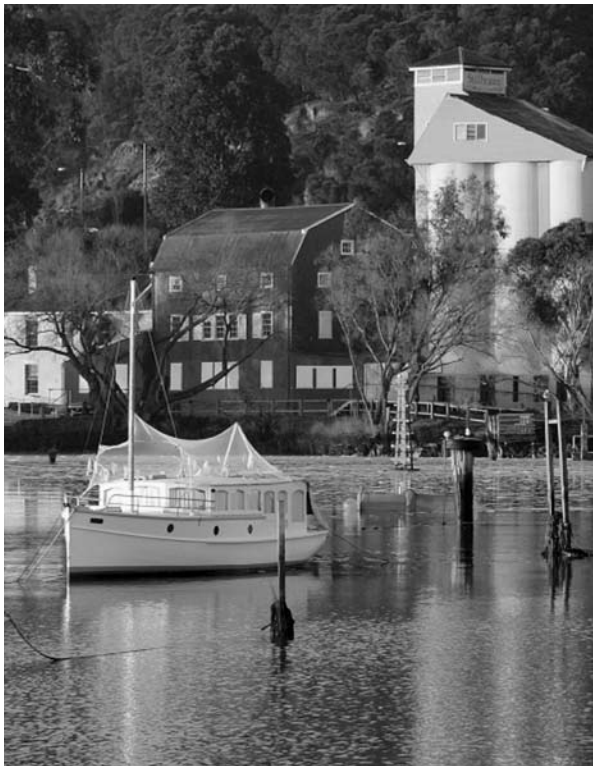
Associate Professor of Ethical Practice, Faculty of Medicine, University of Sydney

Merrilyn Is the Director of Patient Safety in the Office of Postgraduate Medical Education. She also coordinates the Personal and Professional Development Theme in the Sydney Medical Program. Since she designed and wrote the National Patient Safety Education Framework (NPSEF) published in 2005 she has been a leader in patient safety education and training at the undergraduate, prevocational and vocational levels- nationally and internationally.

She was the lead author and editor in the recently published *WHO Patient Safety Curriculum Guide for Medical Schools*. The NPSEF has also been integrated into curriculum for junior doctors in Australia and health care teams in the United States. The Framework identifies the areas of learning and level of responsibility for all health professionals. The framework applies to health care workers in both developing and developed countries.

Patient safety learning- how far have we come?

The state of patient safety learning in health professional education is variable across educational institutions. What and how students learn about patient safety concepts and principles remains uncoordinated and untested. This keynote presentation will examine the state of patient safety education including a description of the recently published WHO Patient Safety Curriculum Guide for Medical Schools.



Peter Carver

Executive Director of the National Health Workforce Taskforce.

Peter is the former Director, Service and Workforce Planning, Victorian Department of Human Services. He has extensive experience in development of health workforce policy and has been involved at senior levels in progressing national opportunities for workforce reform.

Peter's team members are all experienced in policy development and implementation, specialising in the Australian health sector.

Progressing the national health workforce reform agenda

Professor Judy Searle

Principal Medical Adviser, Workforce, Education and Training
BMBS, FRANZCOG, GDPH, MD, GCTE, PCM

Judy Searle's new role can be described as a 'cultural translator' between government and the key national and jurisdictional medical workforce stakeholders.

Her recent roles as Foundation Dean of Medicine at Griffith University and member of national bodies such as Medical Deans Australia and New Zealand, the Australian Medical Council, Medical School Accreditation Committee and the working group for the National Code of Professional Conduct have provided her with a wealth of experience and opportunity to learn about the Australian health and education sectors.

Judy maintains a research profile and her current research projects include a 3 phase longitudinal cohort study examining the predictive factors that impact on medical graduates workforce decisions and 'Environments for Healthy Living' – a 25-year birth cohort study examining the social determinants of health in populations of SE Queensland.

Updates on the national health workforce agenda: A brave new world

Pre-Conference Workshops

Interactive workshop exploring the concept of satellite simulation delivery.

Nigel Chong

The recent arrival of the Laerdal 3G SimMan technology at the University Of Tasmania Simulation Centre at its Launceston Campus has taken simulated clinical education to the next level. No longer limited by the technology and the isolation of the environment, the "wireless" features of the 3G Simulator support the delivery of multidisciplinary, multi-context simulations.

As a workshop participant you will have the unique opportunity to experience this cutting edge teaching & learning technology - firstly as the facilitators of a clinical scenario using the newest technology from a remote control room, and then as a participant in a scenario experiencing it from the student's perspective. UTAS School of Nursing & Midwifery invite you to join us at this exciting pre-conference workshop.

Interprofessional Education

Associate Professor Justin Walls,
Associate Professor Craig Zimitat,
Professor Andrew Robinson

The Faculty of Health Science at the University of Tasmania has recently implemented a range of initiatives to encourage and enhance collaboration in teaching and learning. These initiatives arose as a response to health workforce priorities emerging nationally through the Council of Australian Government's initiatives, the National Health and Hospitals Reform Commission (NHHRC) and within Tasmania through the Tasmanian Health Plan (THP).

Government imperatives to achieve health workforce reform and sustainability will demand new and different responses from providers of education and training. To achieve a more flexible and multi-skilled health workforce, it is likely that both governments and accrediting bodies will be mandating change in health education and training over the next 5 years. One of these initiatives was the development of a cross Faculty unit where students from the Health Sciences were able to learn both with and from each other in a small group tutorial setting. This workshop draws upon the experience of developing, implementing and evaluating this initiative. Upon completion of the workshop participants will be able to:

- Describe the process by which an existing unit within the School of Nursing was developed into a cross Faculty unit
- Outline the process by which interprofessional outcomes were evaluated
- Describe findings of the evaluation process
- Translate and then apply the University of Tasmania experience to their own context

Professionalism through Workplace-Based Learning

Dr John Clark
Professor Judi Walker
Ms Jo Osborne

Emerging frameworks of professionalism suggest that health professionals should attain management and leadership competencies at all stages of their training and careers. This workshop explore what competencies should be attained and when and how through inclusion in curricula and workplace-based learning.

Presentation Formats

Active participation, not only by the presenters, but by all participants is a key component of every ANZAME conference. All presenters are encouraged to note the allocation of discussion time for their presentation and structure their material to facilitate this interaction.

Small Group Presentations

Papers have been allocated 15 minutes including 10-minute presentation time to highlight the main points, followed by 5 minutes discussion.

PeArLS – Personally Arranged Learning Sessions

PeArL sessions have been allocated 30 minutes – 10 minutes to define the topic plus 20 minutes for open discussion. PeArL sessions allow an opportunity for those who are developing ideas, those who are taking ideas from development into implementation, and those who are planning evaluation of their ideas, to share, discuss and gain insight into their positions by tapping into the wisdom and experience of others.

Workshops

Conference workshops have been allocated 45 minutes. Workshops are working sessions with defined objectives, such as defining the scope and nature of an education issue, developing a plan of action, solving a problem, or demonstration of educational innovations with hands-on experience.

Posters

Posters will be displayed for the duration of the conference. Each poster will be allocated a 1-metre wide x 2-metres high board and the poster must fit within this area. Presenters can nominate before the conference to present their poster in a 4–5 minute poster session held concurrently to the regular conference sessions.

Full Paper Publication

We encourage presenters to submit their full papers for consideration for publication in the ANZAME journal *Focus on Health Professional Education: A Multidisciplinary Journal*. For more information go to www.anzame.unsw.edu.au <http://www.anzame.unsw.edu.au/>

Restaurants & Cafés

There are many varied restaurants and cafés to choose from in Launceston, here are a few:

Chefs – Mod-Oz
Hotel Grand Chancellor
29 Cameron St
Ph: 03 6334 3434

Cafi Centro – Café
76 St John Street
Ph: 03 6331 3605

Croplines Coffee Roasters – Café

La Cantina – Italian
63 George St
Ph: 03 6331 7835

Mallee Grill – Steak
1 Tamar St,
Ph: 03 6334 9288

Metz – Mod-Oz
St John St
Ph: 03 6331 7277

Pasta Pasta – Italian
75 George St
Ph: 03 6331 5511

Pierre's on George – Mod-Oz
88 George St, Launceston
Ph: 03 6331 6835

Star of Siam Thai Restaurant – Thai
Charles St
Ph: 03 6331 2786

Provisional Program Overview

Tuesday 30 June

0900 – 1000	Registration	
1000 – 1300	Simulation Workshop – Nigel Chong	Chancellor 3
1400 – 1700	Inter-Professional Workshop – A/Prof. Justin Walls, A/Prof. Craig Zimitat, Prof. Andrew Robinson	Chancellor 3
1400 – 1700	Workplace-Based Learning Workshop – Dr John Clark, Prof. Judi Walker, Ms Jo Osborne	Chancellor 5
1700 – 1800	Registration	
1730 – 1900	Welcome Reception – Hotel Grand Chancellor	

Wednesday 1 July 2009

0800	Registration	
0830 – 0900	Welcome to Country – Nola Hooper and Conference Open – Mayor Albert von Zetten Chair: Professor Judi Walker, Conference Convenor	Chancellor 1
0900 – 0930	**Plenary Keynote** **Professor Allan Carmichael,** President, Medical Deans Australia and New Zealand Chair: Professor Tim Wilkinson, President ANZAME	
0930 – 1000	**Plenary Keynote** **Professor Judy Searle,** Principal Adviser, Workforce Education and Training, Commonwealth Department of Health and Ageing Chair: Professor Tim Wilkinson, President ANZAME	
1000 – 1030	Morning Tea	
1030 – 1245	**Concurrent Sessions – 30 minute PeArLS**	

	IPE Chancellor 3	**Internationalisation** Chancellor 4	**Workplace-based learning** Chancellor 5	**Student recruitment, transition and support** Chancellor 6	**Learning techniques and technology** Chancellor 1	**Posters** **IPE**
1030 – 1100	*Interprofessional learning in an acute care setting: Workplace-based learning across the professions* **S. Saunders Battersby, C. Shennan, R. Ikin** p17	*Internationalising the curriculum: What are the possibilities?* **F. Everingham, A/Prof. S. West, M. Lewis, A/Prof. L. Harris, P. Driscoll, L. Brown** p21	*Exploring the potential of workplace-based assessment tools for promoting quality learning and teaching* **I. Lindermann, Dr S. McAllister, Dr D. Prideaux** p25	*Strategies for increasing recruitment into clinical education* **C. Berryman, L. Sweet, A/Prof. J. Greenhill, Dr S. Wearne** p28	*Integrating science and clinical practice: Basic science alive, an E-learning pilot project for senior medical students* **J. Rudland, J. Swan** p32	Poster 1 – p159 Poster 2 – p160 Poster 3 – p161 Poster 4 – p162 Poster 5 – p162 Poster 6 – p163
1105 – 1135	*Leaders and followers in Interprofessional health care teams: The transition from student to young professional* **Dr M. Barrow, J. McKimm** p18	*International medical students: Factors that enhance and inhibit learning* **Dr E. Storr, Dr M. Williamson** p22	*The link between workforce and health professional education in Australia and New Zealand* **T. Wilkinson, M. Curry, J.Gough, J. Greenhill, M. Groves, C. Hobbs, S. Hyde, C. Mitchell, A. Wearn, I. Wilson** p26	*What is the student experience of practice- based education* **C. Maginnis, M. Smith** p29	*Developing an E-learning surgical decision-making website for medical students* **J. Swan** p33	Poster 7 – p164 Poster 8 – p164 Poster 9 – p165 Poster 10 – p165 Poster 11 – p166
1140 – 1210	*All aboard the interprofessional islander – sailing from silos to solutions* **B. Howe, C. Jones** p19	*A comparison of learning and content for IMGs in intern rotations in two rural settings: General practice and a hospital medical rotation* **Dr D. Hough, A/Prof. L. Walters, P. Stagg, L. Gum, J. Forgan** p23	*Clinical education in the workplace: How best to support clinical teachers?* **Dr S. Pullon** p26	*Does the collaborative learning model assist student transition from clinical practice to competency?* **C. Lee, Dr K. Hanna, A/Prof. S. Ash** p30	*Code Blue simulation for undergraduate medical students* **J. Ahmad, Dr K. C. Yee** p33	**Student learning** Poster 12 – p167 Poster 13 – p168 Poster 14 – p169 Poster 15 – p170 Poster 16 – p171 Poster 17 – p172
1215 – 1245	*Interprofessional education for student preceptors* **S. Keane** p20	*Innovations in teaching anatomy: A Malaysian experience* **Prof. S. Azer** p24	*'Dr Grant won't be teaching students any more': Would peer review have kept him keen?* **Dr R. Pearson, Prof. J. Bushnell, Dr S. Joseph, J. Joughin** p27	*Support systems for advanced entry students in the undergraduate MBBS at James Cook University* **A/Prof. L. Crane, A/Prof. T. sen Gupta, R. Taylor, Dr J. Wight** p31	*How does a simulation-based IPE program impact on interprofessional practice in two different rural hospitals?* **L. Gum, A/Prof. J. Greenhill, Dr L. Sweet** p34	Poster 18 – p172 Poster 19 – p173 Poster 20 – p174 Poster 21 – p175 Poster 22 – p176

	1245 – 1345	Lunch				
	1345 – 1440	**Plenary Keynote** **Peter Carver,** Executive Director, National Health Workforce Taskforce Chair: Professor Judi Walker, Conference Convenor				Chancellor 1
	1440 – 1445	Session change				
	1445 – 1520	**Concurrent Sessions – 15 minute Small Group Presentations**				
		IPE Chancellor 3	**IPE** Chancellor 5	**Curriculum design** Chancellor 6	**Student placements** Chancellor 4	**Assessment** Chancellor 1	**Posters** **Professionalism**
1445 – 1500		*Exploration of student attitudes towards interprofessional learning* **Dr C. Ritchie, Dr D. Eley, A/Prof. M. Groves, Prof. H. Chenery** p35	*Interprofessional education improves safety and outcomes in fetal welfare assessment* **H. Cooke** p37	*The World Health Organisation (WHO) Patient Safety Curriculum Guide for medical schools* **A/Prof. M. Walton, Dr H. Woodward, S. Van Staalduinen, Dr C. Lemer, Dr F. Greaves, Dr D. Noble, Dr B. Ellis, Sir L. Donaldson, Prof. B. Barraclough** p39	*Script concordance test in assessment of medical students in paediatrics: Inter and intra-rater reliability of experts* **Dr A. Morris, Dr D. Campbell** p41	*Improving clinical placement outcomes for CALD students* **Dr S. O'Reilly, C. Margerison, N. Roberts** p43	Poster 23 – p177 Poster 24 – p178
1505 – 1520		*Introducing interprofessional pain management learning sessions as part of medical and pharmacy programs* **Dr L. Hattingh, Dr T. McGuire, A/Prof. G. Rogers** p36	*Interprofessional learning: Tensions between the sacred and the profane* **T. Lawlis, R. Foxwell, J. Anson, D. Greenfield, A. Barnard** p38	*How and why do the cultural practices of PBL groups change over time, across year groups and what effect does this have on academic regulation?* **S. Hyde** p40	*Trialling a 'cake mix' portfolio assessment with final year undergraduate occupational therapy students* **P. Kirke** p42	*The use of standardised patients in cardiorespiratory physiotherapy education* **C. Johnston, J. Mackney** p44	Poster 25 – p179 Poster 26 – p180
	1520 – 1540	Afternoon Tea					
	1540 – 1715	**Concurrent Sessions – 45 minute workshops**					
		IPE Chancellor 3	**IPE** Chancellor 5	**Curriculum design** Chancellor 6	**Student placements** Chancellor 4	**Assessment** Chancellor 1	**Posters** **Innovation**
1540 – 1625		*Developing an interprofessional quality and safety curriculum for undergradute health science students* **M. Gleeson, Dr K. Ogden** p45	*Building an interprofessional state-wide comprehensive training program for practice educators* **A. Hill, C. Fitzgerald, R. Dunwoodie, A. Patane, K. Cooper** p47	*Teaching anatomy in an increasingly crowded medical curriculum: A survey of current practices and an inter-professional solution* **Dr S. Craig, D. Boers** p49	*Exploring quality assurance processes for assessment* **B. Malau-Aduli, A/Prof. C. Zimitat** p51	*Accuracy of and confidence in Objective Clinical Structured Examination (OSCE) pass-fail decisions* **W. M. Hay, M. Tweed, T. Wilkinson, M. Thompson-Fawcett** p53	Poster 27 – p181 Poster 28 – p182 Poster 29 – p183 Poster 30 – p184 Poster 31 – p185 Poster 32 – p186 Poster 33 – p187 Poster 34 – p188 Poster 35 – p189 Poster 36 – p190
1630 – 1715		*Cancer Learning – An innovative approach to interprofessional education in cancer care* **G. Connolly, J. Ross** p46	*The Australian Clinical Education Program: An interprofessional online program to educationally prepare health professionals as clinical educators* **Dr L. Dalton, A. Leversha, D. Best, H. Howarth** p48	*Teaching and learning clinical skills using peer physical examination (PPE): Potential problems and possible solutions* **Dr A. Wearn, A. Vnu, C. Rees, P. Bradley** p50	*Presentation and demonstration of instant student feedback system in improving student participation, motivation and learning in medical education* **Dr S. Venkatesh Murthy** p52	*Rising to the challenges of student placements within a small service* **H. Burnet, K. Strong** p54	**Clinical learning** Poster 37 – p191 Poster 38 – p192 Poster 39 – p193 Poster 40 – p194 Poster 41 – p195 Poster 42 – p196 Poster 43 – p197 Poster 44 – p198
	1715	Sessions End					

Thursday 2 July 2009

	0800	Registration				
	0840 – 0940	**Plenary Keynote** **Associate Professor Merrilyn Walton** Director, Patient Safety, Office of Postgraduate Medical Education, University of Sydney Chair: Associate Professor Jennene Greenhill Chancellor 1				
	0940 – 0945	Session change				
	0945 – 1035	**Concurrent Sessions – 15 minute Small Group Presentations**				
	Personal and professional development Chancellor 5	**Assessment and feedback** Chancellor1	**IPE** Chancellor 3	**Reflective practice and personal development** Chancellor 4	**Curriculum** Chancellor 6	**Posters** **Educational development**
0945 – 1000	*Fostering appropriate reflective learning – 'student as critic' or 'student as insightful observer'* **J. Hamilton** p55	*Attitudes to formative assessment: A clinical skills story* **M. Kidd, A/Prof. D. Gerrard, D. Tordoff** p58	*An innovative, interprofessional, clinical placement for medical students to teach therapeutics and quality use of medicine* **D. Truscott** p61	*Emotional intelligence in medical students: Does it correlate with academic success?* **A/Prof. S. Carr** p64	*Creating a culture of change: Supporting rural allied health clinical supervisors and their students* **C. J. Millar, B. Phillips, W. Hubbard** p67	Poster 45 – p199 Poster 46 – p200 Poster 47 – p201
1005 – 1020	*Exploring surgical trainees' perception of operating theatre learning environments using self-administered survey instruments* **A. Mahoney, Dr P. Harris, Prof. P. Crowe** p56	*The assessment of practice: A complementary perspective* **Dr P. Gallagher** p59	*Demolishing silos and building bridges: A model of the allied health and nursing interdisciplinary education team* **M. Wemyss, Dr J. Davey, R. Galway, C. Smith** p62	*The journey from novice to expert from a learner's perspective: A qualitative analysis of a peer-to-peer OSCE practice program* **Dr K. C. Yee, Dr J. Stringer, S. Scott, S. Yeoh, S. Carlton, N. Lee** p65	*An evaluation framework to investigate ACT Health's allied health, designated Clinical Educator Model* **J. Yaxley, C. McCormack, K. Murphy** p68	Poster 48 – p202 Poster 49 – p203 Poster 50 – p204
1020 – 1035	*CAHE Online Journal Clubs: Assisting professionally or geographically isolated allied health practitioners to achieve evidence-based practice* **L. Lizarondo, K.Grimmer-Somers, S. Kumar** p57	*Hospital electronic discharge letter quality feedback intervention randomised controlled trial for quality improvement* **E. Hibbert, P. Farrell, J. Laurens, M. Bhana, L. Barnsley, S. Clarke, C. Farah, H.Bittar** p60	*Interprofessional teaching of reflection in undergraduate Health Science programs* **N. Chapman, K. Haracz, C. Johnston, L. MacDonald-Wicks** p63	*Transition? What transition? A self-reflective ethnography study of student-to-internship transition* **Dr G. Warren, Dr K. C. Yee** p66	*Developing strong Murries and keepin them in* **J. Godwin, J. Elston** p69	Poster 51 – p205 Poster 52 – p206 Poster 53 – p207
	1035 – 1100	Morning Tea				
	1100 – 1235	**Concurrent Sessions – 15 minute Small Group Presentations & 45 minute Workshops**				
	Personal and professional development Chancellor 5	**Assessment and feedback** Chancellor 1	**IPE** Chancellor 3	**Reflective practice and personal development** Chancellor 4	**Curriculum** Chancellor 6	**Posters** **Workplace-based learning**
1100 – 1115	*Perceptions by medical students of their educational environment for obstetrics and gynaecology in metropolitan and rural teaching sites* **D. Carmody, A. Jacques, H. Denz-Penhey, I. Puddey, J. Newnham** p70	*Using Studiocode to study registrars' teaching skills* **J. Gough, G. McColl** p75	*The Deakin difference: A journey in interprofessional education development* **S. Evans, S. Milnes** p80	*Medical student wellbeing: Painting the picture* **J. Hillis, W. Perry, E. Carroll, B. Hibble, M. Davies, J. Yousef** p83	*Practice makes perfect: Impact of a hands-on evidence-based medicine training session on learning* **Dr K. Mendis, J. Canalese** p86	Poster 54 – p208 Poster 55 – p209 Poster 56 – p210

	Personal and professional development Chancellor 5	**Assessment and feedback** Chancellor 1	**IPE** Chancellor 3	**Reflective practice and personal development** Chancellor 4	**Curriculum** Chancellor 6	**Posters** **Workplace-based learning**
1120 – 1135	*Early medical students as 'caregivers': Issues and outcomes so far* **Dr H. Wilson** p71	*A year on ... Innovation at the Utas Rural Clinical School – an evolving educational culture* **R. Moore** p76	*Health science of tomorrow – a scientific integrative approach of natural and mainstream medicine* **T. Gruner, G. Lorrigan** p81	*Improving clinical preparation, communication, confidence and satisfaction in physiotherapy students through role-playing* **A/Prof. S. Brauer, R. Isles, Dr A. Chang, A/Prof. N. Low Choy, Dr A. Webster-Wright, R. Toppenberg, D. McCook, Dr M. Smith, K. O'Leary** p84	*Postgraduate research student supervisor development within a clinical school setting – application of educational evidence to improve outcomes* **A/Prof. C. Jones** p87	Poster 57 – p211 Poster 58 – p212 Poster 59 – p213
1140 – 1155	*Teaching physiology in clinical context: Reasoning development in a medical program* **Dr T. Tunny, A/Prof. R. Peterson, A/Prof. M. Groves** p72	*Guessing and incorrect unsafe responses in healthcare professional assessment* **Dr M. Tweed, T. Wilkinson, P. Schwartz, M. Thompson-Fawcett** p77	*Enhancing the quality of clinical supervision and clinical leadership through a unique workplace-based postgraduate program* **Prof. Judi Walker, Jo Osborne, Stella Stevens** p82	*Medical communication training for international medical graduates* **J Young, V. Owens** p85	*What teaching and learning methods do continuing nursing students consider most effective?* **H. Mehta, K. Robinson** p88	
1200 – 1215	*The ability of undergraduate physiotherapy students to read and interpret a scholarly paper* **J. Conroy, Dr M. Skinner, Dr M. Sweetnam-Evans, Dr E. Tribble** p73	*A quality assurance model for clinical assessments* **Dr C. Cock** p78			*Distress detection amongst student colleagues in a problem-based learning setting* **C. Leahy** p89	
1220 – 1235	*Teach the Teacher: helping future doctors learn to teach* **J. Hillis, S. Amadoru, T. Bloom, A.Cheng, L. Cutter, B. Jones, L. Lennard, Y. Li, K. Burns, R. Short** p74	*Medical students generating questions for their own written examination: Tips to guide methodology development* **Dr A. S. Babri, Dr V. Kippers, Dr R. Peterson, Dr T. Papinczak** p79			*Exploration of couples' relationships one year after their participation in standard versus modified antenatal education* **D. Bulic** p90	

1235 – 1345	Lunch & ANZAME Annual Meeting
1345 – 1430	**Plenary Keynote** **Associate Professor John Clark** Director Leadership and International Relations, NHS Institute for Innovation and Improvement Chair: Professor Ian Wilson, Vice President ANZAME Chancellor 1
1430 – 1500	Student Prize Winners Session Chair: Dr Misty Curry
1500 – 1510	ANZAME 2010 Overview – Ray Park Chair: Professor Judi Walker, Conference Convenor
1510 –1535	Afternoon Tea

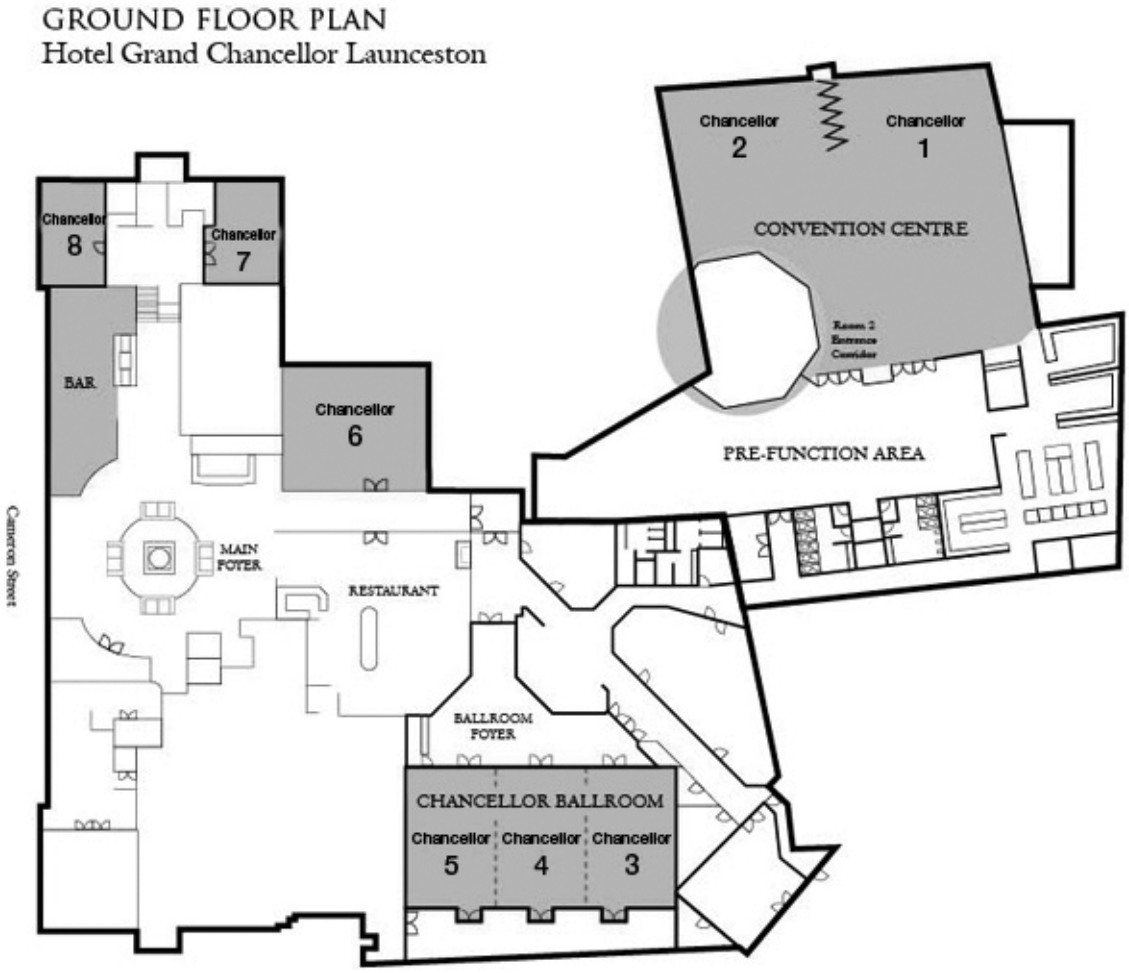
	1535 – 1715	**Concurrent Sessions – 30 minutes PeArLS**				
	Research Chancellor 5	**Curriculum** Chancellor 6	**Assessment and evaluation** Chancellor 1	**Professionalism** Chancellor 4	**Curriculum** Chancellor 3	**Posters**
1535 – 1605	*A beginner's guide to writing ARC grant applications* **Prof. I. Wilson** p91	*Growing self-efficacy beyond Bandura: An augmented model for persistent pain and illness* **Dr D. Buchanan, Dr O. Williamson** p94	*Linking assessment to learning for authentic practice* **J.Stewart, K.Stewart, V. Fester, J. McHaffie, R. Hipkins, G. Dannenfeldt** p98	*Clinical supervision: What is needed to build effective workplace-based supervisory capacity for IMGs?* **B. Bird, B. Sutton Prof. B. McGrath Prof. B. Jolly** p101	*Developing a Wiki Assignment @ UNSW* **Dr R. Thompson, Dr C. Hughes, Dr P. Harris, Dr G. Velan, J. Surman, S. Mobbs** p104	Poster Presentations
1610 – 1640	*What gets measured, gets done – discussing the link between placement assessment and interprofessional competencies* **R. Smith, J. Smith, M. Davidson, K. Dodd** p92	*Student grand rounds – an innovative interdisciplinary teaching strategy* **Dr J. Fardy, M. Campbell** p96	*Assessing communication skills in clinical settings* **Dr S. Hawken** p99	*Evaluating professional development training: Moving beyond participant reaction to monitoring behaviour change and reporting results* **Dr M. Potter, Prof. F. Lake** p102	*Homeopathic clinical reasoning in Australia: Early investigation and implications for complementary and alternative medicine (CAM) education* **D. Levy, R. Ajjawi, C. Roberts** p105	
1645 – 1715	*Developing a conceptual model to relate simulation to real-life clinical practice* **J. Ahmad, Dr K. C. Yee** p93	*Engaging Generation "Y" students through curricula and extra-curricula activities: Developing transferable abilities* **S. Ryan, R. Kentish** p97	*How do we represent multi-source feedback in reflective learning requirements?* **K. Knight** p100	*Matrix re-loaded – leadership and networks for implementation* **S. Harpur** p103	*Exploring learning styles among first year nursing students* **Dr S. James, A. D'Amore** p106	
	1715	Sessions End				
	1900 – 2400	Conference Dinner @ The Boathouse				

Friday 3 July 2009

	0800	Registration		
	0845 – 1040	**Concurrent Sessions – 15 minute Small Group Presentations**		
	Curriculum research and development Chancellor 3	**Postgraduate and workplace-based learning** Chancellor 4	**Teaching tools and strategies** Chancellor 1	**IPE** Chancellor 5
0845 – 0900	*Research projects in medical specialty rotations* **A/Prof. David Kandiah** p107	*Workplace-based learning and the midwifery follow through program* **Dr L. Sweet, A/Prof. P. Glover** p113	*Using online learning to more effectively accommodate clinical attachments – An ALTC Priority Program Project* **Dr B. Dalziel, B. Frankum, G. Mason, L. Cameron, J. Dalziel** p119	*Cross-sectoral leadership and IPL: The skills and attributes required for successful cultural change* **Dr J. Anson, R. Foxwell, K. Murphy** p125
0905 – 0920	*Practising evidence-based medicine at the point of care: The views of junior doctors* **Dr K. Mendis, A/Prof. J. Canalese, S. Van Staalduinen, A/Prof. C. Roberts, T. Forester** p108	*International medical graduates as supervisors and teachers in Australia* **J. Anderson-Wurf, B. Kelly, Prof. L. Pilotto** p114	*CLICKS* **A/Prof. S. Broadley, R. Loudon** p120	*Principle-based competencies – a facilitator for interdisciplinary and interprofessional education?* **A/Prof. M. Chehade, T. Burgess** p126
0925 – 0940	*Development of a method to assess performance of entry level physiotherapists: The assessment of physiotherapy practice (APP)* **M. Dalton, Prof. J. Keating, A/Prof. M. Davidson, Dr N. de Morton** p109	*Doctors and students develop symbiotic clinical partnerships in longitudinal placements* **A/Prof. L. Walters, Prof. F. Prideaux, Prof. P. Worley, A/Prof. J. Greenhill** p115	*Does practice make perfect – does time spent using online resources correlate with academic outcomes?* **Dr K. Robinson, L. Hendrick** p121	*Interprofessional learning for professional/clinical supervision* **L. Beddoe, A. Davys** p127
0945 – 1000	*Development of workplace-based assessment methods and approaches to patient safety* **B. Bird, Dr T. Holt** p110	*How do GP registrars learn to prescribe?* **Dr R. Ajjawi, J. Thistlethwaite, P. Aslani** p116	*Reduce the use of 'super-notes' and increase clinical reasoning in 1st and 2nd year medical students to aid the progression towards a tutor-less learning environment* **E. De Silva, Dr R. Tedman** p 122	*Facilitating IPE goals in clinical education: Identifying key elements for the teaching approach* **Dr C. Delany, D. Watkin** p128
1005 – 1020	*A qualitative study of the effect of Mini-CEX on postgraduate supervision* **A/Prof. J. Weller** p111	*Bridging the gap between university and graduation: Developing an occupational therapy clinical education program* **L. Hansen** p117	*Using an interview in the selection of medical and dental students* **Dr A. Mercer** p123	*An international, multidisciplinary approach to educating health professionals in cancer care for teenagers and young adults* **L. Ewing** p129
1025 – 1040	*Exploring teaching strategies and of the application of client-centred care during undergraduate physiotherapy clinical practice* **K. Moore** p112	*The Hospital Skills Program: Providing a safe harbour for the non-specialist medical workforce* **G. Still, A. Singh, P. Davy, Dr S. Leslie** p118	*Using Multi-Source Feedback for training at postgraduate level* **Professor Kevin Forsyth, Dr Alison Jones, Gillian Sliwka, Michelle Mitchell** p124	*Interdisciplinary teamwork in research: What are the experiences of cross-disciplinary collaboration?* **K. Kumar, C. Roberts, J. Thistlethwaite** p**130**
	1045 – 1115	Morning Tea		

	1115 – 1230	**Concurrent Sessions – 15 minute Small Group Presentations**		
	Curriculum research and development Chancellor 3	**Postgraduate and workplace-based learning** Chancellor 4	**Teaching tools and strategies** Chancellor 1	**IPE** Chancellor 5
1115 – 1130	*Final year physiotherapy students as standardised patients: An effective peer-learning process* **R. Isles, A/Prof. S. Brauer, Dr A. Webster-Wright** p131	*Practice makes perfect: Impact of a hands-on evidence-based medicine training session on learning* **Dr K. Mendis, J. Canalese** p135	*Engaging students in large classes – possible strategies* **V. Brotto, A/Prof. J. Nagy** p139	*What are the views and preferences of allied health professionals on interprofessional supervision?* **Dr L. Robertson** p143
1135 – 1150	*Comparison of the traditional problem-based learning format and larger, directed, independent study groups* **A/Prof. D. Pedler, Dr D. Birks, H. Phillips, Dr E. Wearne, Dr C. Haigh** p132	*Work integrated learning: Mapping the islands in rural and remote Australia* **N. Campbell, A. Smedts** p136	*'Tutoring the tutors' – development and implementation of a 'train the (clinical skills) tutor' workshop* **Dr K. D'Souza, Dr R. Whyte, L. Basham, A/Prof. R. Carne, Prof. B. Crotty** p140	*Bridging educational and cultural gaps for international Saudi Arabian students in medical education* **J. Amed** p144
1155 – 1210	*Designing curriculum, teaching and assessment for a climate-changing world* **Dr E. Bell** p133	*Students, graduates and doctors – recruitment, placement and practice by ARIA* **G. Kelly, T. Sen Gupta, R. Murray** p137	*Functional electrical stimulation for stroke survivors: An interactive eLearning package for allied health, nurses and stroke survivors* **J. Cannell** p141	*Preparing the remote primary health care workforce for work with older people and people with dementia* **H. Jensen, M. Lindeman, P. Kuipers** p145
1215 – 1230	*Results of a survey to RACP 2nd year physicians in training* **G. Sliwka, Dr A. Jones** p134	*The impact of rural clinical placements on career intentions: An analysis of data from the Medical Students Outcome Database* **Dr J Gerber, Prof. L. I. Landau, B Kaur** p138	*Are simulation and video debriefing effective for GP Registrar emergency training?* **Dr R. Kerr** p142	*Filling a need: Dentistry with a difference* **Dr F. Croker, Prof. A. Sandham, R. Hogan** p146
	1230 –1315	Lunch		
	1315 – 1420	**Concurrent Sessions – 30 minute PeArLS & 15 minute Small Group Presentations**		
	Curriculum Chancellor 5	**Clinical education** Chancellor 3	**Simulation** Chancellor 1	**Curriculum** Chancellor 4
1315 – 1345	*Clinical education: The lost acronym* **Prof. D. Prideaux** p147	*The use of video as an educational tool in teaching integrated consulting skills* **A/Prof. J. Radford, Dr K. Rooney, Dr K. Ogden, J. Barr** p149	*Longitudinal patient contact for final year medical students on clinical placement in orthopaedics* **D. Bramwell** p151	*What are good medical notes and what should we be teaching students?* **Dr M. Williamson , T. Egan, Dr E. Storr, Dr J. Ross** p154
1350 – 1420	*Developing a curriculum framework for rural health* **A. Miles, A/Prof. C. Zimitat** p148	*Understanding the differences between medical students' expectations and their experiences of a clinical rotation* **K. Scott, J. Gough, V. Cheetham, M. Phelps, Z. McCallum** p150	*Mind the gap: Supporting new graduate allied health professionals* **B. Fulton, L. Biviano** p152 *Simulation debriefing: Searching beyond closed doors and recognising the value of reflective practice* **L. Gum, K. Dix, J. Greenhill** p153	*Visions of care and student learning in clinical practice* **T. Egan** p155
	1430 – 1500	Closing Plenary Chairs: Professor Judi Walker, Conference Convenor and Professor Ian Wilson, Vice President ANZAME		
	1500	Farewell Drinks		

Hotel Grand Chancellor, Launceston Floor Plan



Abstracts

The abstracts published in these Proceedings have been selected by a process of blind peer review by the 2009 ANZAME Scientific Program Committee consisting of:

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Glen Jacobson – UTAS School of Pharmacy

Geoffrey Couser – UTAS School of Medicine

Justin Walls – UTAS School of Medicine

Wednesday 1 July 2009

IPE

Interprofessional learning in an acute care setting: Workplace-based learning across the professions

S. Saunders Battersby, C. Shennan, R. Ikin

Address

Introduction and background:
Continuous workplace based learning for all health professionals, with particular emphasis on the post graduate period, is an essential part of ongoing professional development and professional satisfaction.

Learning Programs such as communication workshops and simulation activities have the capacity to involve and enhance Interprofessional Learning (IPL) across professional boundaries.

Traditionally, learning opportunities have been offered in siloed discipline-specific educational environments, rather than occurring as interprofessional learning activities.

Future planning for professional learning must take account of the issues that impact upon our capacity as educators to provide appropriate opportunities for learning. These include:

- Limited funding for learning resources (including human)
- Increasing "teacher fatigue" and diminishing good will
- A greater call for a teamwork approach to health care
- A greater emphasis on integrating care between different health sectors
- Changing approaches to learning
- Increasing recognition of the value of simulation for workplace based learning
- Recognition and application of "generic skills" across professional groups

These and other factors in postgraduate health professional learning have led to the development of learning programs which allow different health professional groups to participate together in a range of learning activities, to learn from, with and about each other in their work environment (IPL workshops)..

From early research undertaken at the Launceston General Hospital, it was evident that there was a high level of support for such learning to occur with and between different health professional groups. .

The key themes identified from this research were those of communication, team work and interprofessional collaboration with a strong focus on patient centeredness.

Accordingly, the initial IPL programme at the LGH has included 2 types of activity, notably communication workshops, and teamwork within simulation scenarios.

Objectives:

- To introduce the concept of IPL
- To describe the implementation of an IPL programme at the Launceston General Hospital based on early research at the hospital
- To present the evaluation from the workshops conducted to date
- To generate discussion about the feasibility of such a programme in an acute care setting

Ideas for discussion:

- Is IPL a valuable learning strategy?
- How effective is it?
- How is it best implemented in an acute care setting? Is interprofessional workplace based learning practical and realistically possible?
- What are the long term benefits of such an approach to learning?
- Should this approach be implemented at an undergraduate level?

Leaders and followers in interprofessional health care teams: The transition from student to young professional

Mark Barrow, Judy McKimm

The University of Auckland, New Zealand

Introduction/background:
The role of good teamwork in the provision of quality health care is acknowledged (Baker et al, 2006; Wagner, 2004). Indeed weaknesses in teamwork, particularly perceived inability of multiprofessional healthcare team members to work together, are viewed as an impediment to effective health care provision (e.g.2007 New Zealand Health Workforce Taskforce report).

Education institutions that train health care professionals increasingly recognise the development of team membership capabilities as a core graduate outcome. For some professions, leadership development is included in the undergraduate curriculum, reflecting that the capacity to lead health care teams appropriately is an important attribute. However, this raises issues about the roles of different health professionals working within an interprofessional team; professional identity; who might lead a team at any one time, and what form that leadership might take. Leadership literature reminds us that effective leaders need followers (Densten and Gray, 2001; Grint, 1999). However, no-one leads all the time, followers are very rarely passive, especially professionals. The concepts of 'little leaders' (who lead in small ways) and 'active followers' (Kelley 1992) are enshrined in distributed leadership models that are becoming more popular in health care (Department of Health, 2006). Erroneous assumptions about who might lead and who might follow in healthcare teams may result in overt conflict, tacit followership or subversion and lead to negative impacts on patient care. Thus, we suggest that training healthcare professionals to learn the skills of leadership and active followership might be a useful approach to improve team working.

In this study we interviewed hospital based second year resident medical officers (RMOs) and nurses two years from graduation in Auckland. We identified a range of issues related to their professional identity and belief formation, experiences of providing health care and of working with other healthcare professionals.

Purpose/objectives:
We will:

- explore some of the issues arising from participants' narratives, particularly with respect to an individual's conception of her/his role and the extent to which leadership and followership might affect the roles that healthcare team members play.
- consider the implications for providers of education for health care professions and how they deliver practice experience for students.

Issues for exploration/ideas for discussion:
To what extent can ideas such a leadership and followership be integrated into the delivery of pre-registration education of health care professionals?

What are the issues for academic and clinical teachers in assessing the development of team work attributes like leadership/followership?

All aboard the interprofessional islander – sailing from silos to solutions: Sharing our vision for a collaborative approach to health professional education in the Bay of Plenty Mental Health Service, New Zealand

Bob Howe[1], Carley Jones[2]

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[2] Mental Health and Addiction Service Educator, Bay of Plenty District Health Board, Mental Health Unit, Whakatane Hospital, Whakatane, New Zealand

Introduction/background:
Across the New Zealand and International Health sector key strategic documents have promoted Interprofessional collaborative models of care. Learning initiatives for undergraduate students are already in place and being explored through several pilots, however IPL opportunities exist along a continuum of learning inclusive of postgraduate and continuing education.

The Bay of Plenty Mental Health service offers a unique opportunity to explore IPL within continuing education because of the structure of the in-service program which is not specific to one discipline or profession as is the case in other health boards. IPL will be introduced in an incremental manner with regular evaluations and audits throughout the year. Platform events will introduce specific IPL concepts; teamwork, participation and specific IPL competencies and skills. IPL learning events will take the form of 'Communities of Practice.'

The challenge is to shift a focus to development of professional role identity relevant to collaborative practice, identifying supportive systems and processes and engagement of the community. Part of this is a research project exploring health professional attitudes and outcomes relevant to this initiative.

Purpose/objectives:
Conference Objective(s):
A multi media presentation with lively debate and discussion.To share knowledge, skills and enhance the vision of collaborative care. We wish to present our lived experience to date, including findings of our research project, but also wanting to explore with participants future directions and strategies.

Issues for exploration/ideas for discussion:
1. Share our narrative of how IPL is being implemented in our continuing education program, identifying what is unique to our area and region and how this may be similar to or different from others.
2. Have an opportunity to share and reflect on continuing development of collaborative care initiatives.
3. Explore attitudes and perspectives to interprofessional learning in continuing education.

Interprofessional education for student preceptors

Sheila Keane

Northern Rivers University Department of Rural Health, Lismore, NSW

Introduction/background:
There is an acute shortage of clinical placements for all entry level health professions. Our rural allied health workforce data show convincingly that trained clinical preceptors take more students than non-trained student supervisors. Therefore, the training of clinical preceptors is an essential strategy to increase capacity for clinical placements in rural settings.

The Northern Rivers University Department of Rural Health (NRUDRH) hosts about 600 students on rural clinical placements each year and provides support for medical, nursing and allied health clinical preceptors in the Northern NSW region in Australia.

Due to professional isolation, preceptor training can be difficult to offer in a rural environment. On-line training programs have been developed to address this problem, but uptake may be adversely affected by the need for social engagement in the learning process.

Professional isolation also impacts negatively on the retention of health professionals in rural areas, and is particularly problematic in allied health. The wide array of allied health disciplines often results in insufficient critical mass to afford discipline-specific, face to face education that would ameliorate feelings of professional isolation.

Responding both to the need for increasing capacity for student placements and for ameliorating professional isolation, the NRUDRH designed and implemented a one-day interprofessional (IP) preceptor training workshop targeting allied health professionals. Some nurses also participated in the workshops.

While there are many discipline specific aspects of student supervision, a number of common competencies can also be identified. These include, for example, understanding varieties of learning styles, how to provide feedback, and managing underperformance.

This workshop achieved its educational goals, was well accepted and made possible a face to face, classroom delivery that is so desirable for rural health professionals who feel isolated.

Purpose/objectives:
This paper will describe the IP course design, as well as data from its formal assessment. Participants' description of the added benefits of IP educational delivery identified by participants, as well as their perceived drawbacks, will be presented.

Issues for exploration/ideas for discussion:
- What are the generic educational objectives for training student preceptors?
- Does the content need adaptation for different supervision models (i.e. one-to-one vs. group supervision)?
- Do the added benefits of IP preceptor training warrant separating that content from discipline-specific training?
- Should IP preceptor training be offered in metropolitan settings as well? How would the discipline specific content be covered?

Internationalising the curriculum: What are the possibilities?

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Introduction/background:
Nowhere is the future of the health industry more apparent to students and graduates than when they negotiate the cultural and linguistic diversity of the rapidly globalising workplace. In response to this the Faculties of Nursing and Health Sciences at our University are working on a collaborative project to expand the ways in which the content and pedagogy of a generic undergraduate curriculum can more effectively address 'internationalization'.

In a recent and frequently cited paper, 'internationalization' is defined as 'the process of integrating an intentional, intercultural or global dimension into the purpose, functions and delivery of post-secondary education' [Knight, 2004, p11]. The work of Knight and others pitches the debate well beyond the curriculum, indeed to broader institutional, national and global arenas.

At the curriculum level the current state of affairs appears to be a hiatus of inaction with academics: continuing to delegate language and study skills for international students to external parties; struggling ineffectively with linguistic diversity among local students; and, lacking direction about how to navigate the pedagogical implications of top down policy mandates.

Purpose/objectives:
We would like to generate debate with colleagues outside our institution regarding possible directions for curriculum to meet the pressing challenges implied by escalating workplace diversity.

Issues for exploration/ideas for discussion:
In order for participants to start the discussion with some shared foundation we will briefly report the preliminary findings from our collaborative inquiry and give a succinct overview of the definition to locate it within the current literature and policy context.

To circumvent the potential for discussion to get bogged down in a muddy area of intersecting terms and meanings we would like to take up Knight's question:
'What in the year 2020, will be seen as the major accomplishments of internationalisation [in curriculum, including content and pedagogy]? [Knight, 2004, p29].
Knight question forces a useful' futuring' focus and gives permission to expand the possibilities.

Ref Knight, J. (2004). 'Internationalisation Remodeled: Definition, Approaches and Rationales'. *Journal of Studies in International Education*. 8:5: 5-31

International medical students: Factors that enhance and inhibit learning

Dr Emma Storr, Dr Martyn Williamson

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Introduction/background:
Little research has been done specifically on international medical students' educational expectations, experiences and needs, their enculturation into the New Zealand medical system and the transferability of the skills they acquire to their country of origin. This is particularly relevant given the globalisation of medical training and increasing international mobility of doctors. There is anecdotal evidence to suggest that international students face unique challenges pursuing medical education at Otago University and that they are currently under served by Student Services and have unmet learning and educational needs. The reasons for this are complex and probably relate to a combination of communication difficulties, study skills, learning styles and attitudinal issues.

This research is being conducted with small groups of international medical students from the same country of origin across Years 2-6 of the curriculum. A semi-structured interview is being undertaken with each group to explore their current learning experiences, views about and use of Student Support services. We hope this will provide insight into modifiable factors that might improve the learning environment and support offered to international medical students in the future.

Purpose/objectives:
To identify and understand modifiable factors which affect learning experiences and outcomes for international medical students by a consideration of the learning and teaching environment including:

- the medical curriculum at Otago University
- learning and teaching approaches
- pastoral and practical support
- remedial and supplementary educational support.

Describing medical students' experiences in the four domains above will reveal:

- factors in the teaching environment which inhibit or represent barriers to effective learning
- factors which facilitate or enhance effective learning
- international medical students' experience of accessing student support services and their perception of their usefulness and relevance
- international medical students' ideas and beliefs on how student support services might be further developed and improved to meet specific learning needs.

Issues for exploration/ideas for discussion:
- What have participants found useful in making the learning environment for international medical students most effective and supportive for their needs?
- Multiculturalism and the globalisation of medicine require teachers to have 'cultural competency'. How do we encourage and develop this among staff and domestic students in New Zealand and Australia?
- How can we provide remedial help and tuition at key points in the curriculum to enhance: Cultural competency?
- Communication skills and use of idiomatic language in particular specialties?
- International students' study skills?

A comparison of learning and content for IMGs in intern rotations in two rural settings: General practice and a hospital medical rotation

Dr Debbie Hough, A/Prof. Lucie Walters, Pamela Stagg, Lyn Gum, Julie Forgan

Flinders University Rural Clinical School, Mount Gambier

Introduction/background:
In order to gain full registration as a doctor in Australian, International Medical Graduates (IMGs) are currently required to have a full year of supervised clinical practice with at least 8 weeks of medicine, surgery, and emergency. General practice is not currently included in the list of prerequisite clinical experiences. In Mount Gambier, IMGs all experience a 10 week rotation in rural general practice as part of their supervised clinical year.

This study sort to define how learning occurred in the general practice setting, and in the medical ward setting.

International medical graduates were interviewed on two consecutive days during their general practice and medical ward attachments and asked to describe what they learnt and how they had acquired that learning on the day.

Keys themes emerging from the data included: self-directed learning, opportunistic learning; intentional learning, and supportive supervision. These themes will be defined briefly and differences found in the two settings described.

Purpose/objectives:
To explore the ideas and experiences of peers in relation to learning opportunities for international medical graduates in hospital and community settings

Issues for exploration/ideas for discussion:
- Do international medical graduates learn differently to Australian trained interns?
- How is learning supported differently in the hospital and community context?
- Are the learning supports identified in this study transferable?
- What value does the general practice setting offer for IMGs who are working towards full registration in Australia?

Innovations in teaching anatomy: A Malaysian experience

Samy A. Azer

Professor of Medical Education and Chair of Medical Education Research and Development Unit, Faculty of Medicine, Universiti Teknologi MARA, Malaysia

Introduction/background:
Worldwide, a number of changes have been introduced to most medical curricula such as integrating subjects taught and introducing problem-based learning. With these changes in mind, anatomy teaching as it is the case with other subjects, has been reshaped. For example, the objectives of teaching anatomy, the modes used in teaching/learning, and the emphasis made on the different components of the anatomy curriculum have been revised. However, a number of challenges could face anatomy teachers in regard to curriculum design and implementation. This is particularly important with the current debate about best approaches to teach anatomy.

Purpose/objectives:
Because of these challenges, it was necessary to train our anatomy teachers in training workshop highlighting these changes.

Twenty nine teachers (6 anatomist and 23 surgeons) were trained in one-day workshop addressing current objectives of anatomy teaching, the use of radiology images in understanding anatomy and the use of simulated patients in teaching surface anatomy.

The workshop introduced participants to new techniques in teaching anatomy and added new strategies that they can use in practical classes. Feedback questionnaires collected at the end of the training highlighted these benefits. Interestingly, training on its own did not help teachers to change their attitude and implement these ideas. However, designing follow-up tasks after the workshop, and introducing briefing sessions together with receiving support from the Dean have helped in reinforcing these new strategies.

Conclusions:
Training academics in workshops should be followed by practical tasks and continuous support to reinforce ideas learnt and enable participants to apply what was learnt.

Issues for exploration/ideas for discussion:
- What did you do in the area of staff development and training in regard to anatomy teaching?
- Do you have any innovative ideas that you would like to share with us?
- What did you find that could reinforce new ideas taught in workshops?

Exploring the potential of workplace-based assessment tools for promoting quality learning and teaching

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Introduction/background:
Authentic workplace based assessment is integral to ensure that students' clinical performance can be judged as safe and competent practice. Current thinking is that the development of effective workplace based assessment relies on a programmatic assessment system which aims to meet the educational needs of the learner whilst satisfying practical matters such as resource availability and feasibility (Wilkinson 2007). There is little argument that reliability of assessment is clearly impacted by sampling across a range of contexts and assessors and that validity of assessment improves as students are assessed in more real world settings, however techniques of measurement remain debated (van der Vleuten & Schuwirth 2005). Assessment also must be 'sustainable' and underpin the students future needs for lifelong learning (Boud & Falchikov 2006). To achieve this assessment must instil confidence within a safe learning environment where students can meet clearly described learning goals to specified standards and provide opportunity for critically appraisal, reflection, feedback and self appraisal. We are interested in supporting quality learning and teaching practices and assessment by using assessment tools in which support these principles rather than as ends in themselves.

The MiniCEX is a well accepted form of work place based assessment which at this time is used mainly within medical training and has potential for use in other health professional programs. Investigation of the use of the MiniCEX over many years reveals a robust assessment process which is authentic, reliable, feasible and educationally sound. Despite this, in the pre-professional medical setting, the MiniCEX is mainly used in low stakes formative assessment and high stakes summative assessment of clinical skills remains firmly with the OSCE assessment processes.

Purpose/objectives:
This presentation aims to provide some background regarding quality assessment of workplace learning and to use this to evaluate the utility of the miniCEX as a tool for supporting a sound learning and teaching agenda, including its potential for use as a key component of summative assessment of clinical performance.

Issues for exploration/ideas for discussion:
- Identifying aspects of the learning, teaching and assessment agenda that are currently supported by the use of MiniCEX as an assessment tool
- Strategies that would enable the MiniCEX to strengthen the learning and teaching aspects of assessment.

The link between workforce and health professional education in Australia and New Zealand

Tim Wilkinson, Misty Curry, Jenny Gough, Jennene Greenhill, Michele Groves, Cheryl Hobbs, Sarah Hyde, Charles Mitchell, Andy Wearn, Ian Wilson

Introduction/background:
Recent times have seen an expansion of the training places for some health care professionals. However the capacity to deliver the training is finite. The ANZAME committee of management sees the need to develop a position statement on how there should be a dialogue between health professional educators and workforce planners.

Purpose/objectives:
A draft position statement will be circulated for comment and discussion.

Issues for exploration/ideas for discussion:
- Ideas on how the position statement could be improved
- Ideas on where to go next with a finalised position statement.

Clinical education in the workplace: How best to support clinical teachers?

Sue Pullon

University of Otago Wellington, Wellington Sth, NZ

Introduction/background:
Most undergraduate courses for health professionals involve experiential learning in clinical workplaces, as well as more theoretical and knowledge-based components. Clinicians are often expected to take students into their workplaces, with the expectation that students will learn alongside experienced clinicians working full time directly with patients or clients. Training, remuneration, on-going support and feedback for clinical teachers in workplace settings is highly variable; at best the ability to teach effectively in such settings is largely assumed and students learn by good example; at worst, students are actively resented by overworked health professionals and struggle to provide effective patient care, let alone also meeting student learning need.

In an effort to better support clinical teachers, a clinical education adviser role has recently been established at UOW medical school. Early observations in this newly created role suggest that there are many ways in which medical students learn while on the wards and in the community; the learning environment of the ward or practice may be as important as the designated clinical teacher. Nevertheless, clinical teachers who can assist students to meet curriculum objectives, gain confidence with patient care and practice a range of clinical skills, are key to effective experiential learning. Accurate identification of those who teach in day-to-day clinical situations in larger hospitals is challenging, with very few established channels of either responsibility or accountability for such teaching.

Purpose/objectives:
This session aims to explore ways of effectively identifying and supporting a potentially large number of clinical teachers in both hospital and community settings. The roles of, and relationships between, Faculty leaders, academic teachers, clinical module convenors (often joint university-clinical appointments), administration staff, primary care practice managers, and clinical leaders on wards all need considering in relation to full time clinicians who are asked to teach.

Issues for exploration/ideas for discussion:
How much can be expected from full time clinicians in terms of workplace teaching and learning for undergraduate students? What time allocation or other forms of remuneration are a) common and b) reasonable? How much guidance and training to be a clinical teacher should there be? Who should provide it, and what happens when either clinical teachers or students, or both, have complaints?

'Dr Grant won't be teaching students any more': Would peer review have kept him keen?

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[2] Woonona Medical Practice,380 Princes Hwy, Woonona, NSW

Introduction/background:
The sustainability of community-based health education placements is an increasing challenge as an ageing medical workforce transitions into retirement and the new wave of medical schools compete for finite teaching resources. In addition, to date, community based student preceptors have not been traditionally valued by medical educators.

General practitioners, in particular are unlikely to attend in hours on-campus teacher training sessions. After hours sessions, expensive for schools to run, compete poorly with jealously guarded recreation time. Thus GPs become professionally isolated in their teaching role, and feel the lack of feedback, and training.

Purpose/objectives:
In order to address these issues the University of Wollongong's Graduate School of Medicine intends to commence a pilot Colleague Development Program later this year.

This pilot will enable 6-8 GP preceptors to have a teaching session with their students and patients peer reviewed by a trusted colleague in their own rooms, and a reciprocal peer review will follow.

The doctors would be prepared for this encounter by individual practice based training in peer review techniques from a medical academic and the provision of appropriate literature. On completion of this program an appropriate teaching certificate would be awarded.

Our objective would be to then answer the following question: Does this Colleague Development Program enhance preceptor commitment to future teaching, teaching confidence and competence? To do so, a small research project is envisaged.

This would involve issuing to the preceptors, before and after this pilot programme, a questionnaire seeking qualitative data about teaching commitment and confidence, and the teaching and learning value of the placement.

In addition, the participating preceptors would be interviewed briefly at their initial visit, seeking quantitative data about session structure. After the peer review exercise, a focus group or second interview would revisit those questions.

Issues for exploration/ideas for discussion:
- How innovative and appropriate is this UOW teaching initiative? Is the proposed methodology likely to be effective?
- How valuable would this research feedback be to you? What else would you like to learn? Can you offer feedback about the research methods proposed?
- Is the sustainability of community-based teaching placements an increasing challenge for your school/organization and how are you addressing it?

Student recruitment, transition and support

Strategies for increasing recruitment into clinical education

Carolyn Berryman[1], Dr Linda Sweet[2], A/Prof. Jennene Greenhill[3], Dr Susan Wearne[4]

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[4] Senior Lecturer, Rural Clinical School, School of Medicine, Flinders University, Alice Springs, NT

Introduction/background:
In 2006 the Commonwealth Government of Australia announced a substantial increase in student numbers across all of the health professions, resulting for some in an increased intake of 47% (www.nhwt.gov.au). According to recent government figures (www.nhwt.gov.au) the health system is already under stress trying to meet the demands of clinical placement for the current cohort of health professional students and the growth is not yet complete. With increasing numbers of students of all health professions required to meet the demands of an aging and growing population comes increased demand for supervision and clinical education. As the current workforce of clinical supervisors is beginning to retire, there is a need to explore novel solutions to attract clinicians to the role of clinical teacher. As addressed by the subthemes of the conference, part of the solution to the rise in additional students is to provide authentic learning opportunities within the workplace and this implies an increasing number of clinicians will be required to take on what is in some cases a new and emerging role in clinical teaching, often without concomitant preparation. Effective education takes place in the workplace when the key relationships between health, education and government bodies are symbiotic, and when the clinician identifies with and commits to a role as a clinical educator. Preparing effective clinical educators is a way of bridging professional islands, enabling the health and education systems to maximise the capacity for training a new and responsive workforce and improving and protecting the integrity of the health professions.

Purpose/objectives:
- To identify the challenges related to recruiting the current health workforce into a clinical education program in order to equip the clinician with the skills to embrace the emerging role of the clinical educator within the workplace
- To identify gaps related to health professional policy and practice that hinder the development of this new role
- To identify innovative strategies to increase awareness within the health professions of the emerging need for skilled clinical educators and present some potential career pathways and rewards.

Issues for exploration/ideas for discussion:
Issues for group exploration:
- How do we create an awareness of the need for preparing skilled clinical educators within the current health workforce?
- How do we encourage those practitioners already acting in the role of clinical educator that further costly study will yield beneficial outcomes?
- Potential cross disciplinary innovations for teaching and learning in the workplace.

Ideas for discussion:
- Literature review of current workplace placements, outcomes for students, universities, health services and educators
- Can health professional bodies encourage the development of clinical education skills?
- How do we make clinical education an investment priority for health service managers?

What is the student experience of practice-based education?

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[2] Charles Sturt University, Albury, NSW

Introduction/background:
Practice based education (PBE) refers to university education that is grounded in the preparation of graduates for practice and contains compulsory practice learning such as fieldwork education and clinical placements. Many courses in health professional education encompass PBE. Tools typically utilised by universities to measure the student experience lack specificity and sensitivity in regard to PBE. Given the importance of PBE to health professional education, measurements of the student experience need to be able to discern the contribution of PBE to student's overall experience. If there is to be meaningful enhancement of students' learning experiences it is important to critically appraise the processes used to evaluate the student experience of PBE and to understand the processes used to interpret, disseminate and act upon the findings

Purpose/objectives:
The purpose of this session is to critically discuss methods of capturing and responding to students' experience of PBE.

Objectives include:
To identify and discuss relevant literature on the topic of students' experience of PBE;
To identify tools currently in use to capture students' experience of PBE and in particular their satisfaction with this aspect of their university education;
To discuss staff satisfaction with current tools utilised to capture the students' experience in PBE course;
To discuss methods of data collection to discern the student experience and PBE;
To promote discussion about obtaining data on students experiences courses with PBE components;
To identify ways to utilise this data to enhance the students' experience in PBE courses.

Issues for exploration/ideas for discussion:
Ideas for discussion include the terminology utilised such as PBE and student satisfaction. Other key terms include quality, work integrated learning and fieldwork education.

Tools utilised at the presenters' university will be briefly discussed and their content as examples of tools used to collect data to lead further discussion on other tools utilised and their strengths and weaknesses.

Discussion is required on the need to measure the student experience of PBE and to acknowledge this experience and their satisfaction with PBE to ensure quality, current and appropriate courses are offered that meet student expectations.

Discussion and exploration on the concept of student expectations and the reality of clinical practice and the constraints experienced with PBE will be sought.

Does the collaborative learning model assist student transition from clinical practice to competency?

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Introduction/background:
Confidence, identification with a professional role and self directed goal setting all have been identified as key factors for student transition from clinical practice placement to entry-level competency. Literature suggests the benefit of peers working together include: assistance with learning from others through observation and feedback; better team-work and peer support; confidence building; encouragement of critical thinking; and provision of an increased case-mix and a comfortable learning environment. Alternatively the challenges associated with peers working together on practice placements include: potential conflict and rivalry; student confidence in providing feedback to peers; perceived reduction in feedback from supervisors; and accommodating diverse student skills, ability and learning styles. The collaborative learning model, with two students to one supervisor ratio, has been used for Queensland University of Technology dietetic practice placements.

Purpose/objectives:
To determine whether the collaborative learning model assists student transition to practice. To identify the benefits and challenges associated and to develop strategies to support the implementation of the collaborative learning model.

Issues for exploration/ideas for discussion:
- What are the factors that influence student transition to practice?
- What is the collaborative learning model and how can it be applied in the context of clinical practice placements for dietetic students and students from other health disciplines.
- What features of the collaborative learning model positively/negatively impact on student transition to practice?
- How can the positive features be reinforced/implemented and the challenging features of the collaborative learning model managed by supervisors and educators of practice placement students?
- How can learning outcomes and supervisor/student satisfaction be measured and evaluated?
- How can dietetics be informed by the experience of other health disciplines using the collaborative learning model and how can this be transferable?

Support systems for advanced entry students in the undergraduate MBBS at James Cook University

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Introduction/background:
The MBBS degree at James Cook University is a six year undergraduate program with an integrated curriculum including clinical skills from the first year. The majority of students entering are school leavers. However, every year there are successful candidates with prior tertiary experience who are granted a place in the second year of the program. Although these advanced entry students are carefully selected based on their academic profile they face key academic and pastoral challenges. In late 2007 we reviewed our support processes and in 2008 initiated two interrelated support structures.

The first is a specific orientation session that provides an overview of the curriculum and assessment, important points of contact and emphasises the specific requirements for advanced entry students e.g. cultural awareness and clinical skills sessions. This session provides an understanding of the course and serves as a point of contact for the students, establishing a relationship between them and serving as the basis for continuing group interactions. The second initiative builds on this group rapport through establishing an Advanced Entry Home Group. This is an extension of our well-established group support program (Home Groups) that serves primarily pastoral, but also educational, functions. Advanced Entry students are required to participate in a mainstream Home Group and also to attend regular meetings of the Advanced Entry Group. The objectives are to provide a forum for sharing of experiences with the curriculum, peer support with academic concepts, pastoral support and to familiarize students with assessment processes and examination types. Selection of an appropriate group facilitator is a key element to success; a senior student with sound academic achievement, prior experience as a Home Group tutor and good communication skills was chosen as the tutor in 2008.

Feedback from the group provided support for both initiatives. The overview session was felt to provide general information about the course that served as a useful point of reference. The ongoing Advanced Entry Home Group was also well received by the students meeting its dual objectives of educational and pastoral support. In particular the selection of a student as the facilitator was viewed positively, being seen as an authentic voice in discussions on engaging with the sometimes challenging integrated curriculum and assessment.

Purpose/objectives:
To explore options for providing educational and pastoral support for students.

Issues for exploration/ideas for discussion:
Discussion will focus on the learning and support needs of Advanced Entry students and how medical schools can help to meet them.

Learning techniques and technology

Integrating science and clinical practice: Basic science alive, an e-learning pilot project for senior medical students.

Joy Rudland, Judith Swan

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Introduction/background:
One identified and ongoing challenge in the training of medical practitioners is developing education strategies which necessitate the student to link their science knowledge to their clinical practice. Changes in timing, geographical locations, educators, and foci of learning all contribute to this aspect of medical training being particularly challenging.

Medical schools around the world have approached this issue in different ways and explored different mechanisms for addressing this challenge. The Basic Science Alive e-learning portal, currently a pilot project, is our contribution to addressing this challenge.

Purpose/objectives:
The student objectives of Basic Science Alive are to:

- strengthen knowledge of the relationship between basic science and clinical practice;
- enhance learning through researching a self chosen science concept in relation to clinical practice;
- gain skills in searching, identifying, & applying relevant resources to explain the science concept; &
- reinforce the role of peer review.

Further Basic Science Alive objectives are to:

- create an easily searchable repository of basic science material; &
- compare the reliability of peer and staff review of structured student writing using a review template.

To achieve these objectives the Basic Science Alive pilot project asks volunteer medical students (fourth and fifth years from a six-year programme) to complete a template-structured overview of a basic science concept as it relates to clinical practice – this is the presentation. The presentation is uploaded to Basic Science Alive and is available for student peers to read and review (using a template). The peer reviews are uploaded. A staff review will also be completed and uploaded.

Students will complete an extended multiple question (EMQ) test before selecting a concept or reading a presentation; and an EMQ test after uploading a presentation or a review. Results will be immediately available. Science concepts will be selected from a pre-determined list. The science concepts will be related to clinical conditions listed as examinable in the end of year 5 OSCE.

The research component of the pilot project will use Basic Science Alive as a data collection tool. This data will complement that collected from a yet-to-be-developed online evaluation questionnaire. Together these data will be analysed to assess which of the Basic Science Alive e-learning portal components have contributed the most to student learning.

Issues for exploration/ideas for discussion:

- Good idea or bad idea? Will it work? Has anyone tried something similar? Contacts and access to learn more about the structure and process? What are the potential pitfalls?
- Resources for MCQs / Science concepts / Presentation templates / Review templates.
- Intellectual property – Plagiarism – Ownership of presentations and reviews.
- How could this approach link or support the approach taken by other medical schools?
- Specific issues that have arisen in the project since writing the abstract and appearing at conference.

Developing an E-Learning surgical decision-making website for medical students

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[2] Surgical Decision Making Research Group, Department of Surgery, University of Otago, Dunedin, New Zealand

Introduction/background:
There is very little explicit teaching of surgical decision making within most medical student curricula. This project aims to develop an interactive web based programme for medical students to gain an understanding of the intricacies of surgical decision making. Further, students will be challenged about and tested on their own decision making assumptions.

The e-learning environment will provide the opportunity to incorporate a variety of variables (time, other staff interactions, new patients) into the student interaction with the scenario. This will more closely reflect decision making in the clinical reality.

Purpose/objectives:
- To enhance medical students knowledge of the complexities of decision making, particularly in the surgical context.
- Enable students to analyse their own decision making using a structured, interactive framework.
- To enhance students skills in decision making through understanding of decision making techniques that can be applied in their clinical practice.
- To expose students to the latest research on decision making methodologies.
- To expand the student's awareness of the influence of factors that impact on their decision making such as resources, personal attitudes, physical state etc.

Issues for exploration/ideas for discussion:
- How complicated should the scenarios be (or become) in order to maximise the learning for the student?
- Has anyone tried this or a similar approach before? What worked really well and what are the pitfalls that you can share with us?
- What are the ideas for evaluating the impact of this project?
- How do you teach / assess learning / grade decision making in your health professional undergraduate programme?
- How do you evaluate the decision making teaching in your programme?
- Any other questions that have arisen between submitting the abstract and appearing at conference.

Code Blue simulation for undergraduate medical students

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Introduction/background:
In light of increasing student numbers, simulation has become increasingly popular in improving and maintaining students' knowledge and technical skills. This proves especially true in areas of health that are difficult to teach for various reasons: the infrequency of opportunities to learn/practice, the high risk to patients in involving a student, etc. The Code Blue is such a situation in which correct technical skills and knowledge are paramount, yet it would be impossible to teach in a real life situation.

Purpose/objectives:
This session will benefit participants who are interested in Code Blue education, particularly taught in a simulation/video-reflective format.

Approximately 10 third years and 31 sixth years participated in the program and completed all the surveys. Three sets of surveys were completed: the third years completed a pre and immediate post program survey and the sixth years did the same, as well as responding to a retrospective survey whilst they are in their intern year.

Issues for exploration/ideas for discussion:
- How could the methodology have been improved?
- How could the simulations have been improved?
- How did the students think the program could be improved?
- What did the students enjoy about the program?

How does a simulation-based IPE program impact on interprofessional practice in two different rural hospitals?

Lyn Gum, A/Prof. Jennene Greenhill, Dr Linda Sweet

Flinders University Rural Clinical School

Introduction/background:

The focus of my PhD and is on how to promote and improve interprofessional practice. The research is a comparative longitudinal study using mixed methods. A 'rural' focus has been chosen due to the emphasis on the necessity of rural health professionals to collaborate and provide a team approach to health care with limited services and workforce shortages. Two rural hospitals which are dissimilar in size and service provision will be chosen to participate in the study.

This presentation will assist in formulating my research methodology. I propose to discuss the Interprofessional Education Perception Scale (1-3) and the Readiness for Interprofessional Learning Scale – RIPLS (well validated and revised tool) (4,5) as possible tools to be used for pre, post survey and follow-up at 6 months. The selected scale will be adapted to the rural context and administered to a random sample of hospital staff representing different professions (doctors, nurses, midwives, allied health) including hospital educators and managers. Non-participant observation will be used to observe the health professionals in practice over a period of 2-3 weeks, before and after the IPE training module is introduced. Semi structured interviews with administrators, managers, hospital educators, nurses, midwives, allied health staff and doctors will be undertaken before and 6 months after the training module. Permission will be sought from Curran, Sargeant and Hollet (6) to use and adapt the questions used in their study.

A model of Outcomes of Interprofessional Education has been developed to encourage holistic and comprehensive evaluations as a result of IPE (7). The six levels include learner reaction, modifications of attitudes/perceptions, acquisition of knowledge and skills, behavioural change, change in organizational practice and benefits to patients. This model would be used as a benchmark to evaluate outcomes.

Purpose/objectives:

The hypotheses to be tested

1. A simulation-based IPE program undertaken by rural hospital health care providers will have a positive impact on practice.
2. A simulation-based IPE training module undertaken by rural hospital health care providers can overcome the barriers to interprofessional practice in the hospital setting.

Issues for exploration/ideas for discussion:

I would like to discuss ideas and other people's experiences re:

- Use of these survey tools for measuring interprofessional practice
- Use of non-participant observation in the hospital setting to observe "interprofessional practice".
- Effective IPE modules which could involve simulation in a hospital setting which involve as many staff as possible.

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Exploration of student attitudes towards interprofessional learning

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Introduction:
The Faculty of Health Sciences at The University of Queensland (FHS-UQ) has begun the process of developing and implementing a Faculty-wide IPE Curriculum. The first IPE activity, the Teamwork in Action Day (*TAD08*), was introduced in 2008. The *TAD08* was a face to face event for all first year undergraduate health sciences students and took place early in first semester. The timing of the *TAD08* provided an ideal opportunity to explore pre-entry attitudes towards IPE in first year health sciences students. Based on an evaluation of the *TAD08* data, we feel that to optimise construction of the IPE curriculum, a more thorough understanding of student attitudes prior to and during their pre-registration education is necessary. This small group discussion will include a detailed qualitative and quantitative analysis of pre-entry attitudes to IPE in a second, and expanded, cohort of first year health sciences' students.

Background:
Commencing first year FHS students (N=818, 74%) from nine undergraduate health sciences programs (Dental Sciences, Oral Health, Human Movement Studies, Physiotherapy, Occupational Therapy, Speech Pathology, Nursing, Midwifery, Pharmacy and Health Sciences) attended the *TAD08*. Pre-entry attitudes to shared learning were evaluated using the Readiness for Interprofessional Learning Scale (RIPLS) (Parsell & Bligh, 1999), a validated and widely used tool to assess attitudes towards IPE.

Overall, students were positive about engaging in IPE. Statistically significant differences in attitudes to shared learning were found for gender and educational background. Compared with males, females were significantly more positive about IPE. Students who identified themselves as current health professionals were significantly less positive about IPE compared with school leavers, students who had been away from study for a year, students who had completed a year of undergraduate education, and students who had already completed a bachelors degree.

Less positive attitudes towards teamwork and shared learning have also been shown in graduate entry health sciences students. The reasons for these seemingly negative attitudes in graduate entry and students with a prior health professional qualification are not yet understood. There are, however, recommendations that additional support be provided to students with less positive attitudes towards IPE (e.g., graduate entry students, males) (Anderson & Thorpe, 2008; Pollard & Miers, 2008).

To further explore attitudes to IPE, the **TAD2009** (to be held in March 2009) will be expanded to include students enrolled in Medicine, a graduate entry program. In addition, pro-social behaviours (eg. empathy, volunteering), deemed important for collaboration and a key component of IPE will be evaluated with this cohort.

Purpose/objectives:
The purpose of this study is to explore attitudes to interprofessional learning and the potential intersection with pro-social behaviours in first year Health Sciences students.

Issues for exploration/ideas for discussion:
Attitudes towards IPE in first year Health Sciences Students
Implications for curriculum construction

Introducing interprofessional pain management learning sessions as part of medical and pharmacy programs

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[3] School of Medicine, Griffith University, Gold Coast Campus

Introduction:
A need was identified to introduce interprofessional learning (IPL) into the Griffith University Medical and Pharmacy Programs. Considering desired student characteristics of having some clinical experience and professional identity, cohorts chosen to participate were advanced in their studies: third year medical and MPharm pharmacy students.

A clinical pain management case that followed a problem-based learning approach was developed to facilitate IPL. Six two-hour IPL sessions were scheduled throughout 2008, giving each student an opportunity to participate in one session. In each session, students were divided into sub-groups, with a facilitator from four disciplines: an anaesthetist, medical practitioner, pharmacist and nurse. Students conducted a medical and medication history with a trained patient in the pre-admission setting. All joined together after an hour to present their findings and hear expert presentations from the facilitators.

Objectives:
Specific learning objectives were to:

- Value interprofessional collaboration in taking/documenting a medication history and in prescribing in the surgical setting;
- Become familiar with clinical tools, charts and drug information resources that assist safe prescribing pre-, peri- and postoperatively; and
- Become familiar with strategies for effective acute post-operative pain management.

Issues for exploration:
As IPL skills are not innate, health students need to practise using skills of professional collaboration and teamwork in a clinical and supportive environment.

Results:
In total, 86 medical and 57 pharmacy students participated. Students were requested to complete pre- and post-session surveys to test their knowledge and attitude towards interprofessional collaboration and clinical knowledge before and after the IPL sessions. Although an in-depth analysis of the data is still being performed, preliminary analysis indicates that students' knowledge, attitudes and appreciation of the other health profession improved post-IPL sessions. Qualitative student feedback indicated that they valued the sessions and they would benefit from further sessions. Facilitators reported that sessions achieved their learning objectives.

Discussion:
The study showed various benefits of including IPL sessions involving health students in curriculum, with reported improvements in interprofessional collaboration and knowledge. It is logistically challenging to organise IPL sessions and therefore important to have support at Head of School level. Similar IPL sessions will continue in 2009.

Conclusion:
Medical practitioners and pharmacists need to communicate with each other and work together to improve medication safety and the quality use of medicines. It is therefore important that they study and learn together to understand each other's roles and knowledge base. This can be achieved through IPL sessions.

Interprofessional education improves safety and outcomes in fetal welfare assessment

Helen Cooke

NSW PSN, University of Sydney

Introduction/background:
Fetal welfare, Obstetric emergency, Neonatal resuscitation Training (FONT) is an Interprofessional education program designed to improve safety and quality for maternity service provision, particularly in the area of fetal welfare assessment. FONT aimed to bring together a group of clinical experts from each of the eight Area Health Services (AHS) to train as trainers, in fetal welfare assessment. As a train the trainer program these trainers are then required to provide educational sessions within each of their AHS with the objective to provide local educational sessions to all clinicians responsible for the provision of maternity care. The trainers were a mixed professional group of obstetricians, General Practitioners and midwives who volunteered to take on the educational responsibilities for all educational sessions of the FONT project. Doctors would be teaching midwives and midwives teaching doctors.

Purpose/objectives:
The aim was to strengthen the capacity of the local workforce by providing the state with one consistent educational program and to ensure training support for these selected trainers to provide the education. The project also aimed to provide access to local education, as close as possible to where people work and with an Interprofessional group of clinicians with whom they regularly work, with an additional aim to strengthen the networking and working relationships within each of the Area Health Services. All of these characteristics of the programme informed the development of the evaluation strategies.

Issues for exploration/ideas for discussion:
How best to evaluate an IPE Programme?

Interprofessional learning: Tensions between the sacred and the profane

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Introduction/background:
Interprofessional learning (IPL) is an excellent framework to address the current health care challenges in Australia and improve patient outcomes. In theory, the skills developed and tools used are seen to improve cross-disciplinary communication, teamwork and professional respect. In practice, theory and intentions do not always match behaviour and outcomes.

Purpose/objectives:
The purpose of this presentation is to explore the tensions created and challenges encountered between the theory (the 'sacred') and the reality (the 'profane') while implementing and running an IPL initiative. The best intentions and support still lead to unexpected barriers, challenges and enablers when the reality of the project is underway.

Issues for exploration/ideas for discussion:
The relatively recent introduction of allied health and medical courses in the Australian Capital Territory has enabled a series of IPL opportunities. One of these involves Australian National University medical students and University of Canberra physiotherapy, pharmacy and nutrition and dietetics students spending a week in a rural location and undertaking a project in interdisciplinary groups. Research conducted on the IPL aspects of this initiative over the last two-years has explored issues in cultural and professional change, tensions, interactions and successes arising within and between individuals, disciplines and universities.

Results:
Staff involved in the organisation and running of the initiative were interviewed to identify the expectations, barriers and enablers to IPL. Qualitative analysis of the interviews found that staff expectations and feelings, staff workloads, behaviour modelling, learning outcomes, assessment, student personalities, and attitudes and course structures impacted on IPL delivery. Prior expectations of barriers in running this program due to the involvement of more than one tertiary institution were found to be minimal.

Discussion:
The level of support and enthusiasm for IPL in the tertiary health area becomes apparent when implementing and running a specific initiative. This is counteracted by the confusion in understanding the term IPL and the pragmatics and requirements on how it is delivered. Interprofessional learning is much more than implementing a program to improve interdisciplinary teamwork between students in health professional degrees, it is also about gaining and maintaining support and enthusiasm by addressing the innate and attitudinal barriers towards this type of learning.

Conclusions:
There are numerous challenges to overcome when implementing an IPL experience. Many have been sceptical about the effectiveness of IPL over the last 5-10 years. Finding evidence to support the effective nature of IPL and embed it into the health professional curriculum is key to gaining support and sustaining the IPL model into the future.

The World Health Organization (WHO) Patient Safety Curriculum Guide for medical schools

A/Prof. Merrilyn Walton[1], Dr Helen Woodward[2], Samantha Van Staalduinen[1], Dr Claire Lemer[2], Dr Felix Greaves[2], Dr Douglas Noble[2], Dr Benjamin Ellis[2], Sir Liam Donaldson[2], Prof. Bruce Barraclough[3]

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Introduction/background:
It was the 1999 Institute of Medicine report *To Err is Human* that first brought to the world's attention the need for patient safety education and training for health professional students. Since then the call for education at the undergraduate level in topics relating to quality and safety of care has only grown louder, a call to which medical education has been slow to respond despite being voiced by learners and teachers alike. This is at least in part due to patient safety's status as a relatively new medical education concept and study area, resulting in uncertainty on the part of medical educators as to what should be taught and how best to teach it. To address this issue and the acknowledged challenges of transforming patient safety knowledge into actual curricula, the World Health Organization's World Alliance for Patient Safety has sponsored the development of a comprehensive patient safety curriculum guide for medical students and teachers designed to be implemented in a complete range of geographical and cultural contexts.

Purpose/objectives:
- To prepare medical students for safe practice in the workplace
- To inform medical schools of the key topics in patient safety
- To enhance patient safety as a theme throughout the medical curriculum
- To provide a comprehensive curriculum to assist teaching and integrating patient safety learning
- To further develop capacity for patient safety educators in medical schools
- To promote a safe and supportive environment for teaching students about patient safety
- To introduce or strengthen patient safety education in medical schools worldwide
- To raise the international profile of patient safety teaching and learning
- To foster international collaboration on patient safety education research in the higher education sector.

Results and discussion:
With project teams based in both Sydney and London and under the guidance and input of a WHO reference group comprised of patient safety and medical education experts worldwide, the final draft of the WHO Patient Safety Curriculum Guide for Medical Schools was produced in January 2009. In addition to providing a flexible, practical and evidence-based curriculum applicable in a range of environments (Part B – the topics), the guide also aims to assist teachers in building capacity for and actually implementing patient safety education (Part A – the teacher's guide). Part B of the guide is divided into 11 patient safety topics informed by the internationally validated Australian Patient Safety Education Framework (APSEF), which describes the knowledge, skills and behaviours needed by health professionals to ensure quality and safety in patient care. The topics have been designed with both high and low resource contexts in mind, and may be implemented either individually, in endless combinations or all together as a complete patient safety program.

The WHO Patient Safety Curriculum Guide for Medical Schools is currently in the pilot phase, with various medical schools around the world set to take part. Evaluation will both be in terms of actual implementation and whether or not the guide results in more patient safety-savvy students able to put the principles and concepts learned into practice in the workplace.

Conclusions:
Patient safety is a worldwide problem that has only recently been recognized as a critical area of study not only in the postgraduate phase of health professional education, but in the undergraduate years as well. The WHO Patient Safety Curriculum Guide for Medical Schools provides a flexible, evidence-based curriculum that is freely available for all to use while also providing the tools for building capacity in this important area of health professional education.

How and why do the cultural practices of PBL groups change over time, across year groups and what effect does this have on academic regulation?

Sarah Hyde

Charles Sturt University, Orange

Introduction/background:

Cultural practices are learned systems of activity. Problem Based Learning (PBL) helps to enculturate medical students into medical practice through these systems of activity. Such systems involve recurrent actions or activities that are maintained and valued by the communities that engage in them and are associated with a sense of belonging or identification with forms of discourse (Walker, 2007).

Purpose/objectives:

The cultural practices associated with PBL in the pre-clinical and clinical years of a medical program are explored qualitatively and longitudinally with regard to the effect on academic regulation.

Issues for exploration/ideas for discussion:

The applicability of socio-cultural theory for investigating student interactions within PBL groups and the reciprocal impact this had on their learning in other contexts is examined. The use of PBL in the clinical years is also questioned based on the findings from this study.

Results:

Cultural practices differed in PBL groups between the pre-clinical and clinical years. This negatively impacted on the way students regulated their learning.

Student engagement with PBL, as a community of learners, lacked the depth of preparation and consolidation evident in the pre-clinical years. Factors constraining this engagement, and impacting the extent of academic regulation, were the constantly changing group membership due to students coming and going from rural placements, a different model of PBL used in the clinical years, having a clinician as a tutor who lacked tutor training, the competing roles of student leader and the tutor with unclear role demarcation, lack of resources in the PBL rooms in the clinical years, and competing interest from clinical experiences. The greatest threat to ensuring high student engagement in PBL however was the clinical context. Students were in the clinical context full time in the clinical years and resented time spent away from the wards and in the 'PBL room'. Whilst on the wards they considered themselves more a member of the community of practice than the medical student community of learners, they were part of the ward team. The students' identity and perceived role therefore also impacted on their perceptions of and interactions in PBL.

Discussion:

This study, although having a small sample size, provides an explanation of student perceptions and interactions in PBL across two years of medical school, the pre-clinical and clinical contexts. The cultural practices framework encapsulates many of the differences found across the two years and is a useful framework, in conjunction with socio-cultural theory, to explain student motivation or de-motivation when it is implemented in the clinical years.

Conclusions:

The results lead to questioning whether or not PBL can really work in the clinical years when students are betwixt and between different communities of practice. Within the context of this study, with the way in which PBL operated in the institution observed, PBL did not succeed in the clinical years in terms of further developing academic regulation in the students who participated.

Script concordance test in assessment of medical students in paediatrics: Inter and intra-rater reliability of experts

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Introduction/background:
The Script Concordance Test is an emerging methodology for assessing clinical reasoning skills in written examinations.

It aims to evaluate the student (or clinician) ability to synthesise clinical information in very specific clinical scenarios and compares their performance with that of a panel of experts.

Questions for the Script Concordance Test are ideally those that in clinical practice require the integration of specific clinical information such as history, examination or investigation results in order to prove or disprove a diagnostic or management hypothesis. The Script Concordance Test questions are administered to a group of clinical experts in order to determine the range of likely diagnostic or management decisions. A score for each test item is then generated which reflects the degree of agreement between the experts. Student responses are then scored against the expert responses. The questions require participants to indicate whether specific details of clinical information makes, in their opinion, a stated diagnosis (or hypothesis) more or less likely according to a scale ranging from 'certain or almost certain' to 'ruled out or almost ruled out'.

The University of Sydney Medical Program Child and Adolescent Health rotation currently tests clinical reasoning embedded within the Modified Essay Question examination conducted at the end of the student rotation. Given that there is limited data on the reliability and validity of the test this pilot study aims to determine if the Script Concordance Test measures student performance as accurately as the existing modified essay question format.

Purpose/objectives:
While data is still being collected, in this presentation we will discuss issues related to the development and implementation of the Script Concordance Test with some preliminary results on the inter and intra-rater reliability of the panel of experts responses.

Issues for exploration/ideas for discussion:
- Inter-rater reliability of experts
- Are there certain types of questions where agreement is more or less likely?
- How much variability is acceptable in clinical practice and therefore how do we teach and test for this?
- How much variability is due to the quality of the question itself?
- Intra-rater reliability
- Is the variability real or is it due to error such as misreading questions, confidence with the test style?
- Design of questions
- How do we balance content knowledge with clinical reasoning?
- Do we need to separate them?
- What is our gold standard in testing clinical reasoning?
- How do experts feel about this style of question?

Trialling a 'cake mix' portfolio assessment with final year undergraduate occupational therapy students

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Introduction/background:

Allied health practitioners will often need to maintain a portfolio of evidence to support their claims of competence for professional accreditation or credentialing processes, however the use of portfolio based assessment in allied health undergraduate curricula is still relatively new. Portfolio assessment has potential to promote reflective practice and self directed learning, and it was these reasons that lead to the establishment of portfolio assessment in a new occupational therapy course at Monash University.

On entry to the Bachelor of Occupational Therapy program at Monash University, students begin to compile a portfolio of learning. The portfolio is presented in written form for assessment in the final semester of study, and students are required to provide an oral defence. The portfolio includes documents accumulated across the 4 years of the undergraduate curriculum such as:

- learning contracts used in fieldwork placements,
- reflective tasks,
- fieldwork assessments,
- time sheets demonstrating evidence of completion of the mandated hours of fieldwork, and
- additional evidence supporting personal and professional growth and competency development

The portfolio structure is based on what Webb et al (2002) calls a 'cake mix model', as it requires the integration of a range of elements. In addition to the documents above, students are required to a write a reflective statement of purpose and a professional development plan for the 6 months following graduation. The statement of purpose is entitled 'Why I am fit to practice as a beginning practitioner in Occupational Therapy'. This is presented as an assertive statement of purpose that will integrate the portfolio contents and highlight professional performance, interests and achievements. Students use portfolio evidence to support their claim that they are ready and fit for practice.

In essence, the written portfolio is a summary of the students' professional achievements and competencies across the course. The extent of the portfolio will depend on what each student has achieved, however must provide evidence that the student has achieved the professional competencies required for Australian occupational therapy entry-level practitioners.

Purpose/objectives:
The purpose of this small group presentation is to describe the portfolio assessment trialled, explain the choice of model, its oral and written components and discuss the outcomes to date.

Issues for exploration/ideas for discussion:
Key issues for discussion will include the benefits and limitations of a cake mix portfolio assessment; outcomes for students, employment impact, marking dilemmas, maintaining validity and reliability in assessment, using a portfolio assessment to assess competency and fitness to practice.

Improving clinical placement outcomes for CALD students

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Introduction/background:
The number of Culturally and Linguistically Diverse (CALD) students within health professional training programs in Australian Universities is high and continues to grow, both as a reflection of the diverse Australian population and the large numbers of overseas students in courses. This cultural and linguistic diversity within students has created a challenge for universities to create an appropriate and inclusive learning environment and it extends to the agencies partnering universities as placement providers. Issues of diverse language, learning styles and cultural norms impact significantly on placement performance. Although supports have been initiated, it has been recognised that students, academic staff and workplace supervisors could be better equipped to address these issues as they arise during placement.

Purpose/objectives:
To develop appropriate strategies to assist with placement progression of CALD students, using focus groups on the reported barriers and enablers that CALD students experience on placement.

Issues for exploration/ideas for discussion:
The policies for international students at universities imply a specific responsibility for action to manage the inherent challenges faced by CALD students and their educators. There is debate in the literature about globalisation and internationalisation approaches to higher education for export and there is also discussion about how to approach improving cultural competency in Australian health services. Both of these issues deserve attention in the development of any strategy to tackle these challenges.

Results:
Qualitative data analysis was conducted following a total of seven focus groups with 14 students from dietetic, nursing and social work programs and 12 placement supervisors. The main themes to emerge were differences in learning and teaching styles; identification of individual learning needs; models of care; organisation and structure of placements; language; communications and interpersonal relationships; knowledge of local culture, demography and systems; and pastoral and daily living issues.

Discussion:
Recent developments around cultural competency in health care and an internationalisation approach to education for overseas students provide a context for our approach. The findings suggest that the approach should be a student centred one and aim to promote awareness of difference and its impacts and then develop appropriate responses by both learner and teacher.

Conclusions:
Potential strategies to improve student placement experience and outcomes were identified. We propose that development of approaches to health professional education around cultural competency can incorporate these strategies and provide benefits to quality and equality in education and health care.

The use of standardised patients in cardiorespiratory physiotherapy education

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Introduction/background:
The use of patient simulation in the education of health professionals is increasingly common. In the cardiorespiratory physiotherapy (CRP) area teaching involving human simulation has ranged from the use of simple plastic resuscitation mannequins to high fidelity patient simulators (Blackstock & Jull, 2007). Standardised patients (actors trained to portray patients with various conditions) have also been incorporated (Jones & Sheppard, 2007).

As part of a unit of study in CRP for second year physiotherapy students, a learning module relating to the physiotherapy management of postoperative upper abdominal surgical patients was redeveloped to incorporate a practical class using a standardised patient.

The standardised patient, an actor, was trained and prepared to portray an acute postoperative patient. Students and tutors were provided with detailed notes and pre reading. The class, undertaken in small groups, was held in a nursing lab with a standard ward set up. The session covered practical skills in assessment and treatment as well as clinical reasoning and decision making processes. Students evaluated the class using a written questionnaire.

Purpose/objectives:
To develop, implement and evaluate an undergraduate teaching session in CRP using a standardised patient.

To use the results from the evaluation to further develop and implement the use of standardised and simulated patients in the teaching of CRP.

Results:
The majority of respondents (98%) agreed or strongly agreed that the lab session was useful for consolidating their knowledge and skills in assessment, planning and treatment. Nearly all students (98%) also felt that the lab was valuable preparation for clinical placement. The best thing about the class was reported to be the "realness" of the patient, the setting and the interaction. Suggested improvements related to increasing the length of the class, the amount of student participation and actual "hands on" time for each student.

Discussion/conclusion:
The results of the evaluation indicate that the practical class involving the standardised patient was well received and was perceived as valuable by the participating students. It is planned to use the feedback from the student, tutor and patient evaluations to develop further learning experiences involving standardised and simulated patients for students.

Issues for exploration/ideas for discussion:
- What are the experiences of others who are running similar practical sessions using standardised patients?
- How can we gain maximum benefit from the use of standardised patients with limited time and resources?
- Does the use of standardised patients enhance student learning – particularly performance on clinical placement? How to measure this?
- Assessment in CRP using standardised patients.

Developing an interprofessional quality and safety curriculum for undergraduate health science students

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Introduction/background:
In 2005the Australian Council on Safety and Quality in Health Care released the National Patient Safety Education Framework as an initiative to address the lack of streamlined education strategies available to teach health professionals in the health care system..

Undergraduate curriculum development in quality and safety is a relatively new phenomena and there appears to be a paucity of evidence to suggest that it is being incorporated in a strategic, accessible or interprofessional way in the health sciences.

In 2008/2009 the University of Tasmania Faculty of Health Science provided funding for 2 projects (Teaching Development Grant and Collaborative Teaching and Learning Project Grant) to investigate the Q&S resources being utilized in the undergraduate curricula of medicine, nursing and pharmacy and the ways in which these could be enhanced and integrated in an interprofessional framework.

Purpose/objectives:
To investigate the understanding of health professional teachers and undergraduates towards the concept of quality and safety.

To develop a suite of multi-media resources to support teaching and learning in Q&S

To ensure that these resources have a true inter-professional flavour and are able to be utilized in a variety of settings.

To make these resources accessible and user friendly so that they are easily incorporated into existing curricula.

Issues for exploration/ideas for discussion:
- Ascertaining/measuring the attitudes of health professionals and undergraduate students to current clinical practice and leaning.
- Encouraging health professionals to incorporate Q&S into already overcrowded curricula.
- What type of teaching resources are required to ensure an evidenced based Q&S curriculum.
- Practical use of the ACSQHC Patient Safety Education Framework to map, identify and develop resources required to meet Q&S competency levels of undergraduate students.

Cancer Learning – An innovative approach to interprofessional education in cancer care

Gemma Connolly, Jackie Ross

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Introduction/background:
Traditionally professional development in cancer care has been delivered in an ad-hoc manner to profession-specific participants. Cancer Learning is an innovative resource designed to encourage interprofessional education in flexible delivery formats including workplace-based, online and formal settings.

The Cancer Learning site allows health professionals to FIND existing evidence-based resources and learning activities; BUILD educational programs; and PLAN their professional development pathway to further their careers and improve the patient experience.

Learning activities have been developed specifically for the site utilising innovative educational design including multimedia, case-based learning and flexible delivery formats. The activities are targeted broadly at health professionals to promote opportunities to engage in interprofessional education and practice. Cancer Learning is underpinned by the educational principles of constructive alignment, adult learning and interprofessional learning.

Examples of resources on the Cancer Learning include:
- A toolkit to facilitate the development and optimisation of multidisciplinary teams
- An education module to train frontline health professionals in basic techniques to provide psychosocial support
- A framework to allow educators to plan professional development activities that meet service delivery needs
- A guide to implementing clinical practice improvement activities in the workplace.

While the site is designed for health professionals in cancer-care the education resources developed are also applicable to a wider audience. The site itself might also be of interest to those educators working in other disease-specific areas.

Purpose/objectives:
By the end of the workshop participants will have:
- Experienced a hands-on demonstration of the various resources developed for the site
- Discussed how similar resources may be implemented in their workplace or organisation as part of continuing (inter) professional development of health care workers
- Shared suggestions on how the resources might be improved to meet the needs of health professionals.

Issues for exploration/ideas for discussion:
- Planning professional development activities based on sound educational principles versus ad-hoc, 'just in time' activities
- Interprofessional learning in disease-specific areas
- The pros and cons of online delivery of education to hospital- and community-based professionals
- Evaluation of professional development activities and how it relates to improvements in patient outcomes.

Building an interprofessional state-wide comprehensive training program for practice educators

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Introduction/background:
Work-integrated learning is considered a crucial component of professional preparation programs in the health disciplines. This is achieved through placement of students in both university and workplace environments. Student learning is facilitated by practice educators who, whilst enthusiastic about their role with students, may feel under-prepared (Hook & Lawson-Porter, 2003). It is vital that the training needs of clinical teachers are recognised and met (Hesketh et al., 2001) so that practice education outcomes are maximised for students and educators.

The introduction at The University of Queensland in 2005 of an interprofessional model of educator training in a face to face format was welcomed and supported in formal evaluation (Hill et al., 2007). Whilst this model is in keeping with current literature which highlights the importance of interprofessional education in health education programs (Hays, 2007), the need for a more coordinated capacity-building approach to implementation of these training initiatives soon became apparent. This led to the development of a state-wide flexible training program. A specific focus on inclusion and equity of access for rural and remote health professionals was paramount in the development of a videoconference format as an extension to the face to face large and small group training initiatives.

This workshop will provide a framework through which health education planners can confidently address issues related to learner engagement, content, equity of access, and flexible delivery approaches.

Purpose/objectives:
The aim of this workshop is to facilitate discussion around the development and delivery of a state-wide, flexible, interprofessional training program to support practice educators in their facilitation of student learning on professional practice placements. By the end of the workshop, participants will

- identify the critical components of an educator training program for health professionals
- demonstrate an awareness of the benefits of interprofessional collaboration in delivery of training
- develop a framework for analysing learner engagement, content and other principles of delivery
- have access to materials developed by the presenters to meet key stakeholder needs

Issues for exploration/ideas for discussion:
This workshop will explore the following issues within interactive discussion:

- What are drivers for development of a state-wide training program?
- What are drivers for development of an interprofessional model?
- Who are the customers and what are their needs?
- What are the outcomes to be achieved?
- Who are the stakeholders to consider?
- What resources and media do you have available?
- How will you measure outcomes?
- How will you review and modify content and delivery?
- What are the underlying principles supporting implementation?
- How do we align training with student graduate attributes and clinical course objectives?

The Australian Clinical Education Program: An interprofessional online program to educationally prepare health professionals as clinical educators

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Introduction/background:
Providing undergraduate health students with a successful clinical experience is largely dependent upon the ability of local practitioners to support and facilitate student learning through effective clinical education. Formal educational development and support for preparing and supporting all clinicians to achieve this role is often beyond the scope of faculties in universities especially if this experience is in a rural or remote area.

Purpose/objectives:
This interactive workshop will enable participants to familiarise with an online interprofessional clinical educator program. The program provides a comprehensive, flexible and user-friendly solution for health professionals to develop strategies for facilitating teaching and learning in the clinical context.

Issues for exploration/ideas for discussion:
In this workshop, participants can learn about and explore for themselves this two tier program. The first tier of the program features a core education program which is presented in a series of six stand-alone modules. Each module includes specific educational content, self assessment activities, notice and discussion boards (including a moderator option). The second tier of the program allows health professionals to access longer more detailed sections of the modules, dealing with each topic in more depth.

Specified learning outcomes, individual interest, need, and time availability are accommodated by the program's structure to allow practitioners to work at their own pace within this moderated presentation. The education modules accompany a localised support module designed to include course specific information outlining the requirements of the School or Faculty from which the health professional is accepting students. There are different access options suitable for variable download times, including a CD option.

During 2008, the interprofessional program was trialled with 100 rural allied health clinical educators. The results indicated the program had a positive effect on participants' skills, knowledge and attitudes as clinical educators. A statistically significant positive shift in confidence and feelings of preparedness was achieved. Overall participants were satisfied with the program. Minor suggestions for improvement were made in relation to the delivery platform and its interactive functionality.

The Australian Clinical Education Program uses information and communications technology to bridge disciplinary boundaries, which may lead to strengthened local networks of practitioners across all geographical locations. The program therefore has the capacity to meet a variety of clinical educators learning needs because it allows self-paced learning and regular updates.

Teaching anatomy in an increasingly crowded medical curriculum: A survey of current practices and an inter-professional solution

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Introduction/background:
Recent changes to medical education in Australia and New Zealand include an overall reduction of course hours, a shift toward problem-based learning, and a large-scale expansion of medical knowledge. These changes have left little room for teaching anatomy as a pure discipline and have required increasing co-operation between anatomy science educators and clinicians.

Purpose/objectives:
1) To analyse how anatomy is currently being taught and assessed in Australian and New Zealand medical schools.
2) To develop a clinically integrated and interdisciplinary (anatomical scientists and specialist clinicians) method of teaching anatomy as an alternative to anatomy instruction as a pure discipline.
3) To enhance clinically relevant anatomy teaching within the 4 year post-graduate medical course, and to provide an adjunct to undergraduate education in surgery and gynaecology.

Methods:
1) Using a mailed questionnaire survey sent to each of the 19 Australian and 2 New Zealand medical schools, we examined the time-allocation, content, delivery and assessment of anatomy in Australian and New Zealand medical schools for the 2008 academic year.
2) A problem based and clinically integrated approach to teaching anatomy, developed for undergraduate medical students at the University of Wollongong's Graduate School of Medicine, will be presented in the form of both a generic template and a worked example.

Discussion:
Currently, the degree of divergence between anatomy curricula at the various Australian and New Zealand medical schools is a matter for speculation, without reliable evidence. The results of the questionnaire survey will provide the basis for better understanding of the matter. Our example of a clinically integrated approach to teaching anatomy will be of pedagogical benefit to anatomical and surgical educators in Australian and New Zealand medical schools.

Issues for exploration/ideas for discussion:
- The sufficiency of current anatomy education in Australian and New Zealand medical schools
- Further interdisciplinary innovations and cooperation in clinical anatomy education
- The application of a similar clinically integrated interdisciplinary model to other disciplines such as physiology/ pharmacology.

Teaching and learning clinical skills using peer physical examination (PPE): Potential problems and possible solutions

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Introduction/background:
There have been several drivers for the growth of early clinical skills learning based in skills centres; curricular change, changes in the service environment, patient safety issues and educational rationales. Peer physical examination (PPE), where students act as examination models for one another, is used for both clinical skills (physical examination) and surface anatomy learning. Advantages to this approach include:

- a 'safe' environment (safety being defined in broad terms)
- learning normal before abnormal
- repetition and practice with peers is more appropriate than with real patients
- wider professional skills can be developed (e.g. explanation, consent, empathy, feedback)
- experiencing some elements of the patient's experience

There are also potential disadvantages to using PPE, e.g. (in)appropriate touch, partial undressing, observation and performance anxiety. Student peers are different to patients in a number of ways and although the learning is formalised and in a pseudo-clinical setting it is different to the service setting. There is potential for abuse and embarrassment. Tutor concerns often surface around gender, ethnicity, maturity and finding occult physical abnormalities.

There is now a considerable body of evidence around the practicalities of learning through PPE from students' perspectives.[1-7] The workshop facilitator and his colleagues have contributed to this literature over the last five years.[5-7] Studies have only been carried out within medical programmes, but have included multi-centre, longitudinal and mixed method designs across geographically and culturally diverse settings. [1-3,5-7] This literature has given us insight into what students from a broad range of backgrounds and experience think about PPE and what are their concerns and recommendations for optimal PPE.

Purpose/objectives:

- Provide a background to PPE
- Explore issues of learning through PPE
- Explore potential barriers and practical issues that might lead to problems
- Construct suggestions for good practice, based on empirical evidence and experience

Intended audience: Those who have implemented or plan to implement a PPE course in their health professional program.

Number of participants: Maximum 20.

Issues for exploration/ideas for discussion:
The facilitator and co-authors admit an *a priori* position that PPE is a valuable and workable approach to clinical skills learning (and the learning of functional living anatomy, amongst other things such as professionalism etc.). However, we do accept that potential pitfalls exist and we have each encountered some of these in our respective settings.

This workshop will draw upon narrative accounts from participants, fictional case studies and educational research evidence to assist in the development of guidelines for best practice.

Student placements

Exploring quality assurance processes for assessment

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Introduction/background:
The development of reliable and valid assessment instruments has been a focus in medical education literature for several decades. Whilst the main focus has been on the development of instruments, and assessment of their reliability and validity, there has not been as much emphasis devoted to subsequent steps in the quality assurance process. In this workshop we will explore three aspects of this process.

Through a process of consultation and consensus, the Medical Education Unit at the Tasmanian School of Medicine (TSOM) has developed a QA process for the development of EMQ/MCQ items. The purpose for this was two fold – first to develop the QA process organically and second to prepare for the automation and linkage of these processes to the assessment database. All EMQ.MCQ items for assessments in 2008 were analysed: 23 examinations (formative and summative) comprising 1290 items. For each examination – between 40-80% were of acceptable difficulty, and between 42-85% of acceptable discrimination. Overall, between 40-80% of items on each exam could be considered of acceptable quality. Considering the items individually, 60% of items were within the acceptable range for difficulty and 50% of items within the acceptable range for discrimination. Poorly performing items can be improved through peer review processes, but should they be removed from the examination prior to determination of grades?

Purpose/objectives:
To explore QA processes with assessment, focusing on post analysis processes.

Issues for exploration/ideas for discussion:
1. Participants will be asked to identify key aspects of a QA process for development and use of EMQ and MCQ items. These will be compared and elaborated through comparison with the QA process developed in the TSoM.
2. We will share the templates used for feedback to assessment teams and through a similar process seek feedback for their review and enhancement.
3. We seek advice and consensus about how to treat poorly performing assessment items immediately post examination – (i) include all, exclude all, exclude some, (ii) basis for decision making.

Intended audience: Those who are involved in writing, analysis, review and evaluation of assessment.

Number of participants: Maximum 20.

Presentation and demonstration of instant student feedback system in improving student participation, motivation and learning in medical education

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Successful learning and teaching of complex medical concepts and skills involve efficient two-way communication between tutor and learner.

To monitor and improve student participation, motivation and learning we introduced electronic student response system involving handheld student remote control key pads (www.keepad.com) integrated into Powerpoint© program by software (www.turningtechnologies.com).

The system is in use since September 2005 and preliminary data shows overwhelmingly positive student response with significant improvement in student participation & learning.

Major outcomes from the study are:

- Easy recording of student attendance and participation.
- Improvements in student attendance, participation and learning.
- Instant student assessment with detailed statistical analysis & reporting.
- Instant and interactive assessment feedback and learning.
- Instant feedback on whole class student learning, effective assessment tool for the student and instructor.
- Student progress monitoring and early intervention.

This workshop is to present overview of formative assessment, present tips and tricks of student response system and hands- on experience of using the system effectively to improve student learning.

Accuracy of and confidence in Objective Clinical Structured Examination (OSCE) pass-fail decisions

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Introduction/background:
Assessment of consultation by undergraduates is important. Information may be acquired from different consultations, such as an OSCE, and decisions made on aggregated information. All the effort to improve OSCEs, including blueprinting, scoresheet development and examiner training, counts for nothing if the data are used inappropriately. The accuracy of and confidence in decisions based on aggregated OSCE results has not been well explored.

Purpose/objectives:
The aim of this study was to investigate the accuracy and confidence for decisions made by faculty staff given increasing information on students' performances.

Issues for exploration/ideas for discussion:
Staff were shown authentic scores for an increasing number of stations and asked to make a pass-fail decision and give a degree of confidence in this decision. Subsequently they were given fictional discordant information and again made decisions.

Results:
Faculty staff were shown anonymised scores incrementally for ten OSCE stations. The student scores chosen where used to demonstrate good performance and also variable performance with different degrees of underperformance. The results given included several parameters including examiner scores, passmark scores and running totals. 35 staff made these 11 pass-fail and confidence decisions for a mean of 5.9 candidates. Accuracy was defined from the actual decision of the Board of Examiners (compensatory method on total scores) and also from the staff consensus from this study. Across the 10 stations for the candidate who was above pass threshold for all stations the mean level of confidence in a pass increased from 80 to 90%. For the students that failed the most stations the level of confidence in fail varied between 70 and 80%. Despite progressively poor performances the staff were not as confident in assigning fail. Overconfidence was greatest for students whose performance was closest to the pass-fail threshold. Staff were more confident to pass than fail students, but there was less confidence for some students awarded a pass by the BoE. The anecdotal information changed 12% of the decisions.

Discussion:
Making decisions on students whose performance is close to decision thresholds is difficult and associated with staff overconfidence. Assessors are more comfortable and confident when passing than failing candidates. Assessors will alter decisions based on less reliable but persuasive information.

Conclusions:
Staff decisions are based on more than a compensatory total, what are the factors and should they be taken into account? Why are staff reluctant to award a fail? What are the consequences of this?

Rising to the challenges of student placements within a small service

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Introduction/background:
In the early 90's and before, there was a chronic shortage of Podiatrists The disadvantage of professional isolation, sessional employees and no professional training offered in Tasmania made the task even more difficult.

Since then, the Southern Tasmanian Podiatry Service has successfully addressed the challenges of recruitment and retention by ensuring that our undergraduate program provides enriching experiences for both practitioners and students alike. Investing in meaningful student placements has also strengthened the image and role of public podiatry across both the acute and primary health settings.

Purpose/objectives:
The workshop will provide a basis of comparison for other small allied health/nursing services faced with similar workforce challenges. It will provide scenarios on making the student experience captivating, manageable within a small team, and will help identify easy ways of using resources that are already available.

Issues for exploration/ideas for discussion:
- Pre-placement: the importance of student contracts and interviews
- Robust orientation programs for the service and site(s)
- Matching student needs and interests with what is on offer
- Getting the most out of the placement: identifying projects of benefit for both the student and your service
- Choosing students and the length of placement
- Identifying the right professional development opportunities to equip staff with adult/experiential learning tools
- Feedback tools for improving the program.

Personal and professional development heading

Fostering appropriate reflective learning – 'student as critic' or 'student as insightful observer'

John Hamilton

Monash University

Reflective learning has become an important feature of many health sciences courses, particularly those preparing students for clinical practice. Often writing tasks are used as a means of both promoting and monitoring student reflective learning. However, particularly in their earlier years, students may not fully understand the rationale behind this form of learning, nor have clear expectations about the type of writing required. This paper reports on an undergraduate health sciences course in which initial student reflective writing task pieces, based on critical incidents during clinical placements, tended to be critical of clinicians and adopt a judgemental and sometimes moralistic tone. In response to this, a program was developed to better prepare students for reflective learning and to develop their skills in producing appropriate reflective writing. The paper attempts to determine some key elements expected in reflective writing tasks, and outlines potential areas of difficulty for students new to this form of learning. It raises questions of how best to prepare students for reflective learning and writing tasks, and how to promote a critical perspective while also encouraging students to maintain a positive regard for the institutions and clinicians who enable them to learn on clinical placement. Finally, it acknowledges the challenges for students in taking on the role of participant observer in clinical settings, and suggests that preparation for reflective learning may assist them to have positive clinical placement experiences.

Exploring surgical trainees' perception of operating theatre learning environments using self-administered survey instruments

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Background:
Surgical trainees' operating theatre experiences significantly influence their ability to attain key professional competencies. A validated measure of trainees' satisfaction with this crucial learning environment would allow recognition of factors that influence trainee development and characteristics of highly productive teaching venues. The Surgical Theatre Educational Environment Measure (STEEM) was developed in Scotland for this purpose; however, the small sample size of existing pilot studies has precluded detailed assessment of the STEEM's psychometric properties.

Purpose:
In the present study, we set out to evaluate the STEEM's subscale structure, internal consistency and content validity for surgical trainees in Australia and New Zealand.

Methods:
The STEEM was distributed electronically to 1,500 Australasian surgical trainees via the Royal Australasian College of Surgeons. Construct validity was assessed using exploratory factor analysis with principle axis factoring and both oblique and orthogonal rotations. Internal consistency was assessed using Cronbach's αcoefficient. Content validity was evaluated through manual and automated content analysis of trainees' qualitative responses.

Results:
356 completed responses were received (Response Rate = 24%). The suggested STEEM subscale structure could not be replicated. One dominant factor was identified, relating to trainees' relationship with their supervisor. At least four other secondary factors were identified relating to supervisor facilitation of learning opportunities, trainees' relationship with non-surgical staff, characteristics of the surgical list, and distractions from operating theatre learning. All empirical factors had moderate internal consistency ($\alpha > 0.7$)

Discussion:
We were unable to replicate the STEEM's ***a priori*** factor structure in this study, perhaps because the pool of items comprising the STEEM did not address all relevant learning environment domains. Nevertheless, the empirically-grounded subscales we identified through factor analysis have substantial support from theoretical models of operating theatre and workplace learning; consequently, they have been used as the basis for a revised instrument, the Australian Measure of Operating Theatre Educational Climate (AMOTEC). The AMOTEC also incorporates additional survey items drawn from trainees' qualitative responses, which should improve the instrument's content validity and facilitate factor analysis in future studies.

Conclusion:
We have created a revised instrument, the AMOTEC, which has the potential to make a valuable contribution to surgical education by enabling timely recognition of factors that influence trainees' satisfaction with operating theatre learning and by facilitating adaptation of surgical education programs to suit trainees' needs. Future research should aim to validate the AMOTEC's subscale structure and to establish its internal consistency and test-retest reliability.

CAHE online journal clubs: Assisting professionally or geographically isolated allied health practitioners to achieve evidence-based practice

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In March 2007, the Centre for Allied Health Evidence (CAHE) of the University of South Australia and the South Australian Department of Health organized journal clubs (JC) across South Australia to educate and support allied health practitioners to keep themselves informed with the current best evidence. CAHE conducted a research training program for facilitators of JCs and developed an innovative model for a sustainable JC. The processes involved in this model were segregated into six distinct steps: development of a clinical scenario; development of an answerable review question; development of a search strategy; identification, appraisal and summary of the best available research evidence; publication, appraisal and summary provided to JC; and publication, appraisal, summary presented to JC by facilitator and presenter. At present, CAHE provides support to 19 JCs in South Australia and Victoria. Since the formation of face-to-face JCs, a number of clinicians who are professionally or geographically isolated have raised the need for an online JC which will facilitate formation of a 'virtual' forum for discussion of scientific literature. Taking a further step into technology, CAHE developed an online JC in July 2007 to provide an opportunity for allied health practitioners to engage in a 'virtual' discussion regarding research evidence in practice. A 'server site' was created followed by 'calls for expression of interest' through the Country Health SA and the South Australian Department of Health. There were three pilot groups of allied health practitioners who responded to this call, namely podiatrists, physiotherapists and a multidisciplinary group interested in chronic disease management. The formation of these online JCs was comprised of a two-stage process – tutorial and the actual online discussion of research evidence. Stage I (tutorial) required the participating members to access the CAHE online JC tutorial resources. Three sets of power point slides were made available to facilitate self-directed learning. Podcast recordings were provided to complement the slides. A discussion board was set up, not only to provide peer support but also to allow a CAHE online JC moderator to address questions that evolved during the training period. Stage II (online discussion of research evidence) was the actual JC 'virtual' forum, where exchange of information regarding quality of evidence and implications for practice took place. The steps involved during this stage were similar to that of the face to face JCs. The online forum started with the identification of a topic that reflects issues in clinical practice, followed by the development of an answerable question in the PICO (P: Participants; I: Intervention; C: Comparator; O: Outcomes) format. CAHE then facilitated the searching and accessing of evidence, which was followed by the group's online discussion of findings from the research article, its methodological quality, and implications for clinical practice and implementation. The CAHE online JC moderator facilitated and led the discussion. A feedback questionnaire was later developed to evaluate the effectiveness of this online JC in terms of its utility, ease of use and overall user satisfaction.

Assessment and feedback

Attitudes to formative assessment: A clinical skills story

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Introduction/background:
In 2008 a clinical skills programme was developed for year 2 students in the University of Otago Faculty of Medicine. Each module was accompanied by an assessment portfolio to be completed by the student. The ongoing assessment of these skills was formative and voluntary, and designed to provide opportunities for self-, peer-, and tutor assessment.

Purpose/objectives:
The purpose of this presentation is to report on the success of the clinical skills assessment portfolio and its perceived value to students. The presentation includes completion rates of assessment tasks by self, peer, and tutor in the cardiovascular (CVS), respiratory (Resp), and gastrointestinal (GI) modules. A qualitative summary of the process, and suggestions for future directions in the assessment of clinical skills will also be presented.

Issues for exploration/ideas for discussion:
- the role of assessment in clinical skills learning
- attitudes of students to assessment
- the role of tutor reinforcement in the assessment process
- assessment options in clinical skills programmes

Results:
Tutor-assessed tasks were the most likely to be completed (66%), followed by self-assessment tasks (51%), and peer-assessed tasks (20%). The proportion of tasks completed per module was 54% (CVS), 47% (Resp), and 28% (GI). There was a decrease in tasks completed as the year progressed. Feedback from the respondents reflected that the portfolio had not worked for reasons including its late implementation, poorly defined purpose and lack of buy in from staff. Most students admitted to last minute completion of the assessment sheets with a single tutor sign-off. However, some identified merit in the task and recognised its usefulness as a revision tool.

Discussion:
It would appear that year 2 medical students place least value on peer assessment as a valid means of academic evaluation. In addition, as the year progressed, completion of these tasks became less of a priority.

Conclusions:
The identification of a valid instrument for the assessment of clinical skills remains contentious and to be truly effective demands support from students and tutors and to be identified early as an in-course requirement. Meaningful assessment should therefore measure the competence of relevant skills in an authentic clinical context.

The assessment of practice: A complementary perspective

Dr P. Gallagher

In many forms of vocational education, including medical education, student assessment is undertaken to ensure that students are able to make effective links between the theory and the practice of their particular occupation. Traditionally, and central to the process of assessment, reliance is placed upon a third party to judge whether students are able to apply theory in practical contexts. However, if examines the relationship from an enactivist perspective, the relationship between thought and action is seen conceptual not logical. Furthermore, enactivism contends that the ability to deliberate before doing is a part of being autonomous and the reasons for actions are not always something that is thought about in advance of that action, nor spoken about when that action has been completed. In addition, the reasons for action are an integral part of that action and not a precursor to the action. Thus any link between thought and action is contained in the meaning that they produce for the individual and not in formalised links that may be explained to, or observed by, a third party. This paper will argue that in the context of assessment any relationship between theory and practice becomes what the observer consciously or unconsciously wishes or expects to see.

Hospital electronic discharge letter feedback intervention randomised controlled trial for quality improvement

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Introduction/background:
The hospital discharge letter is an important document transferring information from the hospital to general practitioners and other doctors involved in a patient's care. Numerous discharge letter audits have shown that discharge summaries are of variable quality, often with important information missing or incorrect, particularly regarding medications, potentially resulting in harm to patients. There is little in the literature looking at interventions to improve quality of discharge summaries. Junior doctors often receive little or no training in completing discharge summaries. The use of an electronic discharge summary within the Sydney South West Area Health Service allows easy tracking of discharge summaries and facilitates study of the process.

Purpose/objectives:
To determine:
1. the quality of electronic discharge summaries created by medical students at the end of their degree
2. whether a brief group feedback intervention improves the quality of electronic discharge summaries created by final year medical students.

Methods:
Medical students entering the preinternship term, the final 8 weeks of the University of Sydney Medical Program at Concord Hospital, attached to medical or surgical units, were invited to participate. As preinterns, the students take on part of the workload of interns and routinely complete electronic discharge summaries. However, they need to have these signed off by a qualified doctor on the unit before the discharge summaries can be finalized electronically.

Students were randomized either to receive or not receive specific verbal feedback in a group session midway through preinternship on improving quality of their discharge summaries. The content of the midway feedback session was based on an audit of a sample of 50 discharge summaries completed by the same preintern group during the first 4 weeks of the term, using a previously developed audit tool. All discharge summaries completed by students enrolled in the study during the last 4 weeks of preinternship were then audited using the same audit tool by an auditor blinded to students' randomization status. Students were asked to complete a brief questionnaire at the end of the preintership term regarding whom they received feedback on discharge summaries from and the value of that feedback.

Results:
Results are currently being analysed following completion of the preintership term at the end of 2008 and will be presented at the conference.

Issues for exploration/ideas for discussion:
1. Strategies which have successfully been used at other sites to improve discharge letter quality
2. Novel strategies which could be trialled

An innovative, inter-professional, clinical placement for medical students to teach therapeutics and quality use of medicine

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An innovative teaching and learning activity has been trialled and consequently implemented at the Launceston Clinical School, School of Medicine, University of Tasmania. Unique clinical placement opportunities are created to provide an authentic inter-professional and relevant learning activity to complement allied therapeutics teaching. Identified patients are visited in their own home and students individually comprehensively assess medication management, alongside their therapeutics lecturer who is a broadly experienced pharmacist. Assessment, reflection and discussion following enhances the learning experience and provides formative feedback.

The purpose is to better prepare students to prescribe effective medicine rationally and safely and to enhance their appreciation of Quality Use of Medicine. Students are not always prepared adequately, yet are expected to prescribe independently from day one of vocational practice.

Set against critique of current methods of teaching therapeutics and prescribing are significant changes in health care more broadly that impact on the education of future doctors. Teaching in this community environment, an increasing area for health care delivery, models for students, professional communication and how collaboration towards judicious, appropriate, effective and safe medicine prescribing and patient partnership can lead to significant improvement in patient outcomes. In addition to specific issues around improvement in professional competency active learning in an out-of-class, real world experience provides an avenue for development of generic skills. These include communication, teamwork and problem solving skills. Students need practice at synthesising different professions and a teacher from another profession in an authentic environment can better facilitate integration of knowledge, understanding, skills and attitudes from a different disciplinary world. It represents an authentic learning situation, not only through involving real patients in a real environment, but also encourages students to practice reflecting on the experience.

An initial pilot project involved thirty final year medical students and was evaluated through student feedback, analysis of student reflections, and through the teacher's own reflective journal. Ongoing evaluation and research of broader scale integration in to the curriculum is occurring. To date, the teaching and learning activity has been achievable, aligns and integrates into existing education and enhances teaching and learning in the discipline. The future will allow exploration of the impact on the projected learning outcomes and how the activity is an avenue for 360º assessment.

Demolishing silos and building bridges: A model of an allied health and nursing interdisciplinary education team

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For too long now, the disciplines of nursing and allied health have spent a considerable amount of time pegging out the boundaries and carefully maintaining their individual grounds of professional practice, education and ideology.

In November 2007 there was a radical change in the Allied Health Award that introduced the capacity for a 'Health Professional Educator'. This ground-breaking change has opened the doors for allied health professionals to engage in a new era of career progression as educators beyond the limit of their own discipline.

The nurses at Sydney Children's Hospital have long been supported by a dedicated team of Nurse Educators. This paper attempts to explore the establishment of an allied health professional into an educator role that was traditionally occupied by a nurse. The challenges of this unique model of practice will be presented with discussion focussing on how rigid disciplinary silos are being slowly demolished to enable the building of interdisciplinary bridges with the ultimate goal of creating a truly multidisciplinary education team.

Interprofessional teaching of reflection in undergraduate health science programs

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Introduction/background:
The ability to reflect on professional practice is an important skill for the education and professional development of health practitioners and is acknowledged by many professional associations as an essential element in achieving and maintaining competence.

The School of Health Sciences at the University of Newcastle is aiming to embed the teaching, practice and assessment of reflection into all undergraduate programs. The SHS consists of nine disciplines, placing it in a unique position to develop the skills of academic staff and students across a broad range of health professions. Currently, while each discipline acknowledges the importance of developing reflective practitioners, the process undertaken to incorporate reflective practice in curricula is unknown. The SHS is striving towards a consistent interprofessional approach to the teaching of reflection and reflective practice concepts.

Purpose/objectives:
The purpose of this project is to develop a comprehensive, innovative, interprofessional module to facilitate the teaching and assessment of reflection into all undergraduate programs in the SHS. The current project will allow an evidence based approach to be taken in informing the development of the materials and a platform to institute a consistent approach.

The project will identify via a survey of academic staff:
1. Which undergraduate programs contain teaching or assessment relating to reflective practice and in which years this teaching is situated
2. The extent to which teaching or assessment relating to reflective practice is incorporated into professional/clinical placements
3. Current educational practices used by staff in the SHS to develop reflective abilities in undergraduate health professional students.

Issues for exploration/ideas for discussion:
Is anyone teaching reflective practice in an interprofessional manner?
What are other institutions doing to embed reflection across all professions and programs?
Does anyone have an innovative way of developing the reflective abilities of their students?
How are others assessing the reflective abilities of their students?

Results and discussion:
Data collection using the survey of academics in the SHS is currently underway and the findings will be outlined during the presentation. This will have informed the development of the reflective practice module. The presentation will include a discussion of the development of the module and its implementation to date.

Reflective practice and personal development

Emotional intelligence in medical students: Does it correlate with academic success?

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Introduction/background:
Emotional Intelligence (EI) refers to the capacity to reason with emotions to assist one's thinking. It involves the ability to monitor one's own and others' emotions, to discriminate among them and to use the information to guide thinking and actions. These are qualities recognized by some as being important in junior doctors. Some are suggesting that a higher EI may be linked to competency in interpersonal and communication skills which may contribute to better patient care and clinician outcomes. However, there is currently limited literature examining the relationships between EI and performance of medical students.

Purpose/objectives:
This presentation will explore how the EI scores of senior medical students relates to academic success or performance measures (OSCE, written examination, clinical assessments).

Issues for exploration/ideas for discussion:
Recently, students in Years 5 and 6 of a 6 year undergraduate medical program were asked to complete the MSCEIT™ online assessment for Emotional Intelligence. Their summary score plus scores for the four branches of EI (Identifying, Understanding, Using and Managing emotions) indicated these students demonstrate the full range of possible scores. Most demonstrated overall competence in EI (with scores around 100). Males had higher EI than females and Asian students demonstrated higher EI total and branch scores than Caucasian students. Highest EI scores were obtained for understanding emotion (m =110) and lowest EI scores for perceiving emotion (m = 94). How these EI scores correlate with students' performance in Year 4 and Year 5 OSCE's will be explored and correlations between EI and other measures of performance in medical school presented. Potential means for developing EI will be explored and others' experience with and knowledge of EI discussed.

The journey from novice to expert from a learner's perspective: A qualitative analysis of a peer-to-peer OSCE practice program

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Introduction/background:
The OSCE (objective structured clinical examination) is gaining popularity among medical schools as an examination tool. In order to perform well in OSCE sessions, students not only need to have adequate clinical knowledge and skills but also need to familiarise themselves with the OSCE exam format. In order to assist novice students (3rd year students) to prepare for OSCE exams, a group of final year students, in partnership with university teaching staff started a peer to peer OSCE practice program for 3rd year students in 2008. Novice students and student tutors were invited to participate in focus group interviews at the end of the program.

Purpose/objectives:
This session aims to:

- discuss students' perception regarding the OSCE, both as a teaching tool and an assessment tool;
- discuss student tutors' perception of the OSCE practice program;
- discuss the journey of transition from novice learner to expert tutor and the role of education in facilitating that transition.

Results:
We used a mixed research methodology. A total of 7 focus group interviews were conducted, using a semi-structured interview method. A total of 22 students and 9 tutors participated in the interview. A further 36 surveys with open-ended questions were distributed and 16 surveys were received. The interview sessions were recorded and transcribed. The transcript and survey reply were then analysed using a grounded approach.

Our results showed that novice students initially perceived the OSCE exam as a mysterious process, causing them to be fearful and apprehensive. Students usually cope with their fears and uncertainties by accumulating a strong foundation of clinical knowledge and skills through regular practice and study. With direction from teaching staff and advice from peer tutors during the OSCE practice sessions, students start to develop some clarity regarding the process of performing OSCEs successfully. They developed their curiosity about the OSCE topics and came to see the OSCE exam as an important hurdle to cross in order to prove their ability to adapt to the clinical teaching and learning environment. While many students get passed that hurdle at the end of the year, only some of them were willing to become expert tutors. Students felt they required external positive feedback and internal self-validation of their expertise and understanding of the OSCE process in order to feel confident to become expert tutors. The duration of time to reach this stage is variable and the peer to peer OSCE practice program seems to promote professional maturity among students in order to become expert tutors.

Discussion and conclusion:
The journey from novice student to expert student tutors suggests a journey which mirrors cultural adaptation and socialisation. It is important that mentors and role models be supported and provided with teaching experience to assist that process. We believe this OSCE program does exactly that.

Transition? What transition? A self-reflective ethnography study of student-to-internship transition

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Introduction/background:
The transition process from medical student to intern is both challenging and rewarding. This process is challenging due to the abrupt increase in responsibility of patient care and the uncertainty that many students have to overcome. The process, however can be rewarding if students are equipped with adequate competencies and skills in order to deliver services at an intern level. While student to internship transition programs exist, the transition process itself is poorly understood. As a final year student, my involvement in the SPRINT (***S***ound ***PR***epraration for ***IN***ternship ***T***ransition) project especially aims assist in the development of learner-centred conceptual model and understanding of the student to internship transition in order to develop an evidence-based transition education program.

Purpose/objectives:
This session aims to report my research study from the perspective of a learner. My research aims to identify common tasks required of interns during after-hours shifts, in order to develop a transition program for graduating medical students.

Issues for exploration/ideas for discussion:
- What are the common presentations/clinical encounters during after-hours shifts of interns?
- What skills and knowledge are important from a learner's perspective?
- How could education programs help the student to internship transition process?

Methodology:
The project deploys a learner-centred, self-reflective ethnographic method for data collection. Interns were shadowed by a medical student on after hours shifts. All tasks they performed were documented by the learner-observer during the shift. The learner then undertook self-reflection of the shift in order to better understand the student to internship transition process.

Results and discussion:
I have shadowed 102 hours of after hours shifts. During this period, there were 133 pages and 6 MET calls. Analysis of the data revealed that the most common tasks were fluid management, prescribing medication and intravenous cannulation. Other areas which are important during the transition period include communication skills, team work skills, understanding of working environment, boundaries and barriers, responsibility, tacit and expert knowing as well as psycho-social growth.

The study further suggests that the transition program should be delivered through various methods, including case study and dynamic discussion, simulation as well as electronic resources which allow students to develop individualised decision support tools. The provision of simple guidance and the empowerment of students to develop their own decision support tools are very important to guide students through the transition process.

Conclusions:
Education program can help with student to internship transition. My study provided some insights into the contents and delivery method best suited to assist student to internship transition.

Creating a culture of change: Supporting rural allied health clinical supervisors and their students

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Introduction/background:
Rural allied health professionals are largely aware of the value of undertaking rural clinical placements which are increasingly considered to be a vital component of modern education of Health Science students. However, rural clinical placements can have a negative impact if not supported and monitored appropriately, causing burnout of both students and their clinical supervisors.

In 2005 a partnership between the Department of Human Services Victoria, La Trobe University and Ballarat Health Services was formed to establish the 'Rural and Regional Allied Health Recruitment and Retention Strategy' covering the Grampians region in western Victoria. The objectives are to provide mentoring and support to rural allied health professionals in the areas of clinical research and professional development and to support allied health clinical education.

Purpose/objectives:
Strategies implemented to support the provision of clinical education at Ballarat Health Services and other health services in the Grampians region and insights into both the inter-professional and inter-agency outcomes will be described.

Issues for exploration/ideas for discussion:
The project currently includes one-on-one and group support to more than 130 students and 70 clinicians over a 360 km radius each year. The strategies developed include: a student orientation manual and formal induction checklist, student debrief meetings, professional development for clinical educators and student evaluation of their placement experience. Results from July 2005 to November 2007 demonstrated that the most noticeable changes were an improvement in the student's experience of supervision (O'Brien et al., in preparation). The results of student feedback at Ballarat Health Services for 2008 were also very positive, with all students being satisfied with their clinical placement. Areas of strength are team dynamics, staff friendliness, student support and feedback.

Similar strategies, with some modification to provide a more local focus and increased support through Information Technology and Telehealth, have recently been implemented in health services in the wider Grampians region. The improved support for clinical education has led to increased clinical placements occurring in the region.

Positive clinical placement experience is known to be a good recruitment strategy, particularly in rural areas. This project has created a culture of change in rural allied health support in the Grampians region by increasing support for rural clinical supervisors and allied health students, thereby having a positive impact on the quality and number of allied health clinical placements at both a regional health service and at smaller and more distant rural health services.

An evaluation framework to investigate ACT Health's allied health, Designated Clinical Education Model

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Introduction/background:
Workplace clinical education is undertaken in a complex, clinical service environment yet is fundamental to the development of Allied Health new graduates and students. Historically the education institutions' student-centred service and the patient-focused health services have worked collaboratively to provide clinical education, however the relationship is becoming strained as the demands of one service exceed the capacity of the other. ACT Health has agreed that allied health clinical education is core business in partnership with the tertiary providers. Subsequently, ACT Health has established designated clinical educator (DCE) positions within six different allied health professions. These positions form the nucleus of the Designated Clinical Education Model (DCEM). There is persuasive anecdotal evidence that this model has been successful, enabling departments to accept more students and provide well organised supported student placements and reducing staff stress. However, rigorous evaluation is yet to be undertaken.

Purpose/objectives:
This project developed a rigorous framework to investigate both the service delivery and the education aspects of the ACT Health DCEM. The evidence-based rationale of the framework was developed through a process of literature review, profiling of the local allied health DCE positions and critical reflection. The rationale was used to define the evaluation objectives, target population, key questions, most appropriate methodology and evaluation methods.

The objectives for the evaluation are to: (1) measure the DCEM's impact on the health service, including productivity and resource cost, (2) investigate the impact on the education institution and students, considering the three functions of supervision i.e. administration, education and support, (3) determine the advantages and disadvantages of the current model, identifying what is and isn't working well.

Issues for exploration/ideas for discussion:
This session will present the evaluation framework and seek feedback from those present.

- Is a health-service driven evaluation study of this type ethical, feasible and useful?
- Will this evaluation provide an understanding of the impact of the model on service provision and the quality of clinical placement experience?
- Could this evaluation be developed into a collaborative comparative study?

Developing strong Murries and keeping them in

Jenine Godwin, Jacinta Elston

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Introduction/background:
'Developing Strong Murrie's & Keeping Them In', is reflective of ANZAME09, **'Bridging Professional Islands' sub-themes for a collaborative approach to health professional education.**

In 2006, the Indigenous Health Unit (IHU) at James Cook University (JCU), Townsville introduced across the Faculty of Medicine, Health and Molecular Sciences, an Indigenous student access program called the Indigenous Health Career Access Program (IHCAP).

Purpose/objectives:
IHCAP is specifically designed to support and provide a tailored program of capacity building for students who enrol in a health science degree at JCU. This project aims to achieve the following objectives in health professional education:

- Continue the development of a multi-pronged framework of support for Indigenous students to successfully enter and remain in the health professional education programs of the FMHMS.
- Expand to Cairns the establishment of IHCAP.
- Develop and implement a pilot program called *Health Careers Aspire Program for Indigenous Secondary Students (HCAPISS)*, in Townsville.
- Continue to provide broad-ranging support and pro-active activities, such as ***'Health Careers Roadshow'*** with Secondary schools across North Queensland, to enable the participation of Indigenous students.

Issues for exploration/ideas for discussion:
The IHCAP program will be expanded to the Cairns campus in 2009, whilst the HCAPISS program will be piloted amongst senior secondary Indigenous students in Townsville throughout the semester, and school recess periods.

If research data are to be presented, please include the following sections:

Results:
Since IHCAP's, establishment sixteen (16) Indigenous students have been enrolled into FMHMS programs across five academic disciplines of the Faculty. Of these students four students have withdrawn, whilst the remaining 12 students have continued in their programs of study.

IHCAP orientation 2009, there was a significant increase in student enrolment across the Faculty, consistent with feedback from *'Health Careers Roadshow'*. Resulting in, (22) students participated in the orientation program.

Discussion:
There remains an overwhelming workforce demand for Indigenous health professionals locally, throughout the state and across Australia. Health authorities have determined support and retention strategies are vital to encourage more Indigenous people into health related professions.

Conclusions:
Through the combined activities of the IHCAP program, regular mentoring, the orientation programs and the everyday student support services, the IHU will be in a strong position to identify and determine which students (if any) are experience difficulties/barriers in their learning which are affecting their academic opportunities. IHCAP has increasingly been instrumental in the motivated and championed approaches to supporting Indigenous students.

Personal and professional development

Perceptions by medical students of their educational environment for obstetrics and gynaecology in metropolitan and rural teaching sites

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Introduction/background:
Increasing student numbers and other changes in health care delivery have generated changes to the delivery of medical education programs. At The University of Western Australia the obstetric and gynaecology curriculum in the fifth year of the medical degree is now taught at a tertiary hospital, secondary level metropolitan hospital and small and large health care rural sites. Evaluation of the expanded program delivery is essential to promote effective learning. An important aspect of evaluation is student perception of their learning environment as this has been shown to influence learning behaviours and academic outcomes. In this study we used a validated generic tool, the Dundee Ready Education Environment (DREEM), to measure the student perceptions of their obstetric and gynaecology learning environments.

Purpose/objectives:
To determine if student perceptions of the teaching environment for obstetrics and gynaecology differ in tertiary and secondary level metropolitan hospitals when compared with rural sites, and to determine if student perceptions of their learning environment are associated with improved academic performance.

Issues for exploration/ideas for discussion:
Student perceptions of their learning environment (academic and clinical)
Planning and implementing a positive learning environment(s)
Appropriate clinical and academic support systems for teaching sites
Student perceptions of the learning environment and academic outcomes

Results:
There were no significant differences in student perceptions of their learning environment between the tertiary hospital, combined programs involving a tertiary and secondary metropolitan hospital, rural sites with a population of more than 25,000, and rural sites with a population less than 25,000. Perceptions were similar among male and female students. The overall mean score for all perceptions of the learning environment in obstetrics and gynaecology were in the range considered to be favourable. Higher scores of perceptions of the learning environment were associated positively with measures of academic achievement in the clinical, but not written, examination.

Discussion:
Factors contributing to the favourable student perceptions of the obstetric and gynaecology teaching across sites include a central curriculum, on-site coordinators and responsive evaluation at each site. It is uncertain as to the reasons for the discrepancy in the associations between student perceptions of their educational programs and the results of the written and clinical exam. The DREEM questionnaire was a valuable tool to assess the learning environments in this study. To complement this data, qualitative studies exploring student experience would provide detailed information for remedial purposes, as well as affirming positive environmental strategies.

Conclusion:
Providing appropriate academic and clinical support systems have been put in place, the education of medical students can be extended outside major hospitals and into outer metropolitan and rural communities without any apparent reduction in perceptions of the quality of their learning environment.

Early medical students as 'caregivers': Issues and outcomes so far

Dr Hamish Wilson

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Introduction/background:
In the revised Early Learning in Medicine course at the University of Otago, students do shift work as assistant caregivers in community rest homes. This initiative has been logistically challenging and not without initial apprehension from both Faculty and students. However, extensive evaluation data from various stakeholders indicate good enthusiasm and acceptability of this curricular innovation.

Purpose/objectives:
To outline this initiative and discuss the problematic issues arising.

Issues for exploration/ideas for discussion:
The wide range of student learning outcomes seems to be founded on authentic learning within the workplace environment and reinforced through reflective essays. Topics for discussion include timing of such workplace experiences, students in new and unexpected professional roles, learning about aged care, death and dying, and inter-professional learning.

Teaching physiology in clinical context: Reasoning development in a medical program

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Introduction/background:
Lack of a suitable level of knowledge in biomedical sciences and the ability to apply it to clinical situations in hospital wards has been identified as a significant problem by senior medical students and first year medical residents1,2. In most problem-based learning (PBL) courses, student learning is developed around a specific clinical case. While valuable, it often limits the ability of students to understand a broad range of discipline concepts, particularly in the biomedical sciences as they apply to various clinical scenarios in a particular body system. Teaching physiological concepts in clinical context through a newly developed interactive learning platform which also includes propositional testing of the knowledge gained and reasoning skills, may be an appropriate method of achieving a higher skill set in our medical graduates. It is anticipated that this innovative method may assist in the management of curriculum delivery to increased student numbers, who are often widely distributed across regions and be applicable across a range of disciplines.

Purpose/objectives:
After much discussion between medical educationalists and instructional designers, the project developed an on-line interactive module to help to improve student satisfaction with their on-going education in applied physiological concepts and their decision making and reasoning skills. The module was applied to the student cohort after the completion of their standard studies in the cardiovascular system during the first year of study in the graduate-entry medical program. Students who completed the study module and a control group underwent propositional question testing with an emphasis on the cardiovascular system and an on-line clinical reasoning test (Script Concordance Test). We also analysed the results of a student satisfaction survey to gauge their perceptions of its value to their educational experience.

Issues for exploration/ideas for discussion:
- the ability of students to integrate, transfer and apply biomedical concepts into correct clinical reasoning outcomes across a range of clinical scenarios
- student satisfaction with this style of teaching and its ability to assist in educational development
- improvement in student performance
- expansion to other disciplines and ability to apply to later clinical rotation years when the student population is widely disseminated

The ability of undergraduate physiotherapy students to read and interpret a scholarly paper

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Introduction/background:
Evidence informed learning is an essential element in clinical decision making by health professionals. In order to apply evidence informed practice, students must have the ability to read, interpret and critically review scholarly material. The technical skills of critical review and evidence informed practice are taught to physiotherapy students at the undergraduate level, but it assumes an underlying level of analytical thought in order to interpret a scholarly paper. Most students entering the Physiotherapy Degree programme complete a health science year. This first year has set papers in which students must enrol. In 2006, students were required to enrol in ENG 124 in their health science year of study. The aim of the paper ENG 124 was essentially to teach the skills of summary of technical material. In 2007, this paper was no longer a compulsory paper for health science students.

Purpose/objectives:
The aim is to present the results of two cohorts of first year undergraduate physiotherapy students who were asked to read and interpret a scholarly paper during 2007 and 2008. The cohort in 2008 had not been required to take ENG 124 during their health science year of study.

Issues for exploration/ideas for discussion:
The ability shown in year 2 physiotherapy students to interpret a scholarly paper was poor, despite intervention. It is important that these skills are taught to undergraduate students, in order to develop their competence as practitioners.

Results:
All student volunteers undertook the first critical review then groups were evenly divided into those who had nothing more and those who undertook one, two or three tutorials on how to read and interpret a scholarly paper in order to identify main points made. All students undertook the follow-up review of an article which was in a similar format to the first. The two cohorts of students were well matched. Pooled data for both the 2007 and 2008 cohorts showed mean scores below 50%, even after tutorial support. However, in the 2008 cohort mean pooled data for individual groups who attended two or three seminars were significantly improved compared to the first review ($p<0$ 001). These students had not taken ENG 124 during their health science year of study. The results suggest that the students from the 2008 programme benefited from the exposure to learning about the skills required to read and interpret a scholarly paper.

Teach the Teacher: Helping future doctors learn to teach

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Introduction/background:
Interfaculty initiatives provide great opportunities to enhance medical students' professional development. In particular, relationships between medical and education faculties can be used to build medical students' teaching skills. The medical profession faces a challenge of training more students and junior doctors with limited teaching resources and personnel. It is imperative that such opportunities are used to maximise the number of doctors who can teach.

Teach the Teacher is a joint initiative between the Faculties of Education and Medicine, Dentistry and Health Sciences at the University of Melbourne. It is supported by the Australian Medical Association Victoria. Medical students collaborate with health-method education students (future health-teachers) to provide a series of seminars on sexual health for all education students. It was piloted in 2007 and incorporated into the Masters of Teaching timetable in 2008. It has mutual benefits for the two sets of students. Education students feel more comfortable dealing with sexual health issues in the classroom. Medical students develop their teaching and communication skills. The content of the lectures is reviewed by sexual health and sex education experts to ensure accuracy and prevent oversight.

A detailed two-semester programme means medical students benefit greatly. In the first semester, medical students prepare a series of presentations for health-method education students about contraception, sexually transmitted infections (STIs) and teenage pregnancy. Subsequent discussion covers issues such as presenting medical information to a non-medical audience. During the second semester, medical students and health-method education students collaborate to produce three seminars for all education students. At team meetings, students discuss teaching strategies and presentation methods. They also consult with experts on sexual health and sex education as described above.

Teach the Teacher has been formally evaluated throughout its implementation, and has received positive feedback from students and staff alike. It provides an innovative and energetic way of teaching future doctors to teach.

Purpose/objectives:
To emphasise the importance and suggest an innovative way of training future doctors to teach.
To highlight the potential for interfaculty relationships and initiatives in medical students' professional development.
To discuss the issues encountered in establishing an interfaculty project.

Issues for exploration/ideas for discussion:
- The importance of training medical students how to teach.
- Methods of training medical students how to teach.
- Interfaculty initiatives taking place at other universities.
- Overcoming challenges in establishing interfaculty projects.

Using Studiocode to study registrars' teaching skills

Jenny Gough, Geoff McColl

Introduction/background:
The teaching of medical students by (junior) medical staff in hospitals is a key component in medical courses. There is a need to know more about the quality of that teaching and the subsequent need for introducing/adapting appropriate professional development programs to support their 'workplace learning'.

Purpose/objectives:
In order to systematically observe instances of registrars/fellows teaching, we constructed two simulated settings to record for analysis using Studiocode software. In particular, we required information about the teaching of 'skills'.

The registrars/fellows were volunteer participants in the standard hospital/clinical school professional development program.

Issues for exploration/ideas for discussion:
- How systematically did the registrars/fellows use the recommended model of teaching skills?
- How is Studiocode useful in facilitating analysis of clinical teaching?
- How important is it to promulgate a model for 'Effective Teaching of Practical Skills' in professional development for junior medical staff?

Results:
The analysis of the recorded teaching sessions reveals that the participating teachers do not consistently interpret or apply the recommended 'steps' for teaching practical skills even over two separate simulated sessions.

In the research team, the educationalists and clinical educators placed different value on the need to provide a demonstration of 'the whole' prior to teaching the steps/phases of a skill;

Discussion:
The importance of 'demonstration of the whole' and the practical applicability of providing such demonstrations in clinical settings is one of the challenges identified in this study. The alternative approach of providing mini demonstrations interspersed with the teaching of each 'step' in the skill is more acceptable to the clinicians than to the educators.

Conclusions:
Studiocode provided a means of analysing aspects of junior medical staff teaching in simulated settings. In addition to the coding and analysis of observed teaching, it facilitated specific feedback to and self-appraisal by clinical teachers. The study provided information about each of the participating doctor's application of both a narrow range of recommended teaching practices and other non-specified teaching behaviours. It has provided valuable evaluative data on the current professional development program.

A year on ... innovation at the Utas Rural Clinical School – An evolving educational culture

Rose Moore

Medical Education Adviser Utas RCS/PMCT

Introduction/background:
The RCS, now in its seventh year, is committed to continually developing and refining educational processes and approaches in order to strongly retain within the undergraduate program: academic rigour, workplace relevance and astute resource utilisation.

In 2008 the RCS took an innovative approach to curriculum design and introduced block teaching weeks (Group Learning Weeks) for final year medical students in order to improve the quality of teaching and learning in the classroom setting and to maximise student experience in the clinical setting. The feedback from students and clinicians was very encouraging and now, a year on in 2009, the RCS has applied this curriculum design to both clinical years.

An added challenge has been the significant increase in student numbers, from 26 in 2008 to 41 in 2009 with the probability of a further substantial increase in 2010.

In the Group Learning Week theoretical knowledge is linked with practical application, especially through the use of case based learning and the RCS Skills and Simulation Centre. As well, those teaching into the Group Learning Week are encouraged to define their own teaching needs in terms of resources and time-frames and to develop a close communication with the whole teaching team. An inter-professional approach is an important component of the model, as is the bridging of input between the acute services and primary care sectors.

At this stage in the year we reflect on how the new curriculum structure is meeting the needs of the new 2009 co-hort of 27 Year 4 students. Does it continue to meet the needs of the final year students? Mid and end of term feedback mechanisms continue to indicate a strong support from students for this model and teaching clinicians are likewise supportive.

Even so there continue to be important challenges:

How can we resource quality small group teaching when budgets are limited but student numbers are growing?

How do we support an ever increasing team of clinicians teaching into a model where integration across disciplines and professions is important and the link between theory and practice, knowledge and skills is paramount?

Will this model be sustained into the future with increased student numbers?

Purpose/objectives:
- Share the experiences of the RCS with regard to specific program design and the issue of change management
- Explore the experiences of the whole group regarding similar areas of program development
- Build an appropriate perspective through which to view current and future opportunities for innovation within the RCS and for audience participants within their own educational contexts

Issues for exploration/ideas for discussion:
- The role of the student – from passive to active
- Implications for resource management
- Implications for professional development
- Balancing innovation and flexibility with the need for stability and predictability

Program evaluation data will be available for the first three Attachments and Group Learning Week cycles of the new program for both Year co-horts.

Guessing and incorrect unsafe responses in healthcare professional assessment

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Introduction/background:
Non-constructed response tests with number-correct scoring are widely used in high-stakes examinations. Concerns about number-correct scoring include the implications for guessing and whether an incorrect unsafe response is a true belief or a random guess.

Purpose/objectives:
An evaluation of the effect of a scoring system that reflects candidate confidence and response safety.

Issues for exploration/ideas for discussion:
We developed a new scoring system in which scores ranged from +3 for answers that were correct with high confidence, to −18 for answers that were incorrect despite high confidence in correctness, and highly unsafe. Descriptors for levels of confidence included the degree of likelihood of contacting a colleague/reference. Incorrect responses were reviewed in advance for level of safety.

Results:
An optional MCQ paper was offered to all medical students at University of Otago. A randomized cross-over design with four versions of the paper was used. Each paper had two sets of 12 questions in different order, one set to be answered with number-correct scoring instructions and the other with the new system instructions. 374 students completed the MCQs. Score reliability was sufficient (alpha = 0.80). The year of the candidate and scoring system instructions led to differences in responses. The new system instructions led to more correct, fewer incorrect, don't know and unsafe responses (paired t test for individuals, all $p<0.001$; unpaired t tests for groups all $p<0.001$, except don't know $p=0.004$). Increasing year had a similar effect (all $p<0.001$). The likelihood of an answer being correct increased with confidence. If incorrect the likelihood of being unsafe to any degree fell from 35% for low confidence responses, to 26% for moderate confidence, and 15% for high confidence. There were 37 incorrect highly unsafe high confidence responses from 31 candidates, 26 with one occurrence only. 67% of students had no unsafe responses of any degree.

Discussion:
The scoring system had the effect of increasing the number of correct responses whilst reducing the number of incorrect, and in particular unsafe, responses. The student cohort did have insight into their knowledge with correlation between confidence and likelihood of correct responses and inverse correlation with likelihood of unsafe responses.

Conclusions:
The new system led to improved response patterns. However, this system has not been used in high-stakes examination used to make pass/fail decisions.

Should the confidence a candidate has in responses, especially those that are incorrect and unsafe, be used in decision making in assessment?

A quality assurance model for clinical assessments

Dr Charles Cock

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Introduction/background:
A model of quality assurance in clinical assessments is proposed, based on "principles of good assessment" and "notions of quality". The model relies heavily on the preceding work on quality assurance in higher education by Harvey and Green (1993) and John Biggs (2001). Establishing a model against which judgements can be made was conducted in an *evaluative* way in keeping with the *interpretive* philosophical assumption in *qualitative* research. Practical evaluation of the model in the setting of a final (high stakes) undergraduate clinical assessment was conducted using a *mixed model of qualitative and quantitative research methodologies* and by surveying the internal and external assessors on the levels of compliance with the model using a Likert type scale.

Purpose/objectives:
1. ***Establishing a quality assurance model*** for evaluating clinical assessments in terms of principles of good assessment and Biggs's expansion of Harvey and Green's quality assurance model for the reflective institution.
2. ***Judging undergraduate clinical assessment*** in the Department of Internal Medicine at the University of the Free State, South Africa ***in terms of the proposed model.***

Issues for exploration/ideas for discussion:
What are the principles of good (clinical) assessment?
What are the definitions underlying each principle?
What constitutes quality?
Who are the judges of quality?
To what end(s) should quality be assessed?

Results:
The components of the model are established as:

Principles of Good Assessment	Notions of Quality
Reliability	Quality as Value for Money
Validity	Quality as Fit for Purpose
Practicability	Quality as Transforming
Fairness	Quality Model (Constructive Alignment)
Educational Impact	Quality Enhancement
Accountability	Quality Feasibility
Authenticity	

Analysis of the clinical assessment in terms of the model shows good compliance to principles of good assessment, but less so to notions of quality. External assessors are more lenient in their assessment of the quality of the exam as compared to internal assessors.

Discussion:
Assessment has various purposes, which include determination of clinical competence, establishment of accountability and as a driving force of student learning. The consequences of inadequate or poor quality assessment can be dire and as such the responsibility rests upon medical schools to ensure the quality of their assessments. This model provides an instrument by which to measure quality as baseline and determine areas for improvement.

Conclusions:
The model provides a practical instrument for measuring assessments in order to determine areas for quality improvement. In this study these areas were related to institutional support of teaching and learning activities.

Medical students generating questions for their own written examination: Tips to guide methodology development

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Introduction/background:
Student involvement in the assessment and evaluation process is an essential part of balanced assessment. When students become partners in the learning process, they gain a better sense of themselves as readers, writers, and thinkers. Through assessment allows students reflect on what they have learned and on how they learn, they develop the tools to become more effective learners.

Students need to examine their work and think about what they do well and in which areas they still need help – this is part of the cycle of reflection and self-assessment. To guide students in understanding the process of self-evaluation, one may want to have them complete a Self-Reflection/Self-Assessment sheet of their own.

Once students have reflected on their learning, they are ready to set new goals for themselves. As they work toward these goals, they should be encouraged to reflect on their learning journey at regular intervals. Students should be encouraged to record their observations during these periods of self-reflection to help reaffirm their goals and motivate them to move toward meeting each goal.

With practice, students who self-assess become more conscious learners, able to apply knowledge of their learning needs and styles to new areas of study. As students become more active participants in the assessment process, they will begin to evaluate their strengths and attitudes, analyse their progress in a particular area, and set goals for future learning.

Purpose/objectives:
A pilot study investigated the usefulness of adopting innovative, student centred assessment techniques in years 1 & 2 of the MBBS program at the University of Queensland Medical School. All first-year medical students were recruited to the initial study early in the academic year (N= 384). Approximately equal proportions of male and female students were involved, aged from 20 – 55 years. The aims of the pilot study were to (1) give students greater ownership of their assessment, (2) enhance students' metacognitive abilities (in particular their skills in self-regulation) and (3) create an assessment strategy which aligned with principles of PBL without moving away from traditional examinations.

Issues for exploration/ideas for discussion: Methodological Issues
These are the principles to guide methodology development:

- Train students to participate more fully in assessment processes
- Train PBL tutors to guide and support reflection among students
- Guide students and tutors in development of questions that involve more than rote memorisation
- Develop strategies for collaborative question development
- Anticipate problems with social loafing
- Provide exemplars to guide question development
- Allocate broad topics to students
- Ensure students use a consistent set of high quality resources
- Give students the opportunity to reflect on their questions and provide a forum for student feedback on question quality
- Provide questions as a source of formative assessment well in advance of summative assessment
- Don't assume students are not going to try to memorise questions and their answers.

IPE

The Deakin difference: A journey in interprofessional education development

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Introduction/background:
The delivery of high quality health care is complex requiring effective collaboration between health care professionals. Interprofessional education (IPE) in health care is recognised as an important tool to promote this collaboration. However organising IPE is difficult to achieve, with obstacles including differences in curricula resulting in timetable clashes, geographical isolation, inequalities in the number of students, workload requirements required for development, accreditation requirements and agreeing on joint financial arrangements. This complex range of factors all need to be negotiated and agreed upon in the development of an IPE program.

These barriers were evident in the development of a new unit in IPE within the Faculty of Health, Medicine, Nursing and Behavioural Sciences at Deakin University. The geographical distribution of students on four different campuses across Victoria, timetable and placement clashes across six different courses, a mix of undergraduate and postgraduate students and a varied focus on content of the different courses were particularly problematic.

Purpose/objectives:
This paper describes the journey in addressing these barriers leading to the development of a new unit in IPE for Psychology, Social Work, Occupational Therapy, Nursing, Medicine and Dietetics students at Deakin University. This presentation will also outline the two key distinguishing features of this unit including it being fully online (utilising WebCT and Elluminate technologies) and a focus on case management of clinical cases. Whilst some institutions have trialled a blended approach to the delivery of IPE, there are limited IPE programs internationally adopting a fully online approach.

Issues for exploration/ideas for discussion:
- The challenges of online technologies in the delivery of IPE
- The challenges of facilitating an online IPE unit
- The potential impact of inequalities in the number of students from each course
- Dealing with different schools' focus for content and/or assessment.

Health science of tomorrow – a scientific integrative approach of natural and mainstream medicine

T. Gruner, G. Lorrigan

Introduction/background:
The current medical system is not sustainable in the long term. Preventative and alternative ways of treatment need to be found. Naturopathy can provide cost-effective, individualised advice and treatment before or in addition to medical intervention. The following will give a glimpse of naturopathic training and skills.

The core training of naturopaths in Australia and New Zealand involves scientific training in clinical subjects (biochemistry, anatomy, physiology, pathology, clinical diagnosis) as well as modalities (diet, nutrition including supplementation, phytotherapy plus others). Clinical training involves not only observation and case discussion but also hands-on patient consultation and treatment. In some parts of the world, such as in many states of the US, naturopaths are already recognized as primary care physicians.

This exploration of the curriculum will be followed by a complex case study such as is seen in naturopathic and medical practice. It is hoped that the presentation of a case will not only demonstrate the knowledge naturopaths gain from training and experience, it will also highlight the need for cooperation, on equal footing, between various health professionals.

Purpose/objectives:
The purpose of the workshop is to educate the audience on the training and skills of naturopaths and their role in the care of patients. After an initial brief theoretical introduction this will be followed by the presentation of a complex case study, featuring multi-system imbalances which require an understanding of physiology and biochemistry as well as pathology. This necessitates an integrated treatment approach, including medical, nutritional and lifestyle interventions.

The objectives are to elucidate different views regarding possible causes, with the aim of developing treatment options of the presenting case scenario. The purpose is to foster cooperation between a range of health practitioners in order to achieve an optimal and lasting patient outcome. This approach will benefit health practitioners regardless of their area of expertise as knowledge and skills are drawn from a variety of disciplines. Although the authors will present their actual treatment of the case they do not claim that this is the only possibility.

Issues for exploration/ideas for discussion:
The presentation will emphasise an interactive style. The case will be unravelled in stages to give the audience the possibility to contribute throughout the case development to issues regarding differential diagnoses, possible further investigations and treatment options. This style of teaching, used in the classroom, will challenge and extend students' knowledge through exposure to a real case scenario.

Enhancing the quality of clinical supervision and clinical leadership through a unique workplace-based postgraduate program

Prof Judi Walker, Jo Osborne, Stella Stevens

Faculty of Health Science, University of Tasmania

Introduction/Background:
Strong leadership and governance in health systems are critical to address the challenges and changes in health service delivery. Studies demonstrate that reduced risk and better quality care flow from effective leadership and well-designed clinical systems that are subject to regular multidisciplinary reviews of outcomes.

The University of Tasmania, in partnership with the Sydney South West Area Health Service, has developed a Master of Clinical Supervision and Clinical Leadership. It is the first of its kind in Australia providing a unique opportunity for participants to enhance the quality of clinical supervision and leadership through a health-focused leadership program. The course, with Graduate Certificate and Graduate Diploma exit points, was introduced in July 2008. It blends the theoretical and conceptual underpinnings of clinical leadership and with practical application in clinical practice. It provides accessible and flexible education options for clinicians in a range of environments through a collaborative, multidisciplinary approach. It integrates workplace-based learning with clinical practice.

Purpose/objectives:
- To explore different approaches to health workforce and leadership development
- To discuss ways to develop and enhance partnerships for workforce development
- To critically examine problem solving and partnership extension processes
- To share ideas and experiences about the strengths and weaknesses of workplace-based postgraduate programs.

Issues for exploration/ideas for discussion:
- The relationship between education and research and service quality
- The relationship between workplace-based training and health workforce
- The pros and cons of partnerships between education providers and health services
- The capacity of education providers to respond to health service requirements.

Medical student wellbeing: Painting the picture

James Hillis[1], William Perry[2], Emily Carroll[3], Belinda Hibble[4], Marion Davies[5], Justin Yousef[1]

[1] Medical Student, University of Melbourne, VIC
[2] Medical Student, University of Otago
[3] Medical Student, Flinders University
[4] Class of 2007 Graduate, Monash University
[5] Medical Student, University of Tasmania

Introduction/background:
Medical student wellbeing is an essential part of the medical school curriculum. It must be approached in an appropriate way, and be complemented by adequate support services, to be most effective.

The Australian and New Zealand Medical Students' Associations conducted a survey at five universities in 2007 to investigate students' opinions about the current approach to wellbeing. It focused on four key aspects of wellbeing: personal experience, support services, wellbeing teaching and awareness initiatives.

Results:
1328 students (26.2%) completed the survey. 49% of students report feeling constantly under strain more than usual or much more than usual. 55% of students believe there is a stigma associated with being a medical student undergoing stress and distress. 78% of students feel comfortable seeking support services offered by their university, but only 46% of students feel university services are adequately promoted. 74% of local students have their own GP, while only 45% of international students have one. Students want to learn most about methods of helping somebody else cope with stress and distress.

Conclusions:
Medical students experience high levels of stress and distress, and have identified a number of ways university wellbeing teaching and support services can be improved.

Purpose/objectives:
- To confirm that medical students in Australia and New Zealand experience high levels of stress and distress.
- To establish the extent of the stigma which medical students associate with experiencing mental health problems.
- To present student beliefs about current wellbeing teaching and support services.
- To identify topics and modes of wellbeing teaching that students would prefer.
- To identify student demographic-groups that could benefit from a more targeted approach to wellbeing.

Issues for exploration/ideas for discussion:
- Medical student stress and distress
- Current university wellbeing teaching and initiatives
- Current university support services
- Methods of targeting particular demographic-groups for wellbeing initiatives.

Improving clinical preparation, communication, confidence and satisfaction in physiotherapy students through role-playing

A/Prof. Sandra Brauer[1], Rosemary Isles[1], Dr Angela Chang[1], A/Prof. Nancy Low Choy[2], Dr Ann Webster-Wright[3], Rowena Toppenberg[1], Donna McCook[1], Dr Michelle Smith[1], Karina O'Leary[1]

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Introduction/background:
Prior to transitioning into new professional environments, it is optimal for health care professional students to practise the integration and application of knowledge, skills and professional behaviours within a clinical context. To provide this opportunity, learning tasks for physiotherapy students were developed so that final year students role-played as patients for second and third year students.

Purpose/objectives:
The purpose of this study was to evaluate if role playing by final year physiotherapy students enhanced self-reported confidence, communication, preparation for clinic, insight and satisfaction of the year 2 and 3 physiotherapy students.

Results:
Over 236 physiotherapy students (102 year 2, 101 year 3 and 33 year 4) participated in the study, which involved learning activities in seven courses delivered in 2008. Both quantitative and qualitative research designs were used, with primarily quantitative reported here. A survey was administered before and after each learning activity which included 10 self-reported measures of confidence, communication, preparedness for clinic and insight indicated on a VAS scale. A further 10 questions were answered about the satisfaction with the learning activity and skills developed at the post measurement.

A 95% survey response rate was achieved. Across all courses, second and third year students reported a significant ($p < 0.037$) increase in their: preparedness for clinic, communication with clients, confidence with practical skills, and understanding of their strengths and weaknesses. Confidence in their ability to interact in a professional manner was the only quality that did not improve in 2 of the 4 classes ($p > 0.067$), but their confidence pre was high (7.3/10). Final year students demonstrated a significant improvement in their confidence in giving feedback and insight ($p < 0.001$). All students found it a useful learning experience (mean score 8.5/10).

Discussion:
A new program of peer-assisted learning in a role-playing scenario resulted in positive experiences for both senior (role playing) and junior (learner) students. These positive impressions occurred across a variety of learning objectives, discipline areas, specific tasks, and across different stages of learning in the physiotherapy program.

Conclusions:
These results support the use of students as standardized patients to enhance learning across the physiotherapy program, and warrant further investigation of this methods to optimise learning in physiotherapy.

Issues for exploration/ideas for discussion:
- The impact of assessment on the learning experience
- Issues in the practical implementation of peer-assisted learning through role playing
- Factors to consider in the progression of role playing learning activities.

Medical communication training and support for international medical graduates

Jennifer Young[1], Vickie Owens[2]

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[2] Educator, Centre for International Medical Graduates.

Introduction/background:
The Centre for International Medical Graduates (CIMG), is part of Queensland Health's Clinical Workforce Solutions which provides service and advice on recruitment, assessment, training and support for health professionals from all disciplines in Queensland.

The presentation will outline the educational strategy adopted by the Centre for International Medical Graduates (CIMG) in using educators as simulated patients and realistic clinical scenarios in the teaching of medical communication and cultural appropriateness in the Australian context.

Purpose/objectives:
CIMG delivers education and training for the Queensland Health International Medical Graduate (IMG) workforce. The vast majority of these doctors come from non-English speaking backgrounds.

CIMG programs are delivered state-wide using both face-to-face and technology-enabled modes of delivery, featuring a rich mix of medical and educational personnel in real-time consultations with educators playing simulated patients. Programs using educators include:

- medical content lectures delivered in consultation style with consultants video-conferenced state wide
- one-to-one / small group training delivered face-to-face or by video conference
- medical communication workshops
- trial examinations with individual, peer and consultant feedback

The CIMG team comprises four educators and the skills base within the team includes medical/ health professional communication, English as a Second Language (ESL) expertise and English language assessment.

Educators role-play simulated patients to enable the IMGs to interact with standardised patients in the Australian context. All communication tasks are realistic workplace tasks set in realistic timeframes.

Immediate feedback and the opportunity to practice "new" language, has been documented by CIMG as impacting directly on improved communication outcomes for IMGs in their workplaces and in their performance in Australian Medical Council examinations.

The ultimate aim of the CIMG programs is to enable the IMGs to function safely as health professionals in terms of effective communication and cultural understanding, enhancing the therapeutic alliance with their patients and facilitating a rounded transition for them into the profession in the Australian context.

Issues for exploration/ideas for discussion:

1. We simulate consultations to improve medical communication. How authentic is this? Are the skills transferable?
2. In order to be safe practitioners, all doctors need to have a professional level of English as well as an acceptance and understanding of the professional culture of the Australian health workplace and their patient in their cultural contexts. Does this method of teaching deliver appropriate outcomes for the doctor and the workplace?
3. Can the CIMG Model for teaching medical communication be replicated? Would this transfer to your workplace?

Vickie Owens and Jennifer Young are Educators in the Centre for International Medical Graduates (CIMG). Vickie is the CIMG Educator for the Queensland Health Service Districts of Torres Strait Northern Peninsula, Cape York, Mt Isa, Cairns and Hinterland, Townsville and Mackay and is based at Cairns Base Hospital. Vickie is a Registered Nurse with over 15 years experience with more than 3 years experience as a student nurse educator. Vickie has a sociology degree and a post graduate qualifications in further education and training including teaching nurses from a non-English speaking background.

Jennifer is the manager of CIMG and oversees all education and training programs. Her experience is migrant professional education, medical education and teaching medical communication to doctors who are from non-English speaking backgrounds. She has postgraduate qualifications in TESOL (Teaching English to Speakers of Other Languages) and over the last 18 years has taught medical communication to doctors from overseas. Jennifer is a trained assessor of language proficiency of speakers from non-English speaking backgrounds

Curriculum

Practice makes perfect: Impact of a hands-on evidence-based medicine training session on learning

Kumara Mendis, Joseph Canalese

School of Rural Health, University of Sydney, Dubbo, NSW

Introduction/Background:
The emphasis placed on EBM in the University of Sydney Medical Program reiterates the importance of training doctors that will 'pursue evidence-based medical practice' to deliver optimum quality clinical care. However standard curricular teaching activities in EBM may be not be sufficient to produce evidence-based practitioners.

Purpose/Objectives:
To determine the final year students' (a) favourite resources for staying up to date (b) confidence in the use of some key resources/skills that would be essential to practice EBM in real-time (c) confidence in using these resources could be improved by a single hands-on session, and (d) view of the session (both quantitative and qualitative).

Results:
There were 137 (95%) evaluations for analysis. Google, text books and colleagues were the most frequently used, with review articles, Therapeutic Guidelines and Cochrane Library being occasionally used. One third of the students never used secondary journals. They were most confident in using Google (mean score 3.87 out of 5), OVID Medline (3.55) and PubMed (3.04), and least confident in using MeSH (2.08), Clinical Queries (2.24) and Clinical Evidence (2.28). Post-test highest improvement of confidence was seen in MeSH (2.007), PubMed Clinical Queries (1.679), and Clinical Evidence (1.693). Even the resources with the highest pre-test score (Google) had a significant post-test improvement in confidence (0.036).

For 'usefulness' the session got an average rating of 5.56 on a scale of 1 to 6. 66% said the sessions were excellent (6/6). 26% gave 5/6. Nearly 97% wanted this session to be held before the 4th year, 50 (36%) preferred the 3rd year and 48 (35%) the 1st year.

Discussion:
There is room to improve/change the resources used by final year students to keep up to date. Students' self-perceived confidence in the use of PubMed Clinical Queries, MeSH, pre-appraised evidence resources and general search engines that will be helpful for real-time evidence based practice, can be improved significantly with a single hands-on session. The session may have more value if given earlier in the medical program and repeated at least once. The long term retention rates or the translation of improved confidence into patients' outcomes were not studied.

Conclusions:
This study shows the relevance of having a focused 'evidence based practice' learning session after their 'formal EBM learning activities' to contextualize the theory into practice. In an era where rapid changes are taking place in the resources and methods of keeping up to date, a hands-on session to increase confidence was much valued by the students.

Postgraduate research student supervisor development within a clinical school setting – application of educational evidence to improve outcomes

A/Prof. C. Jones

Introduction:
Previous staff feedback via surveys and ad hoc comments indicated a need to make the existing University of Sydney program (via the Institute for Teaching and Learning) more relevant to the particular needs of clinical and laboratory-based postgraduate supervisors in a clinical school setting.

Objectives:
We aimed to identify the important elements of a postgraduate research supervisor development program for staff based within a clinical school.

Methods:
Fourteen supervisors participated in individual, semi-structured, audio-taped interviews. Interviewees were invited from 75 potential respondents to provide a mix of experience in supervision, gender, and type of appointment (academic clinician, surgeon, or research only staff). Individuals were asked prompt questions about postgraduate research supervision, their perceptions of the existing generic training program and what they would ideally need from a program to enable them to be highly effective supervisors. Issues raised were further explored via open questioning until interviewees had no further comments to make. Analyses of transcriptions were conducted independently by the researchers to identify important themes and mode of delivery for an alternate training program. Three interactive seminars were designed and conducted around major themes identified. Participants were then required to attend and present at an accreditation seminar Feedback from participants in the alternate program. was evaluated to inform a future discipline based program.

Results:
Responses were broadly grouped sixteen themes and grouped into four broad categories:

1. Features of an effective PG supervisor training program in a clinical school setting
   - Positive responses towards existing program
   - Needs for supervisor training program
   - Impact of supervisor's experience on supervisory style
2. Critical issues in successful postgraduate research supervision
   - Planning/ preparation for supervising PG student
   - Meeting/matching student expectations
   - Types/range of students
   - Communication/ Meetings with PG students
   - Monitoring students' progress
   - Getting students to write
   - Mentoring of students
3. Managing problems that arise in postgraduate research supervision
   - Students who fail to progress.
   - Students feelings/ motivation
   - Conflict
   - Time commitments
4. Needs for ongoing professional development of PG supervisors
   - Support of PG supervisor
   - Feedback about their supervision

The major topic areas for Seminars were identified from research data:
- Expectations in Postgraduate Research Candidatures,
- Monitoring Progress in Postgraduate Research Candidatures, and
- Supporting Writing in Postgraduate Research Candidatures.

Conclusions:
Prior to our research, there had been very limited uptake of the University's accreditation pathway for registration of potential research student supervisors in our Discipline. As a result of research and alternate program, six participants were newly accredited to be primary postgraduate research students for semester 1, 2009. Thus, faculty based development and accreditation programs for research supervisors will be utilized if they are accessible and relevant to their target population.

What teaching and learning methods do continuing nursing students consider most effective?

Hemant Mehta, Kathy Robinson

School of Arts & Sciences, ACU National, North Sydney, NSW

Introduction:
By the time they reach second year most nursing students have adapted well to university life and have developed a range of study skills. These students are thus in an informed position where they may evaluate what works best for them. Analysis of second year students' teaching and learning preferences will inform academics and allow them to cater to the ever changing needs of the 21st century student in a high technology world.

Objectives:
This study aimed to evaluate second year nursing students' opinions about the usefulness of a range of teaching and learning strategies.

Three successive second year (2006-2008) nursing cohorts (340-364 students each year) at a Sydney university were invited to participate in this mixed-methods study examining students' perceptions of teaching and learning in nursing science units.

Ideas for discussion:
- How best can academics prepare nursing students to become well-equipped lifelong learners?
- How useful are the current teaching and learning methods in meeting nursing students' needs?

Results:
Each of the three second year cohorts had a similar demography and the main findings were also consistent. Based on a response rate of 42.3% - 44.1%, the majority (86.3%) of students reported that they found it easy to use electronic technology for learning. These technologically adept students felt connected with each other and the course of study via eLearning (Blackboard).

Despite their electronic prowess, students valued their contact with academic staff; 88.5% responded that staff were supportive and responded to their learning needs. Many students seemed to prefer assisted or passive modes of learning. Their responses to how frequently they read science textbooks were: "weekly" 44.0%; "occasionally" 32.2%; "monthly" 10.0%; "daily" 9.6%; "never" 4.2%. Students stated that they considered problem-based learning (PBL) tutorial classes and lectures to be more beneficial than reinforcement style tutorial and practical classes. While many valued exposure to various teaching modes, when asked to prioritise effective teaching modes they reported the following preferences: lectures (33.0%), PBL tutorials (27.2%) and practical laboratory classes (16.3%). Students had a greater affinity for the study of anatomy and physiology (42.7%), and pathophysiology (28.1%) than pharmacology (17.1%) and chemistry and physics (5%).

In focus group discussions, several students expressed low confidence about their learning methods. Some formed small groups to learn "difficult science topics" or for revising for assessments, while others read their course work repeatedly, memorising large volumes of content. A few indicated that "a combined approach of various teaching modes was effective".

Discussion and conclusion:
It was encouraging to see the development of students' self awareness about how they learn best. Second year nursing students appreciated the range of teaching and learning approaches used by academics. While many students had preferences for a particular modality they could also recognise the value in other methods. The provision of varied teaching and learning approaches facilitates learning and enables students to prepare well for clinical practice.

Distress detection amongst student colleagues in a problem-based learning setting

Catherine Leahy

Medicine Learning and Teaching Unit, The University of Adelaide, SA

Introduction/background:
Medical students are reluctant to seek professional help for mental health problems and seem to be reticent to help colleagues experiencing psychological distress. Yet, adolescents are more likely to seek help from peers. Our research was conducted to explore medical students' approaches to colleagues experiencing psychological distress.

Purpose/objectives:
To determine the accuracy with which medical students detect the distress of colleagues within their Problem Based Learning (PBL) groups. To explore the participants' perception of other group member's distress level.

Methodology:
Medical students (Year 1, 3, 5) from The University of Adelaide, and convenience samples from the School of Law (Year 3) and Mechanical Engineering (Year 3) were invited to participate in a web-based mixed-methods project exploring distress and helping behaviours. As part of this larger project, students were asked to complete a measure of distress (including Kessler's Measure of Psychological Distress – the K10) for themselves and then to rate the distress of each of their colleagues in the PBL group (or equivalent small group). Students also provided text responses describing the distress levels of their groups.

Results:
A total of 1881 matched data pairs were available for related sample comparison. The distress levels for Raters (participants that provided a measure of a colleague's distress), and Ratees (students who were rated for distress) were significantly different ($p < .001$, $d = 1.61$). Raters underestimated the distress of their colleagues, and the difference between Rater and Ratee distress level scores was large. All disciplines were equally poor at detecting distress amongst colleagues. Year 5 medical students were slightly better at detection than medical students from Years 1 and 3. Raters gave increased distress ratings: 1) for colleagues that reported treatment for a mental health problem; 2) for local rather than international colleagues, 3) when the Rater was local, and 4) when the Rater was classified as psychologically distressed. The qualitative data indicated that on the whole students thought their groups were functioning successfully. The group's mode of functioning was determined by such things as; the PBL process, tutors, tiredness, workload, group member support and communication.

Discussion:
Distress symptoms were difficult to determine for the participants. All disciplines greatly underestimated the magnitude of their colleagues' distress. The results inform current research which examines medical student helping behaviours and helping preferences towards psychologically distressed colleagues.

Exploration of couples' relationships one year after their participation in standard versus modified antenatal education

Daniella Bulic

Calvary Health Care ACT

Introduction/background:
This study explored the impact of antenatal classes on transiting to parenthood couples who participated in standard, as well as Bringing Baby Home (BBH) psychosocially modified antenatal education, offered in June/July/August 2006 through Calvary Health Care ACT antenatal education. BBH modification introduced a psychosocial education into the standard antenatal classes that targeted couples at the time when they are most perceptive and need extra support.

Purpose/objectives:
The aim of this project was to test the hypothesis that 'Couples That Have Received Bringing Baby Home Modified Antenatal Education Reported Increased Relationship Satisfaction and Coping in a Year Following the Birth of Their Child'. The study endeavored to meet further objectives a) to facilitate limited community consultation through listening and exploring couples' realities; and b) to perform centered evaluation of the BBH modified antenatal classes in terms of evaluating if above classes equipped couples with cognitive and practical skills to successfully navigate through the transition to parenthood.

Issues for exploration/ideas for discussion:
This study did not access the full range of couples who transit to parenthood, in particular those from Culturally and Linguistically Diverse Background, Aboriginal and Torres Strait Islanders, homosexual couples and teenage parents. Another level of research with these couples may reveal different findings of how they cope during their transition to parenthood.

Results:
Although all interviewed couples reported experiencing changes in their relationship after the birth of their child, couples from the intervention group characterised those changes as a 'slight' crisis while couples from the control group reported going through more 'challenging' experiences. Two of them reported having to deal with a severe relationship crisis, another two reported going through 'slight' relationship changes, while one couple declared coping very well, reportedly due to their attendance of 'Pre Birth' relationship counselling through their Church.

Discussion:
This project presented a number of couples with an opportunity to share their experience of their transition to parenthood after participating in Calvary Health Care ACT Antenatal Classes and noted that each and every couple interviewed stated that they wanted more 'warning' on relationship changes.

Conclusions:
The above illuminates the need for the inclusion of the psychosocial component in standard antenatal classes, in terms of equipping couples with skills to negotiate their transition to parenthood. It further suggests the ways of improving hospital's antenatal education in order to empower potentially fragile section of community who are at the stage when they greatly need support and are open and perceptive to the new information.

Concurrent Sessions – 30 minutes PeArLs
Research

A beginner's guide to writing ARC grant applications

Prof. Ian Wilson

University of Western Sydney, Penrith South DC, NSW,

Introduction/background:
Two years ago ANZAME started on a program to improve the availability of research funds to those involved in health profession education research. We had conversations with both the NHMRC and the ARC. The ARC discussions have proven fruitful and they have now added a number of Health Profession educators to their team of OZReaders. Combined with the work of Brian Jolly in organising a Research Code for Health Professional Education has resulted in modest success.

Working with successful ARC applicants and being an OZReader allows the development of an understanding of what is successful and what is not.

To achieve greater success we need to increase the number of grant applications being written for the ARC.

Purpose/objectives:
The aim of this workshop is to demystify the process of writing ARC applications and to improve the number, quality and success of applications from ANZAME members.

Issues for exploration/ideas for discussion:
Please bring any proposals (on paper or in your head) that you would like to work on.

What types of grant are available?

What techniques do successful applicants use?

How are applications assessed?

What gets measured, gets done – discussing the link between placement assessment and interprofessional competencies

Robyn Smith[1], Jenni Smith[2], Megan Davidson[3], Karen Dodd[3]

Northern Health, Bundoora, VIC
Northern Health, Epping, VIC
Faculty of Health Sciences, LaTrobe University, Bundoora, VIC

Introduction/background:
The phrase "what gets measured, gets done" is a summary statement for a wider phenomenon. Students and educators link the perceived importance of different components of health professional education to the extent and focus of the assessment for each component. The literature on interprofessional clinical education clearly recommends that interprofessional practice needs to be an assessed component of a clinical placement if it is to be taken seriously by students and faculty (Davidson et al, 2008). However, there is less guidance in the literature on what constitutes an interprofessional skill or competency and how this can be assessed in the clinical placement context.

Purpose/objectives:
- To present the findings of a mapping exercise exploring the assessment approaches for interprofessional practice among a range of disciplines participating in an interprofessional clinical education project.
- To better understand the key interprofessional competencies that need to be demonstrated and assessed in entry-level clinical education.
- To identify a range of ways of measuring these competencies.

Issues for exploration/ideas for discussion:
- What are the key competencies that could be considered "interprofessional"
- What tools or approaches do PeArL participants currently use to assess interprofessional aspects of practice – specifically for entry-level health professional students on professional/clinical placement?

Developing a conceptual model to relate simulation to real-life clinical practice

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Introduction/background:
Simulation training for undergraduate and post-graduate medical education is becoming more common! This is especially important in the background of increasing medical student number and increasing emphasis on patient safety. Medical students and trainees can no longer have unlimited exposures to clinical environment and clinical teaching. While simulation training has been shown to improve technical skills of trainees, the exact impact of simulation training on the competency and performance of practitioners remains unclear. There is a lack of conceptual models to discuss simulation training and its impact on real-life clinical practice.

Purpose/objectives:
This session will benefit participants who are interested in simulation training.

This session aims to engage audiences to discuss how simulation training relates to real life clinical practice. The session will utilise video materials from simulation training sessions for acute resuscitation conducted by us in order to bring engage the audience in the discussion. The purpose of this section is to brainstorm and discuss the similarities and differences between simulated and real life clinical scenarios. We hope to discuss and share our own conceptual model of simulation training and obtain feedback from audiences to refine that model.

Issues for exploration/ideas for discussion:
- What are the benefits and disadvantages of simulation training?
- What are the similarities and differences between simulated and real life clinical scenario?
- What aspects of skills should simulation training be able to provide? And how these skills could be obtained by students through simulation training?
- Could simulation training improve competency and performance of students?
- Could we develop a conceptual model to relate simulation training to real life clinical practice? Audience will be asked to participate in the construction/refinement of our conceptual model.

Curriculum

Growing self-efficacy beyond Bandura: An augmented model for persistent pain and illness

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Introduction/background:
As advanced directives are issued by Health Commissions across the world for health services to embrace models of self-efficacy (based on an amalgam of Lorig and Bandura's work in the burgeoning fields of self-management in chronic illness), new interdisciplinary understandings about neuroplasticity and neuroendocrine involvement in persistent pain and illness states now begs a better understanding of the self-referential nervous system in any model of self efficacy. This requires an augmented interdisciplinary model of self-efficacy be considered that allows for a greater range of engagement with the sufferer without pathologising them unnecessarily with outmoded frames of body-mind dualism, which amounts to a social disparagement and deauthentication (Merskey, Habermas).

Purpose/objectives:
Bandura's four step model of self efficacy (2007) is analysed and augmented in terms of:

- Skills
- Models and Roles models
- Interpretation
- Social persuasion

Issues for exploration/ideas for discussion:
Self-Efficacy as it stands:

1. Skills – in imparting skills the danger is we still act as experts and the subject – observer divide is maintained wherein errant body-mind pathology reigns within outmoded frames of reference (Varela, Radrauf et al, Erdi, Szentagothai, Quintner et al, Williamson et al)
2. Models – the danger in this step is these models are informed by body-mind dualism and we end up pressing unilateral expert driven models that are not only muddled and circulatory but we know the sufferer is reluctant to engage (Quintner et al, 2008)
3. Interpretation – the danger is the interpretations are still being formulated by expert driven frames of interpretations (see point 2) that we know to be problematic, unidirectional, which are too often lost on the sufferer (Wittgenstein, Derrida, Peters, Buchanan)
4. Social persuasion – the clear danger is that in persuading we are again reflecting a social interpellation (Althusser, Foucault) upon the sufferer rather than a social authentication (Habermas) that connects and empowers.

Augmented model:
Base position: *absence of evidence for pain is not evidence of absence of pain* **(**Williamson, Buchanan**,** *Pain, 2005***).**

1. Skills – what skills and knowledge does the self-referential brain afford us to impart to sufferers in a genuine spirit of openness and humility commensurate with the limits of our expertism: i.e. we need to be more honest about our knowledge base, theoretical and practical frames used in our practice, the science that underpins this process, our understandings, hypotheses, theories, laws… These skills, which we already have rather than shut down ongoing interpretations – that is to say seek to decipher an absolute truth about the sufferer's condition - should instead open up other interpretations, ones that are ongoing and active – in that these skills activate the sufferer to join in this process.
2. Models – what models and role models can we offer to cooperate with these skills to affirm the sufferers own role in engaging and affirming their lives not despite but because they are in pain… These models ought to engage the sufferer in their experience – and ought to target sense-making with actively participating in the new found skills.
3. Reinterpretation – an ongoing engagement at the level of the sufferer in their daily interpretations of their pain state and/or life. This is a crucial third point and must be able to take place in the intersubjectivity of the third space and offer up an active interpretation that amounts to an ongoing re-interpretation. This is active treatment in actual progress. Here

the aim is to expand the repertoire of options to keep this ongoing reinterpretation not only active but meaningful for all concerned in the uniqueness of their interpretation – their narrative – their engagement…

4. Social authentication (as opposed to persuasion)… Each of the previous three steps must invite and ultimately lead to a sense of community, connection and authentication not just of their pain but their subjecthood and intersubjecthood – this is a sense of authenticity leading not just from selfhood but mostly from others - i.e. the dignity, respect and acknowledgement we accord each other to authenticate each other.

Under this new model these steps are not in some teleological and temporal progress but always interwoven always cooperating always intersecting…

Student grand rounds – an innovative interdisciplinary teaching strategy

Dr H. John Fardy[1], Murray Campbell[2]

[1] Regional Hospital Academic co-ordinator, Wollongong Hospital and Clinical Associate Professor, Graduate School of Medicine, University of Wollongong

[2] 3rd year Medical Student, Graduate School of Medicine, University of Wollongong.

Introduction/background:
One of the more important skills of the medical practitioner is the ability to convey information about a patient to a colleague. As part of their early clinical learning, students do clinical clerking on a regular basis.

By linking these core skills together, we have developed the concept of 'Student Grand Rounds" where students, on a rostered basis, do a preparatory full clinical clerking which they then present verbally to their peers. Cases are presented orally as if the patient is being handed over to a colleague (no Powerpoint®). A medication list is to be presented. Results of imaging and other investigations must be accessible.

The case is then open for discussion and apart from the cohort of students present (all those in medical and surgical attachments, n=30) discussants include The Professors of Medicine and Surgery, a Senior Clinical Pharmacist and the Hospital Academic Co-ordinator. Other senior clinicians (who have roles with the students as Clinical Preceptors) are invited to attend.

Discussion topics may range the breadth of clinical medicine, reinforcing the university teaching program and exposing the students to the complexities of clinical practice in patients' representative of those found in medical and surgical wards.

A student view on the Student Grand Rounds as an experiential learning exercise (as presenter) and from a clinical learning perspective (as audience) will be presented.

Engaging Generation "Y" students through curricula and extra-curricula activities: Developing transferable abilities

Professor Susan Ryan[1], Rochelle Kentish

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Introduction/background:
Much of the literature about Generation "Y" students is anecdotal and much stems from business studies of employees rather than from studies of undergraduate health professional learners. Arguments against the hegemonic classification of a generation are now appearing in large Australian studies (Bright, 2009) that state there are more differences between members of one generation rather than between actual generations. This last statement may have truth, nevertheless, group characteristics rather than individual characteristics do appear to assert collective behavioural descriptors that appear to align themselves within the popular Generational "Y" literature. It may be that this "Y" generation is more discerning, more critical, more widely knowledgeable and less likely to accept learning experiences that they perceive as less than optimal for their current needs. It may be that learning facilitators need to be much more explicit about the ways of learning that they are employing as well as being more educationally-wise to newer, more interactive/interesting ways of learning.

Purpose/objectives:
With these contradictory arguments in mind two parallel initiatives were started with a group of undergraduate students in a regional Australian University. One was a research study, the other was a joint staff/student initiative that sought to pro-actively introduce student-led extra-curricula activities that promoted transferable professional abilities.

The research study focussed on the undergraduate learners within the specific profession of occupational therapy. The researchers were interested to see if this group, who collectively not individually, displayed Generational "Y" characteristics, could differentiate the learning methods that they perceived to be the most valuable to their current learning needs. Focus groups were held from each cohort and these findings were relayed to the remainder of the cohorts for further comment.

In parallel with the above research study a pro-active staff / student group introduced extra-curricula activities that were aimed at crossing the staff / student relationship as well as the inter-year class relationships. Developing pride in the profession, having fun and following worthwhile causes were some of the aims across the four cohorts of students. "Making A Difference [MAD] was the motto!

The two parallel programs sought to engage these generation "Y" students in ways that they had initiated.

Issues for exploration / ideas for discussion:
- Working with students – for students – promotes pride in their achievements.
- Involving students increases motivation for their professional learning.
- Student learning initiatives enhances staff facilitation abilities.

Assessment and evaluation

Linking assessment to learning for authentic practice

Gudrun Dannenfeldt[1], Jane Stewart[1], Kevin Stewart[1], Victor Fester[1], Jackie McHaffie[1], Rose Hipkins[2], Gudrun Dannenfeldt[1]

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Introduction/background:
The findings from a previous projects indicated that increased student engagement in learning science did not translate directly into improved assessment outcomes. Seeking to understand this, science tutors identified a possible mismatch between the intent of the intervention and the focus of the assessment tools they continued to use.

Purpose/objectives:
The aim of the proposed project is to explore ways to match assessment with innovative changes in pedagogy and curriculum in science education, so that assessment provides evidence of the links students make to authentic practice.

The purpose of the project is to research modes of assessment which support learning.

Issues for exploration/ideas for discussion:
The research questions are :

1. What type of evidence could show that students are making links between their science learning and their nursing practice ?
2. Educators need to develop, teach, assess and report on science-based competencies.
3. What assessment methods could be used to make appropriate judgments about these types of evidence ?
4. Research innovative assessment methods to strengthen the link between learning and future professional roles.
5. How do students understand and respond to these assessment methods ?
6. Assessment drives student learning, thus the need to enquire about students understanding and responses to new methods of assessment and the impact they have.

The research methodology is based on an action research model with the involvement of the researchers and researched, seeking improvement in practice, understanding practice and improving the situation in which the practice takes place.

Overall, changing assessment practices can be one of the most effective interventions to improve teaching and learning.

Assessing communication skills in clinical settings

Dr Susan J. Hawken

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Introduction/background:
Assessing clinical communication skills in a valid and reliable way continues to be a challenge to health professional educators. Traditionally undergraduate communication skills assessments have been in simulated settings rather than in the clinical environment. However in postgraduate training assessment has already moved to real observed interactions. In the MBChB programme at Auckland year 4 medical students undertake a consultation with a simulated patient that is recorded on a DVD which they then use to appraise their own performance. Later the examiners assess the students' performance as well as their level of insight into their skills. A study (with ethical approval) was undertaken in 2008 to evaluate the usefulness of this examination in terms of developing the students' patient centred skills, and ability to evaluate their own performance. A secondary purpose was to ascertain if the preparation for the assessment and the actual examination was cost effective in terms of adding value to learning for all students, not just identifying poorly performing students. There appears to be a need to create meaningful, reliable and practical assessments of clinical communication skills. Current drivers for change include the pressures of increasing student numbers; fewer opportunities for senior medical staff to observe students taking histories (due to demand on service providers) and the increasing emphasis on communication and professionalism.

Purpose/objectives:
- To explore the issues in clinical communication assessment and to collate a framework for the development of an assessment process which aims to assess 'real' performance of clinical communication skills in different clinical contexts.

Issues for exploration/ideas for discussion:
- How to create valid and reliable assessment methods of core communication competencies for use in different clinical contexts that are also practical under resource limitations?
- How to work with clinicians from varying discipline areas to identify which core components of communication are best suited to being assessed in which discipline/clinical context?
- Identifying barriers to collaboration on the development of this assessment procedure.
- To explore how other members of the healthcare team may contribute to such clinical communication skills assessments.

How do we represent multi-source feedback in reflective learning requirements?

Karen Knight

School of Medicine and Dentistry, James Cook Univeristy, Townsville QLD

Introduction/background:
As part of our reflective practise, the Medical Education Unit in the School of Medicine and Dentistry at James Cook University have undertaken a review of our 'Learning Portfolio'. The Learning Portfolio has been the vehicle through which we have encouraged our students to develop and monitor their reflective learning and professional behaviours.

One of the greatest difficulties faced is the issue of where and how to incorporate multi-source feedback, also known as 360 degree feedback. Feedback from students suggests three main difficulties with multi-source feedback.

1. Student peers mostly fail to make negative comments;

2. Patients usually only make 'nice' comments; and

3. Students see such a large variety of staff whilst in hospitals, it can be difficult to find someone who has had sufficient consistent contact with them to validly complete such an evaluation.

Our review lead us to the conclusion that we needed to ensure that we connected reflective activities to student learning. Essentially, we need to utilise our reflective activities to reinforce and consolidate other learning activities. The impact of this on multi-source feedback is that it needs to be more than simply getting people to complete these forms. We need the students to believe in them, and then make use of the feedback they provide.

Purpose/objectives:

- To hold a discussion on how to integrate multi-source feedback in education of medical students, whilst using it to encourage reflective practice.

Issues for exploration/ideas for discussion:

- Identify how we make multi-source feedback meaningful to students to enable appropriate reflective practice. Facilitate discussion on what the literature says, and the anecdotal evidence of participants.
- Uncover how we as educators, can encourage clinical supervisors to understand the importance of this process so that they provide accurate, honest and meaningful feedback to students. How do we encourage clinical supervisors to do more than tick a box?
- How do we achieve these diversified ideas within budget and time constraints?

Clinical Supervision: What is needed to build effective workplace-based supervisory capacity for IMGs?

B. Bird[1], B. Sutton[2], Prof. B. McGrath[3], Prof. B. Jolly[1]

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[3] Southern Health, Department of Vascular Sciences & Medicine, Dandenong Hospital, Dandenong, ViIC

Introduction/background:
Recent changes to the process of recruitment and assessment of International Medical Graduates (IMGs_have included the need for work-based evaluation as well as pre-employment assessment for those not eligible to work in Australia under the 'Competent Authority' model (Reid, 2007). As part of this evaluation process a period of in-training monitoring, supervision and appraisal has been suggested

A key element of the new registration arrangements is the provision of supervision, monitoring and in-course assessment for IMGs by the hospital health services employing them (Medical Board of Victoria, 2007). Very little is known about the capacity of health systems in Australia to provide good quality supervision at the pre-vocational level. What is known is not very encouraging (Paltridge 2006), and mostly based on comparisons of anecdotal evidence from Australia with Canadian and British systems (Paltridge, 2006; McGrath et al, 2006).

Key components of successful clinical, work-based supervision for junior doctors and IMGs are that the supervision must be structured, consistent and regular (Kilminster & Jolly – 2002).

Southern Health, as Victoria's largest Healthcare Network engages with a number of International Medical Graduates who are working or seeking work in Victorian public hospitals. Southern Health is undertaking a study (December 2008 – May 2009) into the supervision capacity of the network in order to enhance clinical/ work-based supervision.

The methodology has included distribution of questionnaires to all levels of medical staff including IMGs and a series of focus groups and one-on-one interviews with key stakeholders.

Purpose/objectives:
The study seeks to examine:
- what clinically based supervision currently exists at Southern Health
- the current supervisory loads of clinicians in order to establish a benchmark for best practice in clinical supervision at Southern Health
- to establish a framework for building supervisory capacity for IMGs and to
- develop a strategy, underpinned by the framework, for ensuring the efficient and effective training of supervisor of IMGs.

Issues for exploration/ideas for discussion:
What are the expectations relating to clinical / work-based supervision of the key stakeholders?
- Supervisors and Senior Medical Staff
- IMGs
- Pre-Vocational and Vocational Trainees

What is the current capacity in Australian Public Hospital to provide clinical supervision?
What are the challenges of providing adequate clinical supervision?
How can the challenges of providing adequate supervision be met?

Evaluating professional development training: Moving beyond participant reaction to monitoring behaviour change and reporting results

Dr Margaret Potter, Professor Fiona Lake

School of Medicine and Pharmacology, University of Western Australia.

Introduction/background:
Historically most professional development training programs are evaluated used a course evaluation survey with self-reported learning that is easy to complete and generally implemented at the end of the training[1]. This feedback while useful to gauge the experience of participants and to gain suggestions to improve future programs does not measure the extent to which learning has occurred, whether it has translated to a change in practice and what has been the impact on a broader team or organisation level. Determining these outcomes with health professionals is often very challenging as there may be limited available time, as well as human and financial resource constraints, no control group for comparison purposes and program participants can be easily lost to follow up.

Despite the potential difficulties associated with in-depth evaluation of professional development training programs, by doing so it is more likely we can determine with a level of confidence the effectiveness of training in terms of the nature and extent to which an individual, team and/or organisation has derived benefit, and thus whether it is worthwhile for the training to continue or be expanded.

Kirkpatrick and Kirkpartrick[2] propose four levels of program evaluation that include measuring (1) participant reaction; (2) learning; (3) behaviour change and (4) results or return on investment. By utilising this model one can readily build upon the course evaluation survey (level 1) and potentially incorporate pre and post-knowledge assessment (level 2). Identification of both direct and indirect measures of behaviour change through self, peer or third party report and/or observation can assess behaviour change (level 3). To determine the ultimate return on investment, consideration of measures (both qualitative and quantitative) that assess individual/team improvements in terms of competence, confidence and capacity can highlight the benefits of the program to management (level 4).

Purpose/objectives:
In this session we will:
- Share evaluation findings of an educational program using the four-level model proposed by Kirkpatrick and Kirkpatrick[1]
- Seek input from participants regarding different forms and levels of program evaluation that they currently utilise or have utilised in their work
- Brainstorm cost effective ways to measure learning (level 2), behaviour change (level 3) and return on investment (level 4) that may assist program evaluation in health professional settings

Issues for exploration/ideas for discussion:
- How do you routinely determine the quality of professional development training programs for health professionals?
- Based on the evaluation model proposed to what level do you regularly evaluate your professional development training program(s)?
- What are the major barriers to in-depth program evaluation and how can these be managed or overcome?

Matrix re-loaded – leadership and networks for implementation

Siobhan Harpur

Director Statewide System Development, Department of Health and Human Services, Tasmania

Introduction/background:
The imperative for working together has been long understood and as traditional hierarchies are being replaced with multi-agency, cross-boundary, inter and intra organisational governance, networks are the new policy instrument for getting things done (Adams and Hess, 2007)

Successful reform and implementation is reliant on cooperation between health services, non-government and private service providers, clients and patients and the broader general population. The networks required depend on the leadership, flexibility, adaptability and responsiveness of the individuals and the organisations they work in.

The Tasmanian Health Plan was launched in May 2007 stating the need to "re-design the health system to improve health services and community health and well being."(Tasmania's Health Plan 2007:4)

Leadership is required at every level to refocus services and achieve integration wherever possible, and there is value in identifying, fostering and further enabling the networks and the capabilities to respond and collaborate.

Purpose/objectives:
An inter-agency leadership group was established in December 2007 that recognises that the successful implementation of Tasmania's Health Plan requires a new leadership which is distributed and co-produced over time. Kanter (1993) coins the term of "change architect" to symbolise some of the innovation required, identifying the need to work with structures, relationships and language in order to create effective change.

The group met using the facilitation/group method of Open Space, developed by Harrison Owen in the 1980's, and with links to an action learning approach, provided the opportunity for

- networks of trust and reciprocity, through meeting and working with different people and in different ways
- potential to resolve conflicts before they are played out in more formal environments
- potential to expedite initiatives and projects in the Tasmanian Health Plan which could reduce the transaction costs
- creating an "ideas incubator" for spreading change
- review the utility of the Open Space approach

Issues for exploration/ideas for discussion:
A range of opportunities are emerging and more may result that would be useful to discuss for application in other environments, including;

- improved coordination and informal communication networks, innovative examples of reflective practice
- the action learning approach, the utility of Open Space and the attractiveness of the technique
- comparisons with Communities of Practice, Action Learning Sets and other methods
- developing local champions of collaboration and networking
- generating stories of success that can be shared more widely across the system,
- the co-production of knowledge and expertise
- a commitment to further leadership skills development – this and other ways?

Moderating and Evaluating a Wiki Assignment @ UNSW

Dr Rachel Thompson[1], Dr Chris Hughes[1], Dr Peter Harris[2], Dr Gary Velan[1], Jake Surman[3], Suzanne Mobbs[1]

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[2] School of Public Health and Community Medicine, UNSW
[3] Medicine Computing Support Unit, UNSW

Introduction/background:
"Wikipedia" launched quietly in 2001 but now boasts an amazing 684 million visitors a year (2008), 75,000 active contributors working on more than 10 million articles in more than 260 languages". The attraction of free, easily searched and accessible content written through on-line collaboration with open, justified editing has attracted vast numbers of writers, editors and readers. This success has spawned various 'wikipedia-like' offspring, both local and international, as well as software to launch your own 'wikipedia' (e.g. Mediawiki). The Wikimedia Foundation has several other sister projects (e.g. Newswiki). Wikipedia has proved so successful that the Encyclopaedia Britannica is launching its own more formalised collaborative on-line version of its famous encyclopaedia this year . The attraction for most contributors to Wikipedia is the collaborative writing and editing of a wiki page. We thought that the topic-based research and writing, peer-learning via the wiki-editing and learning of skills in on-line formatting, would be attractive and useful to our undergraduate Medical Program students at UNSW.

Purpose/objectives:
The eMedWiki project at UNSW was intended to improve the peer learning experience and also content learning within Phase 1 of the Medicine Program by utilising these special properties. The end result over a few years would also be a helpful, continually edited and updated repository of notes to assist student learning. An assignment task was developed for the two Phase 1 (year 1 and 2) courses in the medical program at UNSW. The wiki assignment required students to construct a wiki page on a set topic. Wiki authors then edited and discussed a peer's wiki and reflected on this process in their final submission. This assessment is based on graduate capabilities (as are all of the new medical program assessments) and contributes to the Phase 1 portfolio which is an end of phase summative and hurdle examination.

Issues for exploration/ideas for discussion:
This PeArL will demonstrate the UNSW 'wikipedia', describe the assignment in more detail and show examples of submitted wiki assignments in order to explore the following concerns about:

- How to moderate the eMedWiki content and editing?
- How to maintain the eMedWiki?
- Who should be able to view eMedWiki?
- Who should be able to edit eMedWiki? –editorial oversight and control
- Copyright issues in wiki writing
- How to assess the peer-learning element of the eMedWiki assessment and improve it, if it is failing.

Homeopathic clinical reasoning in Australia: Early investigation and implications for complementary and alternative medicine (CAM) education

David Levy, Rola Ajjawi, Chris Roberts

Office of Postgraduate Medical Education, The University of Sydney, NSW

Introduction/background:
Despite orthodox resistance (Ernst, 2008), homeopathic medicine is widely practiced in Australia, by some doctors though mainly by complementary and alternative medicine (CAM) practitioners (Cohen, Penman, Pirotta, & Costa, 2005). The National Institute of Complementary Medicine (NICM) was established in 2006 to fund research into CAM practices. Whilst the practice is growing and the public demands services, little research exists explaining the characteristics of homeopathic clinical reasoning. It is not clear whether homeopathic reasoning differs substantially from the reasoning strategies employed in medicine and in other health professional disciplines.

David is undertaking doctoral research into homeopathic clinical reasoning and its education. A summary of the state of homeopathic clinical practice as well as current homeopathic education will precede discussion of the intended research. Using a qualitative approach and data collection methods which include video- and audio-taping of consultations, observation and semi-structured interviews, it is anticipated that research participants will be able to explore their reasoning experiences and knowledge in depth.

Purpose/objectives:
Amongst participants with an interest in the CAM professions this session will help to expand and challenge conceptions of homeopathic clinical reasoning. It will also explore educational strategies and principles for developing clinical reasoning capability. We envisage other health professional educators and qualitative researchers will be able to reflect on and challenge their experiences and insights in relation to this topic.

A deeper understanding of homeopathic clinical reasoning has implications for current and future homeopathic and CAM education. It may also have implications for other medical and health science curricula or issues relevant to CAM clinical education.

Issues for exploration/ideas for discussion:
Conceptions and the nature of clinical reasoning in homeopathy specifically and the CAM health professions broadly.

- Appropriate ways of investigating clinical reasoning.
- Effective ways of developing clinical reasoning capability in entry-level education and postgraduate professional development.

Exploring learning styles among first year nursing students

Santha James, Angelo D'Amore

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Introduction/background:
The foundation science course for nursing students at our University is presented through a combination of methods and media; predominantly through lectures and worksheets. Given the present increase in intake of students to meet the national priority and rising international demand, it is important to trace the changing profile of our Faculty's nursing students.

Our students come from different educational and cultural backgrounds. They are a mix of school-leavers and mature-age students, from English- and non-English-speaking backgrounds, and from rural or metropolitan areas.

Different discipline areas might attract learners with different learning styles.[1] Pedagogical practice needs to be linked to the learning styles of the learner. So, it is important to assess learning styles and determine whether we are meeting the individual needs of learners as we endeavour to achieve general professional standards in large group teaching.

Purpose/objectives:
Our aim is to sketch the profile of First Year Nursing students at our University and investigate their learning styles and preferences. We hypothesised that differences in demographic background will influence learning styles and preferences.

Issues for exploration/ideas for discussion:
A demographic survey incorporating the VARK (Visual/Auditory/Read-Write/Kinaesthetic) Questionnaire, [2] and Kolb LSI (Learning Style Inventory) [3] was used to investigate the learning styles and preferences, respectively, of first year nursing students at two campuses of our University. The VARK Questionnaire identifies perceptual preferences and the LSI classifies students as convergers, divergers, assimilators or accommodators.[4]

This project has helped us to appreciate the diversity of our student cohort. At the same time, it raises many questions and issues:

- Do nursing students at other Universities learn best by a similar VARK mode and Kolb mode?
- How strong is the association between particular modes and demographic backgrounds?
- Will the first year preferences prevail or will it become more homogenous as students gain profession-specific training over the years?
- Is there evidence for a clear association between particular learning styles and achievement in foundation science courses?
- As lecturers, can we apply our findings to tailor our teaching styles and adjust our course resources to match the students' learning styles, to appeal to the type of students we teach?
- Or, rather, should we expose our students to non-preferred sensory and learning modes to maximize their learning potential?
- How can we design novel curricular activities to enhance science learning through multimodal (VARK) approaches and integration of the four fundamental modes according to Kolb?

Friday 3 July 2009

Curriculum research and development

Research projects in medical specialty rotations

David A Kandiah

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Introduction/background:
Full time clinical medical students attending specialty rotations can consolidate their knowledge and skills in the specialty by performing a research project in addition to their clinical commitments and set tutorials.

Performing this research and discussing the research methods, literature review and analysing the results will allow medical students to appreciate the key issues related to that specialty even if their project is on one specific area.

Purpose/objectives:
All students allocated to the Rheumatology specialty rotations in late 2008 and from 2009 onwards, have to prepare a research project to completion sufficient for presentation at scientific conferences and /or publication. The two students attending the specialty at the end of the year were offered a number of projects based on the patients they had seen in their first week. A specific topic which was both relevant to the patient/s seen and topical in the world literature was chosen for research.

Issues for exploration/ideas for discussion:
Students can be stimulated to think of research topics relevant to the patients they are seeing.

Helping students appreciate the role of clinical research and how this can push the frontiers of medical knowledge and evidence-based care.

If research data are to be presented, please include the following sections:

Results:
The topics chosen by the 2 students last year were presented at the Hospital Annual Symposium and the State specialty scientific meeting. Their presentations were well received by the audience of academics and clinicians, who were impressed and encouraged by their efforts to systematically analyse the clinical problems. These were real-life situations that they themselves actually face. The students showed that they were able to investigate the literature for trends, optimum care and further understanding of the pathophysiology of the diseases studied.

Discussion:
Students self-directed focus on obtaining information, papers and collecting data for their project.

Conclusions:
This is a suitable method to stimulate students early in their careers to research clinical topics. This may stimulate some of them to enter specialty training and even combine this with a research career even though the current trend for graduate medical students is to focus on clinical work.

Practising evidence-based medicine at the point of care: The views of junior doctors

Dr Kumara Mendis[1], A/Prof. Joe Canalese[1], Samantha Van Staalduinen[2], A/Prof. Chris Roberts[2], Tanya Forester[1]

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Introduction/background:
A component of this study's strategy for examining how well new intern doctors practice EBM was the tracking of intern doctors' individual online access to the Clinical Information Access Program (CIAP), done by allocating to each participant a special user name and password (UNPW). CIAP provides access to clinical information and resources to support evidence-based practice at the point of care to all Australian hospital doctors. A hypothesis of the larger study was that JMOs' searching for clinical information would be related to their clinical knowledge and clinical competence. After six months, CIAP web logs showed two groups: those who had never or barely ever logged into CIAP – low end users (LEU), and those with a high CIAP log-in frequency - high end users (HEU). The HEU group was the clear minority.

Purpose/objectives:
We explored the reasons behind the discrepancy of CIAP use by doing structured and semi-structured telephone interviews respectively with LEU and HEU. Analysis was done using Framework Analysis.

Results:
Most doctors stated that their use of CIAP varied depending on the term they were completing.

Their primary use of CIAP was for resources such as MIMS and the Therapeutic Guidelines, rather than the journal databases. Most of their journal and database access was from home and not from the wards. Asked what else they would like to see included in CIAP, the majority of HEU cited Up-to-date.

The difference in high and low users was an artefact of the study. The majority of LEU stated that they did login to CIAP at least daily, but did not their individual UNPW. The reasons for this were: not needing to log on for access as many metropolitan hospital computers are continuously connected to CIAP, time constraints, or that they had either lost or forgotten their study UNPW.

While the HEU logged in using their UNPW much more often than the LEU, even they stated that due to time constraints, their actual log-in rates would have been much higher than those recorded by the study web-log analysis.

Discussion:
The study was carefully designed to track JMO usage of CIAP but even three seconds (the time needed to log-on to CIAP using the assigned UNPW) is precious when looking for evidence to support clinical care. This may be an obstacle to web-log tracking as a useful research tool. In order to accurately track what JMOs are looking at, we would like to discuss opportunities for CIAP to consider the potential value of individual log-ins. We discuss a number of strategies for working with individual institutions or Colleges in order to make use of already existing infrastructure/technology for improving evidence-based practice among new doctors.

Conclusions:
This underlines the importance of qualitative methods in clarifying issues of problems in quantitative web-log analysis.

Development of a method to assess performance of entry level physiotherapists: The assessment of physiotherapy practice (APP)

Megan Dalton[1], Professor Jenny Keating[2], Associate Professor Megan Davidson[3], Dr Natalie de Morton[4]

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Introduction/background:
Valid, reliable and practical assessment procedures are important for meaningful summative assessment of the clinical performance of physiotherapy students.

A preliminary search of the physiotherapy literature revealed a lack of systematic studies to determine the validity and reliability of instruments for assessing clinical competence of students in physiotherapy programs.

The APP was developed to standardise evaluation of clinical competence of physiotherapy students in Australia and New Zealand.

Purpose/objectives:
To investigate the psychometric properties of the APP instrument using Rasch analysis.

Sample:
A total of 747 APP assessments were conducted on physiotherapy students from nine universities in Australia and New Zealand. Three focus groups and 9 'think aloud' interviews were conducted and 189 surveys were returned by clinical educators.

Methods:
The APP consists of 20 items, each with 5 response options (0-4). The APP was administered by clinical educators during usual clinical placements. Students attended a comprehensive mixture of practice environments across core areas of physiotherapy practice such as musculoskeletal, cardiothoracic and neurology. Qualitative methods were employed with to assess clinicians' views on the utility of the instrument.

Analyses:
Rasch analysis was conducted to assess overall fit of the data to the model, the response scale, individual item fit, differential item functioning (DIF) and person separation.The clinician surveys were analysed using descriptive statistics and thematic analysis of transcripts of the focus groups and interviews.

Results:
Analysis showed overall fit of the data to the Rasch model. The difficulty of the items was well matched to the abilities of the persons being assessed and the 5-level rating scale performed as expected. Analysis demonstrated excellent person separation (0.92), little disordering of the thresholds and no evidence of differential item functioning for gender, age, clinical area, or educator experience.

Conclusions:
Rasch analysis and qualitative data supported the validity of the APP and support for its application as a measure of clinical competence across a diverse range of clinical environments. Clinician feedback supported the use of the APP.

Development of workplace-based assessment methods and approaches to patient safety

Beverley Bird, Dr Tangerine Holt

Monash University, Notting Hill VIC

Introduction/background:
This project, funded by Department of Human Services (DHS) Victoria, specifically addresses patient safety issues with respect to the orientation, training and competence of International Medical Graduates (IMGs) who make up around one third of the Australian Medical Workforce and 13% (725 doctors) of the total Victorian public hospital workforce. In collaboration with key health service organisations, simulation and education centres across Victoria, Monash University and the University of Sydney undertook *The Patient Safety Study.* The Study undertook the process of developing, trialling and validating an integrated suite of workplace-based patient safety assessment tools.

The *Patient Safety Performance Profiling Tool* (PSPPP) is the core tool of the suite developed in response to the identified need for national standards of competence and safety in the delivery of healthcare in Australia.

This presentation will discuss briefly the background to contemporary work-placed patient-safety initiatives internationally and nationally, the development of the PSPPT which is based on the Australian *National Patient Safety Education Framework (Walton et al 2005)*; the Think Tank review of the PSPPT and patient safety issues, and the trialling of the tool in the workplace setting

Purpose/objectives:
- To engage in a wide-ranging discussion on patient safety with an emphasis on IMGs;
- To identify key principles of patient safety in the workplace;
- To identify the impact of the utilisation of workplace assessment on patient safety and its systemic effects;
- To discuss the aetiology of the patient safety tool;
- To provide the opportunity for participants to evaluate the adequacy of the PSPPT item pool;
- To discuss the application of the PSPPT in relation to workplace assessment for all levels of clinicians.

Issues for exploration/ideas for discussion:
- Patient safety within clinical settings – should it be audited and if so what areas should be included in the audit?
- Is it feasible to carry out individual clinician patient safety audits using MiniCEX / DOPS approaches in a busy hospital setting?
- Who should undertake the patient safety audits and how many audits should each clinician undertake?
- Should all levels of health care practitioners be subject to patient safety audits

A qualitative study of the effect of Mini-CEX on postgraduate supervision

A/Prof. J. Weller

Introduction:
We previously reported the strengths and weaknesses of the Mini-CEX in anaesthesia. (1). Its positive educational impact was offset by assessor variability in scoring, leniency, and reluctance to fail trainees.

This qualitative study aimed to explore how the Mini-CEX affected interactions between trainees and their supervisors in order to develop strategies to optimise its implementation and educational value.

Methods:
We conducted surveys, focus groups and interviews with trainees and specialists familiar with the Mini-CEX. Data were recorded, transcribed and entered into nVivo8. Themes were identified using the constant comparison technique (2).

Results:
We coded data into the following themes:

Assessor Factors: assessor skills and how they used Mini-CEX; what influenced scoring; effect on specialist-trainee relationship.
Trainee Factors: value according to training level; impact on trainee performance.
Teaching and Learning: impact of focussed observation on knowledge of trainee; impact on structuring teaching and learning.
Feedback: usual environment for feedback and how it changed; value of feedback relative to expected standard; effect on quality and quantity of feedback.
Mini-CEX process: factors affecting acceptance and implementation; ease of use; case selection; initiating assessments.
System: Concerns regarding use of assessments; comparison with current in-training- assessment; identifying poor performers.

Discussion and conclusion:
Mini-CEX formalised the supervisory relationship, promoting educational conversations. During the observation period, trainees took responsibility for decisions, and specialists learnt more about their abilities. The structured form broadened the scope of positive and negative feedback, but specialists were uncomfortable awarding failing scores on this scale for a number of reasons. A scale rating level of independence with the case may be more intuitive. Initiation of assessments was problematic and the assessment could alter trainees' performance.

Based on our data, we propose the additional recommendations for Mini-CEX.
Implementation:
- Assessments should be frequent and routine.
- Need explicit, written "rules" for conducting assessments.
- Available on-line.

Training in Mini-CEX should include:
- Optimising the benefit of feedback.
- Addressing poor performance.
- The various roles of the clinical teacher (assessor, colleague, teacher etc)
- Identifying "learner level" through focussed observation (identify limits of trainee knowledge, skills and decision-making)
- Targeting teaching to "learner level" to build on existing knowledge and abilities.

Rating Instrument:
- Rate against expected standard.
- Different criteria for beginner and advanced trainees;
- Consider rating "level of supervision required to manage this case".

Our study describes how mini-CEX affects supervision, areas for assessor training and implementation strategies.

Exploring teaching strategies and the application of client-centred care during undergraduate physiotherapy clinical practice

Keri Moore

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Background:
The worth of any clinical teaching program can be measured by the extent to which it meets both the students' learning needs and is consistent with the health care needs and the rights of the client.

Purpose: To explore the perceptions of students, facilitators and clients regarding present-day clinical teaching, learning and client care events.

Method: Using survey, observation and interviews the illuminative evaluation, explored the motivation of the key participants to identify ability enabling elements for learning in a clinical teaching setting.

Ideas for discussion:
What clinical teaching behaviours and strategies promote client-centered care?

Results and Discussion:
Students say the greatest impact on learning is derived from the discussion surrounding the clinical encounter. Students actively seek feedback from clients and clients do give genuine feedback about how the students' activities are affecting them.

The feedback students are given from their facilitators and the clinical facilitators' teaching behaviours are in accordance with what the literature says is best practice. However, when the students' suspect the client may have had an adverse clinical event, they do not always discuss this with their facilitator.

Conclusion:
There are three Phases in contemporary physiotherapy clinical teaching strategies: i) Preparatory, ii) Management, and iii) Explanation and a Reflective Phase, which are underpinned by both the experiential model of teaching and learning and the principles of client-centred care. Physiotherapy clinical facilitators in this study were, in the main, able to address the student's learning needs and balance this with responding to the client's rights, needs and preferences.

Workplace-based learning and the midwifery follow through program

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[2] Associate Professor, School of Nursing and Midwifery, Flinders University, Adelaide, SA

Introduction/background:
Contemporary midwifery practice is developing models of midwifery care that support continuity of care and carer. Working in partnership with women is an integral aspect of providing women centred care in these models. Midwifery students are required to develop partnerships with pregnant women as a major component of their Work Integrated Learning (WIL) experiences. The Follow Through Experience (FTE) is a mandatory component of the national midwifery curricula standards where midwifery students are required to undertake 30 FTEs over the duration of the three year Bachelor of Midwifery program. The students' clinical involvement in the FTE is dependent on their year level where they go from undertaking an observational role under the direct supervision of a registered midwife to increasing participation in a more active role providing care for the woman and her family.

Purpose/objectives:
This presentation will be based on findings from an Australian Teaching and Learning Council funded study that sought to understand the midwifery learning that occurs through a continuity clinical practice model called the Follow Through Experience (FTE).

Issues for exploration/ideas for discussion:
This small group presentation will present the findings of the research and then generate discussion around:
- Out of sequence development of canonical knowledge
- Development of heuristics
- Scaffolding of student learning
- Development of professionalism

Results:
Data was collected from the written summary documents of the FTE on completion of the Bachelor of Midwifery and focus groups. The focus groups were with students in each year level of the three year program and with midwifery academic staff. Analysis identified the following themes within the FTE

Intended curriculum
- Value of partnerships
- Professional practice and boundaries
- Models of care
- Communication
- Consolidation of procedural skill
- Value of reflective practice

Hidden curriculum
- Midwifery rhetoric
- Relationship building
- Time dependence
- Social/personal costs
- Personal boundary

Implications of these for Work Integrated Learning and ways to transform pedagogy and practice in a midwifery curriculum will be presented.

Discussion:
The discussion will centre on the intended and hidden curriculum themes as identified above.

Conclusions:
This research, the first to examine the FTE, has demonstrated clearly that the FTE is a valuable learning experience in the work place. It has identified positive and negative features and while we can work with and strengthen the positive features, more research needs to be conducted on the negative features. The FTE lends itself to the development of canonical knowledge and can therefore be transferred to other professional groups who are able to use patients as teachers.

International medical graduates as supervisors and teachers in Australia

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Introduction/background:
The recent expansion of medical education in Australia will result in a substantial increase in the numbers of medical students and registrars training in Australia over coming years. The increase in numbers will be evident both in hospital training programmes and post-graduate training and will lead to heightened demands for trained supervisors and teachers to oversee their training needs. While this will place a strain on available resources, it will also create an opportunity for the further development of vertical integration involving clinical and teaching activities.

This vertical integration would include International Medical Graduates (IMGs) as supervisors of GP registrars, and in turn, IMG GP registrars as teachers of medical students. The IMG GP Supervisors have a role in teaching as do the IMG registrars and this presents opportunities and challenges for the development of their teaching skills.

Purpose/objectives:
It is widely acknowledged that the literature addressing medical supervision is limited (Kilminster and Jolly, 2000) and a literature search revealed no information about the issues which affect International Medical Graduate doctors as they progress into a supervisory role.

A project was developed with the aim to:
- explore the progression of International Medical Graduates into a supervisory and/or teaching role;
- identify any specific needs of this cohort and
- identify any challenges that may arise for this group of medical supervisors and teachers.

Issues for exploration/ideas for discussion:
Following a systematic literature review a focus group was held with International Medical Registrars currently working in rural and remote locations in south western NSW. The factors influencing positive outcomes in supervision raised by the IMG doctors were consistent with those identified in the literature. These include: the quality of the supervisory relationship, availability of the supervisor, the structure and content of teaching sessions, sufficient time, delivery of feedback and input from the trainee.

However, other issues specific to the needs of the IMG supervisor included the impact upon the supervisory relationship if the participants were from different ethnic, social, educational or linguistic backgrounds. IMG doctors articulated their need for professional development to maintain clinical currency, development of explicit teaching skills, understanding of different teaching and learning styles, ongoing mentoring and cultural training opportunities.

Doctors and students develop symbiotic clinical partnerships in longitudinal placements

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Introduction/background:
Lave and Wenger have proposed that "situated learning" is a process of participation in communities of practice. Participation is initially legitimately peripheral with gradually increasing engagement and complexity.

In the Flinders University PRCC, a year-long medical student education program, the rural general practice setting is used to teach the basic foundations of medicine in all disciplines and is consolidated by students following patients and doctors through the hospital system.

Purpose/objectives:
This paper will ask the audience to consider the proposition that longitudinal supervisory relationships between rural clinician preceptors and students create a context for situated learning.

Issues for exploration/ideas for discussion:
Does rural general practice provide students with more opportunities for legitimate peripheral participation?
Is the longitudinal nature of the PRCC progam an essential factor?

Results:
When students engage in a clinical role with patients in parallel with the doctor, the doctor is entrusting them with some agency for the doctor-patient relationship. If the student is deemed personable and safe and they demonstrate respect for the GP preceptor's subject mastery they are given the opportunity to actively participate in the consulting process. In short-term rotations GP preceptors gain positive feedback by seeing students learn a discrete skill and through sharing their mutual interest in clinical medicine. In a rural setting, personable students are also often included in social activities to help them gain a perceptive of life as a rural doctor. There was little evidence that personal or professional relationship matured beyond this superficial nature during short term student attachments.

When students spend a full academic year learning in the practice setting GPs witness their development over time and assist them to have progressively more authentic clinical participation. Students become sensitive to the pressures affecting GPs and describe becoming helpful in the clinical setting. A sense of companionship develops as GP and student work together. These firm personal relationships motivate GP preceptors to contribute to student-centred learning outcomes.

Discussion:
As relationships between clinician preceptor and student mature, students are provided with opportunities to have a more active role in clinical consultations.

Conclusions:
GP preceptor's student-centred buy-in is not seen in short term rotations. Longitudinal integrated medical education programs demonstrably increase the symbiotic nature of the student-doctor relationship.

How do GP registrars learn to prescribe?

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Introduction/background:
Prescribing is a complex process in which inadequate skills translate to suboptimal prescribing. The literature offers little insight into the barriers and enablers GP registrars face with respect to participation in programs to enhance their prescribing skills.

Purpose/objectives:
The research aims were to:
- Explore how GP registrars learn to prescribe.
- Analyse the barriers and enablers to uptake of existing quality use of medicines programs by GP registrars.

Issues for exploration/ideas for discussion:
- Barriers and enablers to workplace learning (GP registrars learning to prescribe)
- Strategies to promote rational GP registrar prescribing.

Methods:
An analysis of GP registrars' learning needs for quality prescribing was conducted using survey, interviews and focus groups. The online national survey comprised open and closed questions. Focus groups were conducted with GP registrars at various stages of training to explore issues raised in the survey in more depth. Medical educators' views were canvassed in semi-structured interviews in order to gain a broader perspective on the registrars' needs. Qualitative data analysis was informed by a systematic framework method involving a number of stages starting with iterative reading of transcripts to identify participants' interpretations and constructs. Quantitative data from the survey were imported to an excel spreadsheet for descriptive statistical analysis.

Results & Discussion:
Sixteen of 21 regional training providers (RTP) contacted agreed to participate by sending the online survey link to their registrars (n=225; 20% response rate). Seven focus groups were conducted (n=34 registrars) at SIGPET[1], GPTT[2] and GetGP[3]. Nine medical educators participated in the interviews.

Registrars learned to prescribe mainly through situated and social means. This included actually prescribing patients' medications, learning from patient outcomes and reflection on their experience. GP registrars tended to model their supervisors' prescribing and were influenced by opportunistic discussions with their supervisors. Pharmaceutical company representatives were reported as a source of educational activities and information regarding medicines, via sponsored lunches, workshops or GP clinic visits.

Five main barriers to the uptake of quality use of medicines resources and activities were discussed by GP registrars. These were: time, information overload, access to resources, motivation and cost of educational activities. Many of the newer GP registrars reported difficulties in the transition from hospital prescribing to prescribing in the GP context, for example, understanding PBS, costs to patients etc.

Conclusions:
GP registrars learn to prescribe primarily and opportunistically in the workplace. The results highlighted the importance of contextual factors in prescribing decision making. Although situated learning is appropriate for learning to make prescribing decisions, a more structured approach is called for. Ways of easing the transition into GP practice and of managing the information 'overload' related to medicines (and prescribing) in an evidence-based, efficient and timely manner are needed.

Funding:
This project was funded by the National Prescribing Service

Bridging the gap between university and graduation: Developing an occupational therapy clinical education program

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Introduction/background:
The Health Practitioner Award for Queensland Health provided a significant investment into Clinical Education Workload Management Initiatives (CEWMI) for Allied Health staff, directed at workload related to pre-entry student and new graduate supervision and training. For Occupational Therapy this equated to over $1.6 million.
In developing discipline specific proposals for the CEWMI, an obvious model was to appoint new positions to primary supervisor roles or clinical backfill for other supervisors. For the Occupational Therapy Steering Committee however, adequate workload relief was deemed to require a more complex solution. Of vital relevance is the context within the Occupational Therapy profession in 2008:

- Minimum curriculum standards for student education stipulated by the World Federation of Occupational Therapy are broad and do not detail specific clinical experiences or competencies. This presents significant challenges for supervisors to know what experiences to give students, and in turn creates significant workload. It also results in enormous variance in the quality and nature of experiences that students receive and subsequent skills of new graduates.
- Various projects carried out in Queensland had resulted in more than sufficient offers for pre-entry student placements
- Two new university courses commencing in 2008 and 2009 mean demand for pre-entry student placements will again peak in 2011

Purpose/objectives:
This paper will outline the CEWMI developed for Occupational Therapy, implemented to assist workload in the traditional view, but also to:

- Build capacity for student placement offers towards 2011
- Increase the consistency and quality state-wide of student and graduate clinical education experiences
- Better prepare students and graduates to meet the needs of a health employer
- Reduce supervisor stress and workload

Three levels of integrated support result in both at hand support as well as access to specialist support:

- Local District Clinical Education Officers
- State-wide Clinical Education Leaders for practice areas
- State-wide Clinical Education Program Manager

Local and state-wide reporting lines for staff create opportunities for local flexibility and state-wide consistency.

Issues for exploration/ideas for discussion:
Emerging challenges include:

- Allowing these roles to meet the needs of the OT profession, which result directly from tensions between university curriculums and health service delivery, whilst also contributing to capacity building within Allied Health clinical education at local and state levels
- Maintaining a balance of flexibility and structure within a 'clinical capability framework' so as to achieve a level of consistency and quality whilst allowing for variation in local service delivery, autonomy for supervisors and support for adult learning principles.

The Hospital Skills Program: Providing a safe harbour for the non-specialist medical workforce

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Introduction/background:

The NSW Institute of Medical Education and Training (IMET) has developed a new and innovative medical education and training program - the Hospital Skills Program (HSP). The HSP aims to improve the quality and safety of patient care by recognising, maintaining, and enhancing the skills of the current and future non-specialist medical workforce. These non-specialist doctors are from a wide variety of backgrounds, including Career Medical Officers (CMOs), General Practitioners (GPs) and doctors beyond postgraduate year 3 who have not entered vocational training. They have different levels of experience and career aspirations.

The governance for the HSP will be based on area health service structures with oversight by an Area Director of Hospital Training responsible for the delivery of training and performance management and an Education Support Officer supporting the organisation and coordination of the training program.

Purpose/objectives:

The HSP provides a framework for assessment and multi-level certification of skills appropriate to the various roles of medical officers in hospital settings. This shall include skills acquired through the training program, recognition of prior learning and recognition of current competency. The HSP also provides effective professional development assistance to doctors in line with their career aspirations and their need to safely fulfill current and future roles. This in turn will provide assistance to the NSW Area Health Services in their goal of ensuring that NSW doctors practice at a high standard of competency and provide safe patient care to the NSW public.

Curriculum has been prepared or is currently being prepared for seven key clinical areas – Emergency Department, Aged Care, Mental Health, Surgery, Medicine, Obstetrics & Gynaecology and Paediatrics plus a "core" curriculum which covers communication, leadership, quality, safety, governance and system engineering principles.

The performance of individual doctors and their capacity to fulfill roles will be assessed in the workplace against the capabilities as detailed in the curricula. The assessment process will be administered at various levels including an initial self-assessment, verification by peers and clinical supervisors and certification required to progress to the next level. This will facilitate the development of a personalised and achievable personal development learning plan and portfolio via our online system.

Issues for exploration/ideas for discussion:

- Feedback and comments on the overall program?
- Suggestions for further development of the program?
- National portability of the program?

Using online learning to more effectively accommodate clinical attachments – An ALTC Priority Program Project

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Introduction/background:
It is common for medical students to return to their university campus (or similar place of centralised learning) several times a week for lectures during clinical attachments. In the new medical degree at the University of Western Sydney we have an opportunity to revise and renew the way that the medical curriculum is traditionally taught and to use eLearning technologies to replace the need for students to physically relocate when learning about the scientific basis of medicine. This method of learning allows flexible and independent student learning and is a basis of life-long professional learning. It is also important that students continue to link the pathophysiologic mechanisms that underlie diseases with the patients that they are seeing, and not separate their science learning from their clinical experience. Online learning allows this sort of flexibility in a way that scheduled lectures find difficult.

The Learning Activity Management System (LAMS) was chosen for the delivery of ten modules based around scientific basis of medicine themes (Scientific Streams). Each module is a total of 25 hours, with around five case studies per module of five hours each. The first three modules have been rolled out to the current year three students, and represent different learning designs, from highly collaborative through to self-paced, independent learning environments. Student feedback will be used to look at which Learning Designs were most successful at teaching the Scientific Streams and successful Learning Designs will be reused in future module development

Purpose/objectives:
We will be presenting our experiences of developing and implementing these modules, and discussing the relative merits and disadvantages of the learning designs that have been used so far.

Issues for exploration/ideas for discussion:
Some of the questions that we will be addressing include:

- What is considered "best practice" for the teaching of the scientific basis of medicine within the field of medical education?
- What learning designs can be readily adopted by the School of Medicine as a means of delivering best practice?
- What learning designs can be readily adopted by other disciplines as templates for best practice?
- How can identified barriers to academics' adoption, adaptation and reuse of learning designs be overcome to ensure sustainability?

CLICKS

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Introduction/background:
The delivery of clinically relevant teaching material to large numbers of medical students across a variety of clinical teaching sites in an efficient manner is difficult. The traditional format of large scale lectures is of doubtful educational value and is logistically problematic, given that most medical courses are dispersed both in terms of space (multiple sites) and time (discipline rotations).

At Griffith Medical School we have developed the Core Learning and Integrated Clinical Knowledge System (CLICKS). These multimedia presentations are interactive web-based resources which can incorporate a narrative and video material. Utilising standard Adobe® Flash® architecture CLICKS can be accessed by students online in real time. At the end of each CLICK students are asked to complete an online evaluation form.

CLICKS are prepared by discipline experts using a PowerPoint format and MPEG sound files and then converted by IT staff to the required format.

Purpose/objectives:
We have undertaken an evaluation of the usage and student feedback of CLICKS accessed throughout the first 2 years of the Griffith Clinical Medial Program with the aim of assessing the value placed on these learning materials by students and also in order to identify areas for potential improvement.

Results:
Each of 72 CLICKS was accessed on average 255 times by 190 students. That is a total of 18,336 'hits' in total. There were 6118 evaluations completed with an average evaluation rate of 85/190 (44%). The overall average rating on a 7 point Likert scale for all CLICKS was 5.25.

A review of student comments found that they liked CLICKS and would like to see more topics covered in this format. Positive aspects of CLICKS included: ability to access from home; ability to access when clinically relevant to current rotation; being able to review CLICKS repeatedly; being able to work through CLICKS at own pace; linkage to learning objectives; and consistency of material regardless of clinical location.

Discussion:
CLICKS have been popular with students and the direct connection between clinical experience, learning objectives and assessment has been welcomed. A number of areas for further improvement including the use of more interactive elements and formative assessment on the material covered have been suggested.

Conclusions:
CLICKS provides a practical solution to the delivery of learning resources across a distributed curriculum such as Medicine and provides some unique features which are not otherwise easy to implement across a whole cohort (e.g. demonstration of clinical signs).

Does practice make perfect – does time spent using online resources correlate with academic outcomes?

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Introduction/background:
Current tertiary students are more resource rich than those of any other generation. However, evidence to show that the plethora of available information actually benefits student learning is lacking. Although educational institutions have rushed to embrace Blackboard and eLearning technologies based on the flexible learning opportunities they offer there is little documented evidence as to how effectively students are actually using the new technologies. While the fact that students spend time online is indisputable, there is scanty literature as to whether this time correlates with academic outcomes. Academics are concerned about a growing population of "squirrels", that is students who glibly print off, file and store notes and other resources, yet fail to refer to them. The unfounded belief in the ability of academic content to diffuse into brains once it is accessed needs to be discouraged!

Purpose/objectives:
The aim of this investigation was to determine whether spending time on eLearning platforms actually promoted learning.

Issues for exploration/ideas for discussion:
- Does spending large amounts of time online benefit students' learning, ie does practice make perfect?
- Is there a statistically significant correlation between time spent online and academic outcomes?
- What is classified as effective use of online resources?

Results:
The access patterns of two cohorts (240+ students) of second year nursing students taking the same unit in successive semesters were investigated. Overall student grades and rankings were compared with the number of online sessions and absolute amount of time spent on the Blackboard platform supporting the unit of study. The number of accesses seemed to be more relevant than the absolute amount of time on Blackboard, presumably allowing for the fact that high achieving students accessed material more rapidly and effectively than did struggling students.

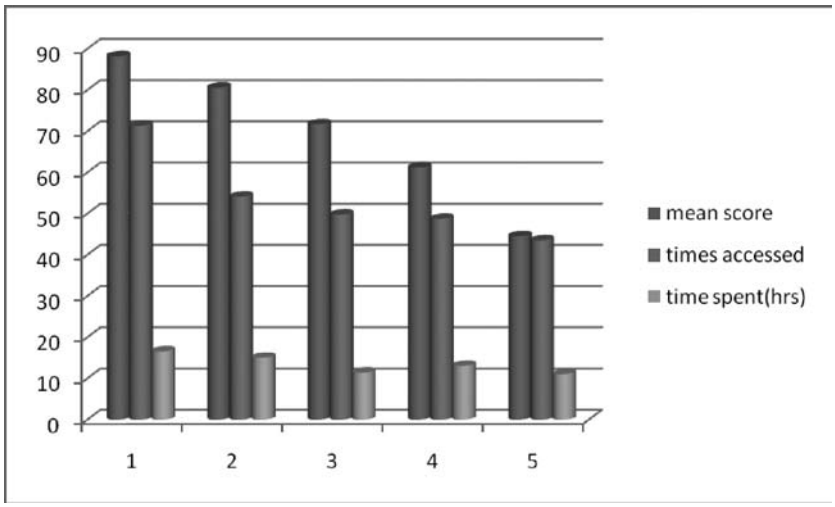

Fig 1 Relationship between academic grade, number of site access and time spent online the Blackboard platform

There was a statistically significant correlation between student grades and the number of times they accessed Blackboard. Students in the bottom quartile sometimes spent long periods of time online but did not access the site as frequently as those in the top quartile. Many failing students did not use online resources extensively. Students were selective in the material they accessed; good students accessed the site selectively, they used past papers but generally did not access practice tests as frequently as did lower achieving students.

Conclusion:
Students who frequently access online resources achieve better academic outcomes than those who do not.

Reduce the use of 'super-notes' and increase clinical reasoning in 1st and 2nd year medical students to aid the progression towards a tutor-less learning environment

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Introduction/background:
Increasing numbers of medical schools in Australia and overseas have embraced Problem Based Learning (PBL) to address the need to improve the clinical reasoning skills and communication skills as well as to encourage self-directed lifelong learning of medical graduates. At Griffith, PBL has utilised e-learning as a tool to deliver curriculum elements and monitor the curriculum and student progress. It has not replaced regular contact and interaction with teaching staff (Tedman, Alexander and Loudon, 2007). The Griffith MBBS program graduated its first cohort of students in December, 2008. Like other PBL curricula, students in years 1 and 2 gain access to notes from earlier cohorts and some students depend solely on these notes at report-back time in PBL sessions, while other students attempt to cut and paste information from reading materials, without synthesising the material. Krasne and Wilkerson (2008) found that students, who struggle academically, seek out longer study time by ineffectively embracing the concept of problem based learning through the use of a "cut and paste" approach to report back sessions.

Purpose/objectives:
This presentation will report the result of a pilot study using the basics learned from both the presentation delivered by Krasne and Wilkerson (2008) and the workshop undertaken with Wilkerson, Krasne and Stevens (2008), and changing it to a) suit the Griffith MBBS Curriculum, b) develop clinical reasoning skills to a higher level, c) progress towards the elimination of the use of "super notes" handed down from students in previous year levels, and d) assist in the development of a tutorless learning environment.

Issues for exploration/ideas for discussion:
- How important is the report back process for developing clinical reasoning skills and teamwork?
- How important is inter-student interaction/communication between PBL sessions for developing teamwork and improving student collaboration and involvement in the PBL process?
- What are the most important skills that students need to acquire in preparation for a tutorless learning environment?

Using an interview in the selection of medical and dental students

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Introduction/background:
The University of Western Australia (UWA) has been using a structured interview in its three-component medical/dental student selection process since 1998. Other Australian/New Zealand medical/dental schools use a semi-structured interview format, a version of the multiple mini-interview or in some cases no interview at all.

As well as the ongoing monitoring of data resulting from the annual interview process, in the last four years several specific research projects have been conducted to assess the reliability and validity of this interview process in the Faculty of Medicine, Dentistry and Health Sciences at UWA.

Purpose/objectives:
The purpose of this paper is threefold. Firstly, to present an overview of the outcomes of the UWA research projects, which involved the collection of both qualitative and quantitative data. These projects included an interview reliability study, interviews with stakeholders and predictive validity studies for the various categories of students admitted under this process. The results have generally been positive and the selection interview continues to evolve based on the evidence from these projects and ongoing analysis of the interview data.

The second purpose is to consider the merits of the various interview formats currently used in Australian/New Zealand medical/dental school admissions; and thirdly, to look to the future of the use of an interview in selection, given increasing student numbers and diminishing resources.

Issues for exploration/ideas for discussion:
- What do we want from a selection interview?
- Do different interview formats have different outcomes?
- What is the optimum interview format for achieving the desired outcomes?
- How do we take selection interviews to the next stage in their development?
- Is there a less expensive alternative to interviewing?
- Why use an interview at all? Can effective selection be achieved with paper-and-pencil tests alone?

Using Multi-Source Feedback for training at postgraduate level

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Introduction/background:
The RACP Multi-Source Feedback (MSF) assessment tool was developed collaboratively with RACP staff, Fellows and key personnel from other postgraduate physician Colleges. Review by experts improved content validity and further shaped the tool. In December 2008, a draft of the RACP MSF, comprising a Colleague Questionnaire, a Self Questionnaire and a Feedback Report was piloted at a focus group with a trainee in the Basic Training program, and potential assessors including an Educational Supervisor, a Director of Paediatric Physician Training (DPPT), a senior nurse, an allied health professional and a Ward Consultant at a local NSW hospital. After further refining, we converted the MSF tool to an on-line format and tested it for functionality with trainees and assessors. It is now ready to be introduced in the RACP PREP program for Basic Trainees in 2009. The intention is to pilot the MSF with all trainees and assessors with each questionnaire to have in-built evaluation questions. When the trainees and assessors submit the MSF questionnaires on-line as part of the reporting requirements, the responses will be analysed for quality improvement, statistically tested for validity and reliability and evaluation responses will be collated to inform quality improvement.

Purpose/objectives:
We want to explore and draw on people's experiences of using MSF and share this knowledge amongst trainees, supervisors, College staff, Fellows and other groups planning on using MSF in the postgraduate training environment.

Issues for exploration/ideas for discussion:
- We want to know about people's experiences with MSF.
- We want to know about experiences around giving assessment feedback to the trainee.
- How do we ensure this is a valid and reliable tool?
- We want to devise a list of ten tips for introducing MSF.

Cross-sectoral leadership and IPL: The skills and attributes required for successful cultural change

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Introduction/background:
Within the Australian Capital Territory (ACT) a wide variety of Interprofessional Learning (IPL) initiatives have been introduced, in part due to the excellent relationship between ACT Health and the tertiary sector. Success has been achieved through a coordinated approach assisted by the small jurisdictional size.

Top down direction or mandating of change creates difficulties with sustainability. Furthermore, poor communication between different sectors in society can lead to misunderstandings and negative outcomes. Cross-sectoral leadership is therefore complex, participatory and distributed, and requires complementary skills and attributes for change to be sustained.

Purpose/objectives:
IPL seeks to 'soften' professional silos – to create deeper understanding between 'tribes' of the health workforce. Learning 'with, from and about' other professions increases communication and the likelihood of successful collaboration. For cross-sectoral collaboration between the government sector and academics this is also true. The diverse and hierarchical cultures of the service sector and the more autonomous research-orientated culture of the tertiary sector initiate barriers that create a need for effective communication, and a will to explore common meanings behind words/and behaviours.

Issues for exploration/ideas for discussion:
Based on critical reflection of successes and failures, the authors explore the characteristics of leadership necessary to achieve cultural change associated across the higher education and government sectors with regards to IPL.

The authors have developed a model of leadership with judgement and discernment that defines the critical elements for success. Key factors include: contextual understanding of the issues; knowing when and how to communicate a strategic vision; recruiting flexible, forward-thinking staff for key positions; adaptability in allocating resources for optimal impact; and a strong understanding of governance and what actions need to be undertaken to create an enabling environment. Cross-sectoral leaders must understand not only the need to balance the production of career-ready graduates with an appropriate currency in their skill-base but also the priorities of staff in the maintenance of research skills and research outputs that are mandatory for promotion in a research-focused tertiary sector.

Principle-based competencies – a facilitator for interdisciplinary and interprofessional education?

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Introduction/background:
Students may learn many facts and concepts, but they may not understand the key principles underpinning this knowledge. It is largely through these principles that key concepts are appreciated and applied. There is a commonality of many of the key principles that drive practice across the health related professions and the disciplines within these professions. It is the extent to which these principles require application that may vary markedly depending on the profession and the level of expertise. Identifying the core principles and concepts of musculoskeletal (MSK) medicine has been the basis for the development of the Australian Musculoskeletal Education Competencies (AMSEC) project. This process has required significant consultation and innovative processes which are different from most medical curriculum development processes.

Purpose/objectives:
- The aim of AMSEC is to advance national health care standards by ensuring the delivery of world leading MSK education to trainee medical professionals and to have the defined MSK core competencies developed for implementation into the curricula of Australian Medical Schools by 2010.
- A future aim is to improve the overall delivery of MSK care by ***all*** Australian health care professionals by establishing a minimum national baseline standard for MSK education for both medical graduates and allied health practitioners. This multidisciplinary and multi-professional, horizontal integration of education ensures that all Australian health professionals are suitably equipped to address the increasing impact of MSK conditions.
- This project has undertaken a significant inter and intra disciplinary consultative process aimed at identifying core MSK competencies classifying them for use at a basic, median and advanced level of specialisation across a variety of relevant professions .

Issues for exploration/ideas for discussion:
The building blocks of competency based curriculum development – knowledge, skills and attitudes– can use principles as their basic currency. The fundamental concepts that underlie these principles can be expanded depending on the extent to which the principle requires application within the competency requirements for a practitioner with a given level of expertise. Thus, the level or type of application of the principle will determine the depth/extent/complexity to which the concepts underlying the principle will need to be learned.

It is therefore critical to identify the key evidence based principles that apply across medical disciplines and health professionals. These principles (and the concepts which support their application) must be maintained at a consistent national standard and benchmarked against international standards. If common resources are developed and shared and consistent teaching (irrespective of discipline or profession) facilitated, individual and inter-professional learning will be enhanced.

Interprofessional learning for professional/clinical supervision

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Introduction/background:
The authors have both taught clinical supervision for many years in both workplace training and within formal university programmes for practitioners. They have taught mature and experienced practitioners from diverse professional backgrounds in health, education and social services. Students have shared a common focus on learning to become a professional supervisor, often as part of a professional career path, but previous exposure to supervision varies by discipline. A small qualitative study of participants' views on learning in interprofessional supervision courses supports an interdisciplinary approach.

Purpose/objectives:
This paper presents some findings of a small qualitative study in order to stimulate discussion about good practice in supervisor education in diverse health contexts.

Issues for exploration/ideas for discussion:
At the end of the study the presenters had further research questions: should supervision become a generic process? Does this weaken or strengthen supervision practice within professions? Can interprofessional supervision learning and practice strengthen connections between professions in multi-disciplinary teams? How well is supervision supported following interprofessional training opportunities?

Results:
Several themes emerged:

- Interprofessional learning was seen to increase the appreciation of the possible range and breadth of supervisory practice. It deepened both the learning experience and understanding of the subject material.
- The need to communicate with others from different professions each with different experience of supervision required each participant to be clear and specific about what he or she wanted to say.
- Respondents recognized assumptions commonly made about other professions and between those of the same profession and way in which these assumptions could limit effective, collaborative problem solving.
- Finally respondents spoke of the benefits and challenges of sharing different knowledge and world views and how they understood their professional work.

Discussion:
The researchers explored how the different professional perspectives of the participants had affected their experience of an interprofessional learning situation, their participation and their actual learning. Overall the study findings supported interprofessional learning.

Conclusions:
A small study indicates that interprofessional programme professional development in clinical supervision provides rich opportunities for learning. This poses some challenges to ensure that 'mixed' learning groups enhance not impede the educational experience. Effective course design and learning process are important factors.

Facilitating IPE goals in clinical education: Identifying key elements for the teaching approach

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Introduction/background:
IPE initiatives claim to affect understanding of professional roles, communication between professionals and team working (Kilminster 2004 and others). However there is very little information and evidence as to how to realise these claims from a strategic and targeted educational perspective. Three dimensions that have been identified as important for effective IPE include the context, the goals and the teaching approach (Harden). A work-based context for interprofessional learning has been shown to be most effective for achieving interprofessional learning because it replicates the actual workplace environment. The goals of the interprofessional learning activity should also be relevant to the goals of working collaboratively in the workplace.

Purpose/objectives:
This paper will highlight the third dimension or criteria for achieving the goals of IPE, the teaching approach. Drawing from research about physiotherapy students' experiences of learning on their first clinical placement (Delany and Bragge 2009) and their participation in a critical reflection program (Delany and Watkin 2008), we identify key elements in educational approaches that work towards meeting the goals of IPE.

Issues for exploration/ideas for discussion:
Strategic teaching approaches for IPE on clinical placement.

Results:
Findings: Students' descriptions of effective learning experiences included the importance of time and opportunities to observe other health practitioner team members working. Similarly in the critical reflection program, students discussed the value of learning through communication with other members of the health care team in addition to members of their own discipline.

Discussion:
To incorporate the goals of IPE into clinical education, our research suggests, students need opportunities to discuss comparative approaches to health care scenarios. Through such discussions, they are able to make sense of their own role and the role of others. In our research, clinical educators focused on providing a structured framework for progressively developing competency with staged goals (Delany and Bragge). We suggest two approaches for incorporating IPE goals into the structured learning goals of clinical placements. Firstly, to provide opportunities for students to critically reflect about clinical learning events, and secondly, to ensure they have opportunities observe and interact with members of other health disciplines. These approaches to incorporate IPE goals have been shown to be effective in our research and are also supported by themes in the literature about effective IPE.

Conclusions:
Structuring clinical education for students to allow interaction with other professionals and supporting critical reflection on these opportunities can facilitate IPE goals.

An international, multidisciplinary approach to educating health professionals in cancer care for teenagers and young adults

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The Post Graduate Certificate in Cancer Care for Teenagers and Young Adults is a multidisciplinary, international course offered by Coventry University, United Kingdom (UK). This course was developed in response to an identified international gap in educational programs to support health professionals working with teenagers and young adults with cancer.

The gap in education programs was identified by Professor Helen Langton from Coventry University who undertook an international tour in August 2005. The outcome of this tour was the formation of an International Curriculum Development committee. Representatives from Australia, New Zealand, Canada and the UK were invited to participate in a meeting which was held in Bangkok, Thailand. During the 4 day meeting in Bangkok, a curriculum outline and module outcomes were developed. A Nurse Teacher was then employed by Coventry University to develop and collate materials and consult with content experts.

This online course aims to introduce the theory and practice of caring for teenagers and young adults with cancer and their family to students at an advanced practice level. The course comprised 3 Modules totalling 60 Credits at Masters level. Teaching methods included interactive web based learning, patient journeys/ blogs, group discussions, chat forums and on line presentations with student's questions. Assessments comprised of on line discussions, reflective summaries, essays, policy critiques, and project development.

The first intake for the course commenced in February 2007. A total of 22 students applied for the course, 3 withdrew, 18 started the course and 12 completed the course. Of the students who did not complete the course most deferred or chose to enrol in one subject at a time. All students were nurses - 8 from the UK, 8 from Australia and 3 from New Zealand.

In June 2008 the course expanded to include other health professionals. A total of 12 students have enrolled in this course, these include 2 doctors from Australia, 1 doctor from United States, 1 nurse and 1 social worker from the United States, 1 occupational therapist from Sweden and 6 nurses from Australia, New Zealand, United States and the UK.

This paper will give an overview of the strengths and challenges in developing and facilitating an international, multidisciplinary online course. Feedback from students will be incorporated along with the experiences of facilitators working on different sides of the globe.

Interdisciplinary teamwork in research: What are the experiences of cross-disciplinary collaboration?

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Introduction/background:
Research is becoming an increasingly collaborative endeavour. Within academic settings, researchers, academics, and health professionals across various disciplinary, professional, and institutional backgrounds are increasingly working together in teams and integrating concepts and methods from areas of specialised knowledge or practice in investigating issues of significance. This approach is referred to as interdisciplinary[1-3]. The interdisciplinary approach has the potential to integrate evidence and strengthen links across disciplinary and professional boundaries, but can also be challenged by a number of factors such as differences in team member knowledge, skills, and expectations and disciplinary based frameworks for funding, staffing, evaluating research quality, and reporting outcomes.

There is little empirical evidence in the literature about interdisciplinary team work in academic research settings. This study explores the experiences of researchers working in interdisciplinary research teams and how they manage the process of cross-disciplinary collaboration and negotiated associated challenges. There is a particular focus on the interdisciplinary experiences of researchers in the broad areas of Health/Medical Education, Public Health, Allied Health, Health Services, and Social Sciences. The study will also investigate team members' conceptions about resilience and their interpretations of how resilience may be reflected within interdisciplinary teams in the academic research environment. Resilience is described as the capacity to cope with challenge, change, and adversity in a positive manner[4].

Purpose/objectives:
The purpose of this paper is to report on preliminary findings from interviews with researchers working in interdisciplinary research teams.

Methodology:
Data has been collected via interviews (n=21) with purposefully sampled participants. Participants are those who have self-identified as currently working in or having had involvement in interdisciplinary teams, and are from a diverse range of settings including universities, hospitals, and research organisations and a range of research areas including medical/health education, public health, health sciences, pharmacy, health services, clinical medicine, and social sciences. A thematic analysis is being conducted to identify recurrent themes and subthemes emerging from the data.

Results:
Preliminary analysis of the data indicates several emergent themes related to participants' experiences and/or perceptions of the drivers of interdisciplinary collaboration; the nature of challenges faced in cross-disciplinary collaboration; how these challenges are managed; and sources of support. These findings will be discussed more fully in the conference presentation.

Issues for exploration/ideas for discussion:
- How do interdisciplinary team members' experience or perceive working in interdisciplinary teams in the academic research setting?
- How do interdisciplinary teams and their members manage and negotiate the process of cross disciplinary collaboration?

Final year physiotherapy students as standardised patients: An effective peer-learning process

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Introduction/background:
Preparing students for professional life involves a range of teaching strategies. Two effective strategies, peer learning and the use of standardised patients, have been integrated in this study. Peer learning has been recognised as a valuable asset in higher education, with benefits to both the learner and the peer mentor. Difficulties in accessing real patients in health settings for clinical teaching in earlier years of programs are experienced across all health disciplines. Standardised patients provide a realistic alternative to real patients in a safe setting for student learning.

Purpose/objectives:
The study aimed to evaluate the effectiveness of using fourth year physiotherapy students as standardise patients for cohorts of second and third year students learning patient interview, physical examination and treatment skills incorporating clinical reasoning. The study included both quantitative and qualitative data analysis to determine the impact on younger students' learning outcomes and preparation for clinic and on older students' peer-mentoring skills, and issues to optimize the learning experience were explored.

Results:
This paper focuses on data from focus groups of second, third and fourth year students. Qualitative results supported and extended quantitative data in finding positive learning outcomes related to development of insight, skills, and enhanced preparation for clinic through 'bridging the gap' between theory and practice. Students valued having other students as teachers over academic staff. Fourth year students gained insight into their roles as peer mentors, their ability to give feedback and into the learning process. Feedback was gained into student's perspective on how to optimize the learning experience.

Discussion:
Overall this was a very positive learning experience. There was strong evidence that fourth years fulfilled dual roles; one as SP and one as a peer mentor and learning facilitator. Both roles were valued by the junior students and there were benefits to both groups in relation to their professional development. The findings support current research into collaborative learning and peer mentoring.

Conclusions:
The findings contribute to knowledge about standardised patients and peer learning in the physiotherapy context.
This innovation should continue to be used in developing generic patient-interaction skills and physiotherapy-specific management skills. It gives confidence to all students and may give students insight into their continued learning as graduate physiotherapists.

Issues for exploration/ideas for discussion:
- What is the experience of others using peer teaching activities?
- Which activities work best in sessions with peer mentors?
- Does involvement in peer mentoring activities as undergraduates increase likelihood of working as future clinical educators?
- Does insight into learning help prepare students for their continuing learning as graduates?

Comparison of the traditional problem-based learning format and larger, directed, independent study groups

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Introduction/background:
Problem based learning has been implemented as a pedagogical tool world-wide across a range of health professions since its inception at McMaster University, Canada, in 1969 (Neville & Norman, 2007). In addition to enhancing knowledge and understanding it is also claimed that PBL develops communication skills, encourages teamwork, sharing of information and respect for others, furthers problem solving skills, and allows students to assume responsibility for their own learning (Wood, 2003). However, the cognitive outcomes of PBL and traditional pedagogy (based on didactic teaching) are similar and hence widespread adoption of PBL has been questioned (see Colliver, 2000). Criticisms of PBL include its resource hungry nature, requiring, as it does, experienced tutors to facilitate .learning across several clusters of students dealing with the same problem. Given the actual and anticipated increase in numbers of medical students in Australia other strategies that retain the advantages of PBL, while minimising the demands on faculty, should now be explored. This paper reports our experience with a modification of the traditional PBL approach, termed PBL***plus***. This innovation was trialled in a regional clinical school, attached to a hospital, with a group of 19 graduate entry students, who had completed an integrated Year 1 / 2 of the MBBS. PBL***plus*** involved allocating students from the whole class to three task directed groups. Groups had specified assignments to complete to facilitate learning across the whole class. A tutor listened to student presentations and provided an interactive presentation. Hence use of tutors was made more efficient, and faculty input was more specialised.

Purpose/objectives:
The aim of this study is to explore whether a more structured form of PBL does offer advantages in addition to the non-cognitive benefits afforded by conventional PBL. Experiences are compared within groups who attended both PBL and PBL***plus*** sessions, and who previously had experience of traditional PBL learning sessions.

Issues for exploration/ideas for discussion:
- How does group size impact on learning outcomes e.g., is diffusion or dodging of responsibility more apparent as numbers increase?
- Does increased structure in PBL sessions decrease student anxiety about performance issues?
- What is the faculty perspective on PBL*plus?*

Results:
Focus groups provided insights into the experiences of students engaged in externally structured versus less directed learning. The prospective design of the study revealed how knowledge expanded within and across learning modes. The faculty perspective in relation to efficiency and satisfaction was also outlined.

Conclusions:
Providing external structure to PBL sessions does not sacrifice the noncognitive benefits of the traditional format.

Designing curriculum, teaching and assessment for a climate-changing world

Dr E. Bell

Introduction/background:
A large body of research now exists on the subject of what climate change will mean for healthcare needs. There are also calls for health education and training to better prepare health professionals for a climate-changing world. The keynote in this literature is the importance of adaptive practices for responding to climate change. It is known that health professionals will need to respond to a wide range of direct and indirect consequences of climate change, requiring not only content knowledge but also flexibility and responsiveness to diverse regional conditions as part of complex health problem-solving—adaptation. This will be particularly important in rural and remote education and training. However, little has been written exploring what this means for the 'bread and butter' practices of curriculum design, teaching and assessment.

Purpose/objectives:
This presentation examines how adaptive practices for climate change can be a part of education and training programs for health professionals.

Issues for exploration/ideas for discussion:
The presentation identifies clinical and non clinical dimensions of adaption for climate change, particularly as it relates to rural and remote health practice. It provides practical suggestions for designing curriculum, teaching and assessment that helps health professionals be adaptive in a climate-changing world. Using the education literature on best practice, as well as available models such as the Primary Curriculum document of the Australian College of Rural and Remote medicine (ACRRM) as a point of departure, it offers examples of competencies, teaching approaches, as well as assessment models, useful to ensuring health professionals can adapt to the new conditions brought by climate change.

Conclusions:
Meeting the challenges of climate change in health professional education and training will involve a questioning of some approaches to education and training and an embracing of others. The practical demands of designing curriculum, teaching and assessment that helps health professionals adapt to climate change will reinforce and extend existing knowledge of best practice in education and training.

Results of a survey to RACP 2nd year Physicians in Training

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Introduction/background:
As part of educational developments at the RACP, we conducted an evaluation of trainees in their second year of training in 2008. From 2009 onwards, trainees commencing Basic Training at the College, registered in the new Physician and Paediatric Physician Readiness for Expert Practice (PREP) Program. We intend to conduct a similar evaluation in 2009 of the trainees in 2nd year of the PREP program and compare results with the 2008 evaluation of 2nd year trainees.

After piloting the survey with Basic and Advanced Trainees in Australia and New Zealand, an on-line survey was sent to 774 2008 2nd year Basic Trainees in Australia and New Zealand in December 2008. Questions were drawn from a range of sources including the RACP Professional Qualities Curriculum, the Basic Training Curriculum for Adult and Paediatric Medicine and the RACP Multi-Source Feedback tool. The survey consisted of four main sections: 1) 'About You', which included demographic questions, 2) 'Your Educational Experience', which asked them to rate their educational experience for different aspects such as clinical skills, patient care, communication, procedures, safety, ethics and legalities, etc., 3) 'Feedback' – how much trainees are getting on their performance, 4) 'Supervision and Training', including how many times they meet with their supervisor and their expectations of supervision, and 5) 'Reflections', including open-ended questions about training concerns and perceived support needed from the College. This paper will present the findings relating to supervision and training.

Purpose/objectives:
- To present baseline data from this evaluation and consider relevance to the broader postgraduate training arena.
- To explore issues relating to trainees' acquisition of knowledge and skills in preparation for progression to the next stage of training.

Issues for exploration/ideas for discussion:
- How can we best prepare trainees in the specialty setting for progression to the next level of training and towards consultant level practice?
- What are the specific difficulties in providing a good quality learning experience to trainees?
- How can the institution overseeing training best play a role in ensuring high quality learning experiences?

Results:
Over two hundred trainees responded to the survey. Preliminary analysis suggests that trainees are having a generally positive training experience and feel moderately or well-prepared in most of the training areas. They felt best prepared in their clinical skills, communication and acute care and felt least prepared in a range of areas including 'procedural skills', 'neurology', 'immunology' and 'research'. Most trainees said that they only received feedback 'some' of the time due to consultants' time restrictions and many said they were 'rarely' observed in clinical practice. Their concerns about moving into Advanced Training included needing to 'learn more' and passing the exams, as well as anxieties about the availability of jobs. To remedy this, trainees want more educational support in the form of 'teaching sessions', 'information evenings', 'allocated educational time' and 'career advice'.

Discussion and Conclusion:
There are ranges of areas that this evaluation has highlighted that affect the quality of the training experience at postgraduate level. These data will help us determine how to target resources and training for supervisors as well as reflect on the infrastructure needed to support high quality specialist training. The results can also help others ascertain standards across their training environments for other specialty areas. There may be opportunity for collaborative work to ensure that the clinical environment remains supported in providing an excellent learning experience at postgraduate level.

Practice makes perfect: Impact of a hands-on evidence-based medicine training session on learning

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Introduction/Background:
The emphasis placed on EBM in the University of Sydney Medical Program reiterates the importance of training doctors that will 'pursue evidence-based medical practice' to deliver optimum quality clinical care. However standard curricular teaching activities in EBM may be not be sufficient to produce evidence-based practitioners.

Purpose/Objectives:
To determine the final year students' (a) favourite resources for staying up to date (b) confidence in the use of some key resources/skills that would be essential to practice EBM in real-time (c) confidence in using these resources could be improved by a single hands-on session, and (d) view of the session (both quantitative and qualitative).

Results:
There were 137 (95%) evaluations for analysis. Google, text books and colleagues were the most frequently used, with review articles, Therapeutic Guidelines and Cochrane Library being occasionally used. One third of the students never used secondary journals. They were most confident in using Google (mean score 3.87 out of 5), OVID Medline (3.55) and PubMed (3.04), and least confident in using MeSH (2.08), Clinical Queries (2.24) and Clinical Evidence (2.28). Post-test highest improvement of confidence was seen in MeSH (2.007), PubMed Clinical Queries (1.679), and Clinical Evidence (1.693). Even the resources with the highest pre-test score (Google) had a significant post-test improvement in confidence (0.036).

For 'usefulness' the session got an average rating of 5.56 on a scale of 1 to 6. 66% said the sessions were excellent (6/6). 26% gave 5/6. Nearly 97% wanted this session to be held before the 4th year, 50 (36%) preferred the 3rd year and 48 (35%) the 1st year.

Discussion:
There is room to improve/change the resources used by final year students to keep up to date. Students' self-perceived confidence in the use of PubMed Clinical Queries, MeSH, pre-appraised evidence resources and general search engines that will be helpful for real-time evidence based practice, can be improved significantly with a single hands-on session. The session may have more value if given earlier in the medical program and repeated at least once. The long term retention rates or the translation of improved confidence into patients' outcomes were not studied.

Conclusions:
This study shows the relevance of having a focused 'evidence based practice' learning session after their 'formal EBM learning activities' to contextualize the theory into practice. In an era where rapid changes are taking place in the resources and methods of keeping up to date, a hands-on session to increase confidence was much valued by the students.

Work integrated learning: Mapping the islands in rural and remote Australia

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Introduction/background:
Professional entry health education programs across Australia have experienced progressive difficulty in sourcing work-integrated learning (WIL) placements due to significant increases in student numbers, workforce shortages, a proliferation of courses, and changes in service delivery models. There is a critical need for improved models of training that meet educational and health systems' requirements as well as add value back to local communities and the healthcare workforce. The nature of the current allied health (AH) workforce in the Northern Territory is poorly defined, as is the capacity and efficacy of local student training models. This study, which also contributes to the national Rural Allied Health Workforce Study (RAHWS), will provide valuable data to inform health workforce policy and training program reform.

Purpose/objectives:
The objective of our study was to profile the current AH workforce in the Northern Territory and compare the various existing models of AHWIL placements. We will present our preliminary findings about the local workforce and describe the attitudes and experiences of AH professionals in regard to WIL placements in the Northern Territory. Our aim is to define the factors that support or challenge the capacity for and provision of student training in the work environment.

Issues for exploration/ideas for discussion:
Are the demographics of the NT AH workforce unique?
What are the barriers and benefits perceived by non-NT universities that place students in the NT?
Are the barriers we describe common to other programs? What are potential/practical solutions?

Results:
We will present preliminary results from a web-based survey (N=146) spanning across allied health professions in the public, private, and NGO sectors. From the data, a detailed demographic profile of the NT AH workforce has emerged, as well as key insight into our AH professionals' training experiences, job satisfaction, career plans, current workload, work environment, and perceptions about student supervision. Younger respondents and those having spent less time in the NT, for example, were more likely to report an intention to leave within 2 years, irrespective of job satisfaction. We have identified themes among respondents' perceptions of the barriers and benefits to student training which appear to differ by training model. Interestingly, our data also reveal some under-utilised teaching capacity, and a lack of clarity about the needs and capabilities of students on placement.

Discussion and Conclusion:
The Northern Territory Clinical School has undertaken the first comprehensive study in the Northern Territory to characterise its AH workforce, define the AHWIL setting, and identify the factors that impact capacity and willingness to support student training. The outcomes of this study will provide an evidence base for the development of more efficient and effective AHWIL placement models.

Students, graduates and doctors – student recruitment and graduate practice location by ARIA

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Introduction/background:
The School of Medicine & Dentistry at James Cook University in North Queensland enrolled its first cohort of medical students in 2000. The aim of a regional medical school in North Queensland was to address health care needs and workforce issues by recruiting northern and rural background students, providing a curriculum that addresses rural, remote, Indigenous and tropical health themes and implementing that curriculum in Northern Queensland.

Purpose/objectives:
We need to fulfil our mission to provide the unique communities of tropical North Queensland and beyond, with empathetic, highly skilled and work ready interns who will remain or return to the location as GPs, registrars and specialists. This research aims to determine if there is a pattern between rural and / or North Queensland origin and rural and / or North Queensland practice location.

Issues for exploration/ideas for discussion:
Does the background of the student impact on their intention to practise medicine in a rural remote and / or Indigenous setting?

Results:
The School achieved its initial goal of enrolling a high proportion of rural and northern background students, many of whom expressed a preference to practise medicine in northern Australia. To date 265 Dr's have graduated, 37% being of rural (aria >3) origin and 60% of northern (post code 4700 – 4891) origin. Eight Indigenous Dr's have also graduated (3%). Each year since graduation they are 'tracked' for our longitudinal tracking project. 128 became interns in north Queensland (48%) and an additional 27 (10%) did so in other regional and rural towns around Queensland. Comparative analysis of their origin ARIA scores and postcodes and their subsequent practice location ARIA and RRMA scores therefore shows an encouraging pattern between the two.

Discussion:
Can the rural clinical schools attached to the metropolitan universities have as much success retaining their graduates, if their students are in the main based in a capital city? And are regional universities the answer to the problem of underserved communities?

Conclusions:
There is much global research surrounding the link between recruitment of students from a rural background and whether this leads to them practising medicine in these areas. Our research certainly adds momentum to this argument.

The impact of rural clinical placements on career intentions: An analysis of data from the Medical Students Outcome Database

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Introduction/background:
Rural clinical placements are one strategy utilised to encourage medical students to consider rural practice, although their effectiveness remains unconfirmed. Data on rural clinical placements and the career intentions of exiting medical students are collected by the Medical Students Outcomes Database (MSOD), a longitudinal tracking project amongst medical students in Australia and New Zealand. The MSOD data will be able to give an indication of the impact of rural clinical placements in modifying outcomes.

Purpose/objectives:
We will briefly report data on the impact on generalist and rural career intentions from rural clinical placements.

Results:
Analysis of MSOD data by Jones, Humphrey & Kaur (2009) suggest that, among commencing medical students, increased rural residence and generalist intentions predict rural career intentions.

The first wave of data on exiting students was completed in late 2008 and the data are in the final stages of cleaning and coding. We will extend previous findings to the first wave of exiting medical students. In particular, our findings will examine rural teaching and experiences during medical training and outcomes. 10% of commencing medical students reported an interest in practicing in small towns or rural communities, and 30% of these students undertook rural placements.

Issues for exploration/ideas for discussion:
Many ANZAME members attended the MSOD national workshop last year and expressed interest in this further analysis. We seek feedback on new questions and directions arising from the current analysis. We seek suggestions of other variables that might impact on the effectiveness of rural placements.

Engaging students in large classes – possible strategies

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Introduction/background:
Often students will not engage with a subject until their interest is piqued and it is apparent that many students see this to be the role of the educator. In large classes this can be a challenge as students have diverse expectations about teaching with many students expecting to be 'edutained' and others preferring a more traditional approach to teaching and learning.

Practical strategies to stimulate this student curiosity in a subject are essential as they can allow students to engage with the material and hopefully lead to deeper learning. These strategies are sometimes hard to find or implement. This session will present some strategies that have worked for the presenters and will hopefully engage the participants to share some of their own.

Purpose/objectives:
Multiple intelligence literature suggest that effective teaching involves reaching students, and that reaching students involves taking their frames of reference into account. The purpose of this presentation is to discuss/showcase various methods for student engagement. These strategies focus on positive methods to assist with maintaining class control and promoting recall of concepts as part of the student learning experience.

Issues for exploration/ideas for discussion:
- Practical strategies for engaging students in large classes
- Positive methods for crowd control in large classes
- Innovative ways of presenting subject material to large groups.

'Tutoring the tutors' – development and implementation of a 'train the (clinical skills) tutor' workshop

Dr Karen D'Souza, Dr Rod Whyte, Leanne Basham, Associate Professor Ross Carne, Professor Brendan Crotty,

School of Medicine, Deakin University, Waurn Ponds, VIC

Introduction/background:
Medical education increasingly uses small-group tutorials in clinical skills laboratories to teach clinical and procedural skills early in the curriculum. These sessions are often staffed by casual Clinical Tutors, drawn from various clinical backgrounds. Clinicians vary in their effectiveness as teachers, with many lacking formal training1. As a relatively new teaching modality, even experienced tutors' comfort and expertise with this format is often limited, particularly in medical curricula utilising systems-based and problem based learning (PBL) techniques. The current literature focuses mainly on training PBL tutors rather than clinical skills tutors.

Purpose/objectives:
On employing our second cohort of Clinical Tutors at the Deakin University medical course, we set out to develop a workshop for tutors based on their perceived areas of weakness, rather than what faculty thought they ought to know.

Methods
Issues raised by our first cohort of Clinical Tutors and those identified by the Year 1 Tutor Coordinator, formed the content of the workshop. The workshop was run as a day-long program, which qualified for Continuing Professional Development points for Fellows of the Royal Australian College of General Practitioners. Content included applicability of adult learning principles to tutoring, role plays on dealing with 'difficult' students, how to give effective feedback, exercises on getting to know fellow tutors, and utilising information technology. Feedback was obtained through formal questionnaire. Qualitative results were analysed, including comparison of perceptions of new and returning tutors.

Results:
The feedback obtained from workshop participants was overwhelmingly positive, from both new (n=5) and returning (n=8) tutors. Areas particularly well received included relevance of material and impact on tutor confidence and perception of competence. Participants valued the opportunity to meet their fellow tutors. Tutors also expressed a desire for more coverage of information technology in future training sessions.

Conclusions:
There is a lack of evidence in the literature concerning the optimal method to 'tutor the tutors' in clinical skills education. We have developed an interactive and informative workshop which included content based on tutors' perceived needs in addition to faculty's assessment of what was required. The program was well-received by new and returning tutors alike.

1Barrat, M.S. and Moyer, V.A., Effect of a Teaching Skills Program on Faculty Skills and Confidence Ambulatory Pediatrics, Volume 4, Issue 1, Pages 117-120.

Issues for exploration/ideas for discussion:
- Clinical Skills Tutor training programs in use at other medical schools
- Issues identified by Clinical Skills tutors as important in providing tutoring to students
- How to actively engage clinicians in training workshops
- How to measure change in tutor ability following such workshops

Functional electrical stimulation for stroke survivors: An interactive eLearning package for allied health, nurses and stroke survivors

John Cannell

Launceston General Hospital, Launceston, TAS

Introduction/background:
Stroke is one of the leading causes of disability, affecting over 345,000 people each year in Australia.

While an average of 70 per cent of stroke survivors are able to walk, only a third of those who suffer arm weakness as a result of stroke recover functional usage of their arm.

Electrical Stimulation is the use of a small device to help weak or paralysed muscles to contract.

Whilst the National Stroke Foundation 'Clinical Guidelines for Stroke Rehabilitation and Recovery' recommends the use of Electrical Stimulation to manage the consequences of stroke, it is not used routinely and consistently in Stroke and Rehabilitation Units.

Purpose/objectives:
The use of an electronic learning package has just commenced for training staff across several health disciplines at the Launceston General Hospital.

The package provides interactive education through interactive pages, short videos (over 45 videos), cloze quizzes, summary sheets with photos supporting each video section, links to online resources and journal articles, and prepares staff for meeting minimum requirements for delivering the therapy.

The package is designed to support the training needs across Tasmanian rural and urban health sites.

Stroke Survivors are provided with the options of written and electronic information to help continue the therapy at home. Later this year the package will be shared across Australian and New Zealand health services.

Issues for exploration/ideas for discussion:
- Targeted electronic learning is not routinely available for these professions and this package strives to provide education to those who have limited access.
- Interdisciplinary learning is supported via a common learning tool.
- Electronic Learning can support the training and development needs of a population unfamiliar with computers and self directed learning.

Are simulation and video debriefing effective for GP Registrar emergency training?

Rohan Kerr

GPTT (General Practice Training Tasmania), New Town, TAS

Introduction/background:
GPTT recently made a significant investment by purchasing new audiovisual equipment and training staff to use it. The aim was to video GP Registrars in simulated scenarios and to deliver feedback to them immediately after the completion of the scenario. Our hope was to improve the educational experience for the GP Registrar by replacing the Medical Educator "sitting in", and therefore providing a more immersive environment for GP Registrars as well as providing video feedback to help educators extract maximum value from each scenario.

Since the installation of the new equipment in 2008 we have run several Emergency Courses for GP Registrars and Rural GPs. As part of the course program time is devoted to discussing the role of simulation and video debriefing, its limitations and then allowing time for the course participants to familiarise themselves with the equipment as well as offering opportunities for participants to discuss concerns and fears they may have.

Purpose/objectives:
The purpose of this presentation is to look at how the effectiveness of simulation and video debriefing as an educational tool can be measured.

Issues for exploration/ideas for discussion:
- Presently our method of evaluation is in the form of written feedback from the participants.
- Issues relating to technical complexities and limitations of simulation and video debriefing will hopefully be explored.
- Does simulation and video debriefing aid in deep learning, and how can long term skill acquisition be measured?

What are the views and preferences of allied health professionals on interprofessional supervision?

Linda Robertson

Otago Polytechnic; PBag 1910; Dunedin; New Zealand

Background:
In 2004/ 2005 we undertook research looking at the language used and patterns of communication in multi-disciplinary and inter-professional teams. (Sheehan, Robertson, Ormond, 2007) One of the themes that emerged from this study was that health professions working in a team (such as rehabilitation teams) are also members of a particular profession so have these professional team alliances as well and this creates a dual membership. This issue of allegiance raises interesting questions around who provides supervision. Who supervises you when you work outside your registered profession and part of an interprofessional team? Should it be the professional expert or the rehabilitation or service delivery specialist with generic skills who provides supervision?

Purpose:
The aim of this project was to survey registered allied health professions in New Zealand to gain information about their views and preferences relating to interprofessional supervision.

Issues for exploration/ideas for discussion:
When is it OK to be supervised by a 'different' professional? What checks and balances need to be in place to ensure beneficial use of interprofessional supervision?

Method:
An online questionnaire survey was sent to 3,000 registered health professionals from Occupational therapy, Speech language therapy, Physiotherapy and Medical Radiation Technology.

Results:
Data from 550 responses is currently being analysed and will be presented and discussed.

Bridging educational and cultural gaps for international Saudi Arabian students in medical education

Judith Amed

Office of Postgraduate Medical Education (OPME), Faculty of Medicine, The University of Sydney, NSW

Introduction/background:
The University of Sydney with the Saudi Arabian Government devised the Saudi Arabian Health Scholarship program SAHSP. It caters annually for 60 Saudi Arabian international students to enter a mentored program from pre-tertiary, graduate and postgraduate studies in Medical Education. This presentation will report on the preliminary analysis of data from the student's perspective

Purpose/objectives:
The SAHSP has its own specific academic and cultural needs that are currently being researched as part of a PhD degree: The Saudi Arabian Health Scholarship Program: the Students Perspectives. Students from each year cohort between 2005-2008 were selected randomly and participated in 12 individual and 12 focus group interviews. Students were interviewed to obtain data pertaining to their experiences within the program.

Issues for exploration/ideas for discussion:
Cultural and academic experiences
Selection process evaluation
How students are enriched
Linguistic challenges with studying in English
Teaching and Learning barriers and successes
Cultural compence and marginalisation
What sort of Medical and Health professionals with the returned Saudi's be upon their return to Saudi Arabia?

Results:
Students within the program identified and presented personal narratives on a range of issues. Majority agreeing that they already have been educationally and culturally enriched in a wide variety of ways. Students reported a number of significant challenges that were generic to the plight of an international student. However most significantly there were specific findings that were unique to this group. Coined the 'Saudi Syndrome' this provides a deeper understanding of how, prior knowledge skills and attitudes have affected the experiences, most notably in, academic performance, teaching, learning, independence and cultural immersion.

Discussion:
- How with these findings be used in assisting tertiary providers to cater better for international Saudi Arabian students and those with a similar profile.
- The changing nature of medical students within global institutes.
- English language teaching support.
- Appropriate mentoring.
- Tertiary readiness programs.
- Staff development opportunities.
- Reviewing and evaluating the current model.
- Supporting students upon their return.

Conclusions:
The student perspectives have generated valued insight into the deeper and more relevant issues surrounding student's experiences with the SAHSP. Whilst the are many successful aspects of the program, student welfare, understanding program expectations and dealing with discrimination are issues frequently raised as aspects of the program that may need further investigation to ensure a holistic approach to medical education.

Preparing the remote primary health care workforce for work with older people and people with dementia

Heather Jensen, Melissa Lindeman, Pim Kuipers

Centre for Remote Health, Alice Springs, NT

Introduction/background:
There is a need to develop appropriate models of care and service responses for older people in remote and Indigenous communities, and a resultant need for workforce development to facilitate these new approaches. Knowledge translation offers insights into the processes involved in facilitating the uptake of research evidence into practice.

Purpose/objectives:
This paper discusses the challenges present in developing professional development programs for the remote primary health care workforce, drawing on a recent learning program developed, implemented and evaluated in the Northern Territory, Australia: Recognising and responding to dementia in Indigenous communities.

Discussion:
The paper addresses key considerations for knowledge translation for these settings such as:

- characteristics of remote areas (particularly where the needs of older people may not be a priority due to basic public health concerns and the high prevalence of infectious and other chronic diseases);
- cross-cultural contexts;
- the profile of the primary health care workforce;
- difficulties in responding to workforce learning needs where a public knowledge base is inadequate and an evidence base is lacking or emerging; and
- challenges presented by geographic and professional isolation.

Conclusions:
The importance of developing a research and education agenda that is relevant for working with older people and people with dementia in remote and Indigenous communities is highlighted. The paper concludes by proposing key principles for effective knowledge translation which will facilitate changed practice and service development.

Filling a need: Dentistry with a difference

Dr Felicity Croker, Professor Andrew Sandham, Rose Hogan

School of Medicine and Dentistry, James Cook University, Cairns Campus

Introduction/background:
This year, James Cook University (JCU) commenced an innovative dental program which aims to prepare "work ready" graduates for dental practice in rural, remote, Indigenous and tropical settings. The curriculum is designed to meet the oral health needs of underserved populations and combines dental science with a focus on population health and social justice. JCU provides a student-centred learning environment that enables students to develop the knowledge, skills and attitudes they will need to be competent professionals. This will be accomplished through early and continuing exposure to clinical skills, including communication skills, evidence-based practice, strong underlying scientific knowledge, information analysis skills, population health and preventive health strategies.

The educational approach involves applying the best elements from a variety of learning models including cross disciplinary curriculum design and interdisciplinary teaching. We are using the experiences we have gathered over the years from delivering programs using the complete range of teaching styles, from didactic to problem-based learning, in order to develop a very effective and efficient hybrid model.

Purpose/objectives:
This presentation will:
- Report on the first six months of the program
- Describe collaborative curriculum design and development
- Discuss designing a curriculum for the changing nature of the student and the workplace
- Outline emerging issues and challenges

Issues for exploration/ideas for discussion:
- Implementing a student-centred curriculum with a social justice framework
- Exploring the relative merits of the interprofessional agenda versus a collaborative model incorporating community partnerships
- Preparing students for clinical practice in resource-poor contexts.

Clinical education: The lost acronym

Professor David Prideaux

Deputy Dean, School of Medicine Flinders University, Adelaide, SA

Introduction/background:
In medical education, at least, acronyms abound, the two most ubiquitous and enduring being PBL for (Problem-based Learning) and OSCE for (Objective Structured Clinical Examination). Yet, there are few acronyms for what is considered to be at the apex of health professional programs, clinical education.

Teaching hospitals have provided much of the context for clinical education. Many of the approaches to teaching and learning in those contexts have remained unchanged. Yet the hospitals themselves have changed markedly. They are marked by:

- Increased pressure for clinician time;
- A preponderance of emergency and acutely unwell patients
- The use of complex technological procedures
- Short patient stays.

As the population ages there is a greater incidence of chronic disease much of which is treated in ambulatory settings by multi-professional teams. These developments call for new models and approaches to clinical education.

Purpose/objectives:

- To share models of clinical education in health professional education
- To consider sustainability of the models
- To discuss the concept of symbiotic clinical education
- To consider new models of longitudinal placements and ambulatory care placements
- To consider models for the future

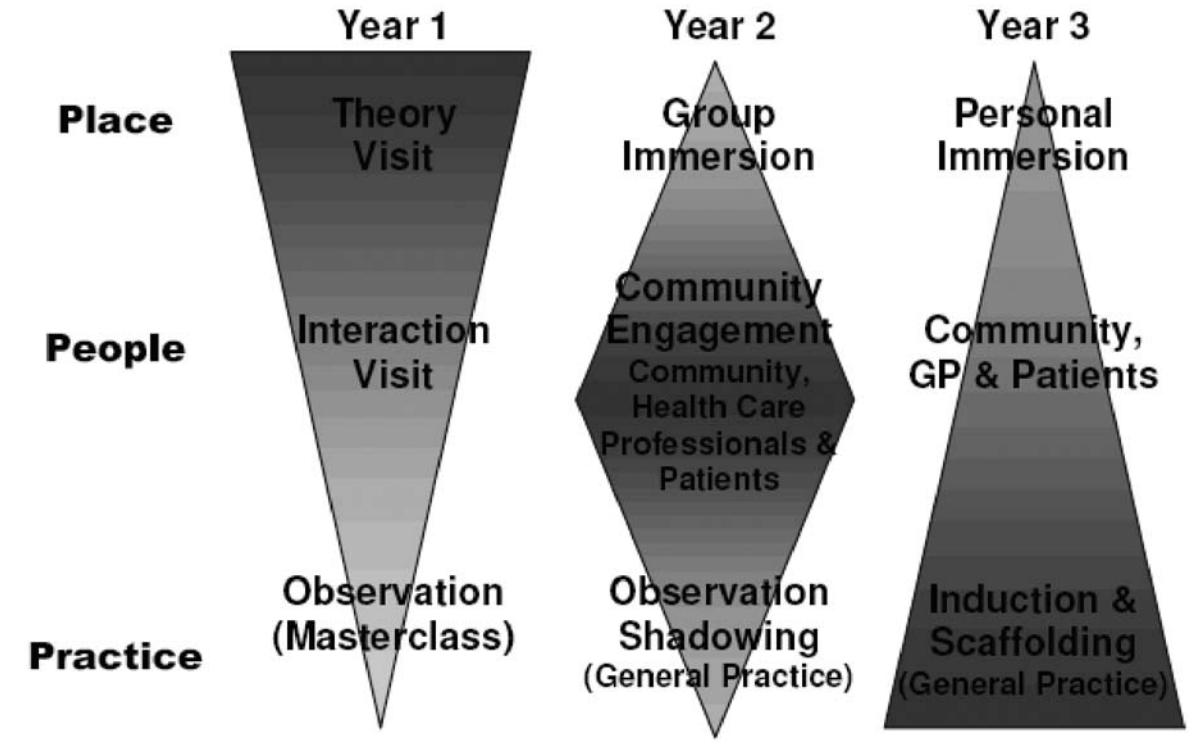
Issues for exploration/ideas for discussion:
The main discussion will focus on the sustainability of current models. The concept of symbiosis will underpin discussions of how health professional students can make a contribution to health care settings while at the same time gaining valuable learning experiences. Examples will be briefly presented from the longitudinal clinical education programs at Flinders University and elsewhere. Using this as a guide the participants will be encouraged to demonstrate how symbiosis can be achieved in their own clinical settings. From this consolidated models will be built up and discussed. The challenge will be to ensure that the models are both responsive to and feasible in current clinical settings. This will provide the basis for ongoing deliberations and discussions.

Developing a curriculum framework for rural health in medicine

Alison Miles, Craig Zimitat

School of Medicine, University of Tasmania, TAS

Introduction/background:
The curricula of most Australian and New Zealand medical schools is well organised, based upon a curriculum framework comprising of themes that provide for vertical integration across a clinical continuum. The development of rural health curriculum is well discussed in the literature, however it remains under theorised with few articulated frameworks for organising rural health curricula.



Miles & Zimitat, 2009

The 3P (People, Place, Practice) framework is presented for discussion, together with evaluative data from the implementation of this framework. This framework is based upon Collins ideal curriculum framework (Collins, Brown & Duguid, 1989). The focus in Year 1 is on understanding the rural context. In Year 2, the focus is on engaging with the community. In Year 3, the focus is built around a two-week Primary Care rotation in a rural community.

Purpose/objectives:
To discuss and refine a curriculum framework for rural health in medicine.

Issues for exploration/ideas for discussion:
- Using a grounded approach, the presenters will facilitate participant discussion of key rural health themes and issues.
- These will be tested and compared against the TSOM rural health framework, with opportunity for review and elaboration.

Intended audience:
Those who are involved in developing and teaching rural health curricula.

The use of video as an educational tool in teaching integrated consulting skills

Dr Jan Radford, Dr Kim Rooney, Dr Kathryn Ogden, Jenny Barr

Launceston Clinical School, University of Tasmania

Introduction/background:

Video has the potential to provide a powerful teaching and learning medium offering multi-sourced feedback, self-assessment, a means to develop clinical reasoning skills, and a platform for educational research.

Traditional clinical teaching models face challenges promoting a truly patient centred approach to health care. The Launceston Clinical School's Patient Partner Program (P3) tackles this by providing senior medical students with mentored small group learning with real patients (patient partners) from the community, engaged and consented as participants in teaching.

As part of P3 students are video-taped conducting an integrated consultation with one of our patient partners. Students are then asked to watch their video and provide a self-assessment, in addition to being provided with feedback from a clinician who has also watched the video. Peers present at the time of the interview also provide feedback as do the patient partners. This learning strategy allows formative structured multisource feedback to facilitate and map student progression.

This program has evolved over two years based on feedback, evidence of benefit and perceived student needs.

Purpose/objectives:

- To share our experiences and that of others in the use of video as an educational tool.
- To explore the educational benefits, and strengths and limitations of the use of video in student learning in the undergraduate setting.

Issues for exploration/ideas for discussion:

- Others experience of the use of video for teaching purposes
- Acceptability to students and patients
- Security, consent and other ethical considerations
- How to maximise the methodology to provide multi-sources feedback
- Resource issues – can we justify the resources required?
- What potential benefits other than educational?

Understanding the differences between medical students' expectations and their experiences of a clinical rotation

Karen Scott[1], Jenny Gough[2], Vikki Cheetham[1], Meg Phelps[1], Zoe McCallum[2], Susan Donath[3]

[1] The Children's Hospital at Westmead Clinical School, Westmead, NSW
[2] Department of Paediatrics, University of Melbourne, Royal Children's Hospital, Parkville, VIC
[3] Royal Children's Hospital, Parkville VIC

Introduction:
Research to date into expectations of medical students has focussed on expectations of future careers (Draper and Louw 2007) or specific aspects of medical programs, such as expectations of feedback on formative assessment (Perera et. al 2008) and clinical skills training (Guldbrand Nielsen et. al 2003). However, Draper and Louw (2007) highlight the importance of understanding students' expectations of their medical program as unmet expectations can affect students' ability to learn. They claim that if students' values, beliefs and priorities are different to those of the institution in which they are training, students may develop resistance to the institution's 'hidden curriculum', which could hamper their learning and the institution's goals.

Recent evaluations of the Child and Adolescent Health specialty block at The University of Sydney reveal that, while students are pleased with the learning and teaching experienced, a small number of inappropriate expectations have lead to disappointments, for example, the inability to practise clinical procedures on child and adolescent patients. A joint research project was established with the Department of Paediatrics at The University of Melbourne to establish if similar concerns existed.

This project is employing the survey method to gain input from approximately 550 students at both institutions throughout 2009. The survey involves qualitative and quantitative components, and student participation is through de-identified codenames. This enables the researchers to match pre-course data on student expectations with post-course data on student experiences, and examine both individual and group results. Open text questions in the surveys provide a better understanding of quantitative data.

Purpose:
This research will enable the researchers to improve learning and teaching in Child and Adolescent Health by determining:
- areas of the Child and Adolescent Health curriculum that appear 'hidden' to students;
- areas of unmet student needs; and
- areas of inappropriate student expectations.

Issues for discussion:
The results of the initial phase of the research will be presented to the small group, leading to a discussion of the following:
- What expectations do students have of your program?
- What areas of your curriculum may appear 'hidden' to students?
- What areas of unmet student needs may exist in your program?
- What areas of inappropriate student expectations are you aware of in your program?
- How can the 'hidden curriculum' be made explicit to students?
- How can communication be improved between staff and students about values, beliefs and priorities?

Longitudinal patient contact for final year medical students on clinical placement in orthopaedics

Donald Bramwell

Orthopaedic Surgery, Flinders University, Adelaide, SA

Introduction/background:
Final year medical students on 6 week rotations in orthopaedic surgery split their time between

wards, outpatients clinics and operating theatres. In the past there has been little connection between the activities students perform in each setting and few opportunities for the students to develop an understanding of longer term patient care or of the role of all members of the healthcare team.

At the start of 2009 we instituted a program in which students were assigned patients to follow through the length of the patients' engagement with orthopaedics from pre-admission clinics, or from emergency presentation, through surgery to post-surgery clinic visits.

Purpose/objectives:
The program aims to:

- Allow students to develop a broad understanding of the different aspects of patient care in orthopaedics
- Encourage students to develop their skills in communicating with patients and with other members of the healthcare team
- Address the need for the development of clinical reasoning to take place in a context that is realistic in terms of later medical practice and that allows students to draw on their current knowledge and extend their awareness of different diagnoses, treatments and management
- Enable students to make a realistic contribution to patient care and to the orthopaedic team
- Provide an opportunity for students to gain an insight into the role of an intern, while maximising access to a wide range of learning opportunities that are available
- Allow students to understand continuity of care by considering the patients' care before, during and after admission to the tertiary hospital setting

Issues for exploration/ideas for discussion:
This PeArL session will provide a brief overview of the strengths and weaknesses of the program to date as a basis for discussion of other people's experience and ideas.

We could discuss issues such as:

- The value of such longitudinal patient contact, within the confines of a single rotation.
- The extent to which the program assisted students and clinical staff to establish and agree on a curriculum.
- Benefits of students' closer involvement with the team through having a defined role.
- Ways of building on the benefits of such a program across other elements of students' final year activities.

Feedback has pointed to some benefits and indicated some changes to the format and content of the program.

I would be interested to hear about and learn from similar initiatives and to look at developing research projects to compare different approaches.

Mind the gap: Supporting new graduate allied health professionals

Lyn Biviano[1], Beth Fulton[2]

[1] The Children's Hospital at Westmead, Westmead, NSW
[2] Sydney Children's Hospital, Randwick, NSW

Introduction/background:
The Children's Hospital at Westmead (CHW) is a tertiary paediatric hospital in NSW. Allied Health is a clinical service made up of 15 departments. In 2008 a multidisciplinary new graduate group was established to support allied health professionals in their transition from student to clinician. The challenges new graduates face when first entering the workforce has been highlighted by new graduates, experienced clinicians and the literature. Despite profession specific supports such as clinical supervision being provided, a core set of issues common to all newly graduated allied health professionals remained. The primary aim of the support group was to provide educational opportunities and support in a multi-professional context. A secondary aim involved the modelling of a multidisciplinary team to encourage a shared understanding of roles within the allied health care team. The group was co-facilitated by two senior allied health clinicians and based on principles of mutual aide. The group ran for 6 months with fortnightly sessions of one hour duration. A range of allied health professionals participated from nine different disciplines. Each session had a specific theme and involved a mixture of didactic teaching, group exercises, self reflection and case studies. Themes were identified through review of literature, clinician experience, collaborating with heads of departments and through new graduates themselves. As adult learners, new graduates were encouraged to take on responsibility for their learning within the group. The group was evaluated both at midway and at the conclusion of the group. At the conclusion of the group 12/ 14 (85.7 %) participants completed the on-line survey. The feedback rated the group highly on both support and educational objectives.

Purpose/objectives:
This presentation will outline objectives, process and evaluation of this program:

- To outline and discuss a model of support for allied health graduates in the workplace.
- To present common themes or challenges faced for transition amongst allied health disciplines within an acute care setting.
- To present evaluation data on the effectiveness of the group program in supporting transition.
- To provide a forum for discussion on how this framework may translate to other disciplines or contexts.

Issues for exploration/ideas for discussion:

- Providing structured new-graduate support in a multi-professional context.
- What is the optimal framework to provide this education/ support
- Group dynamics and developing group cohesiveness, safety and sharing of knowledge and experience.

Simulation debriefing: Searching beyond closed doors and recognising the value of reflective practice

Lyn Gum, Kerry Dix, Jennene Greenhill

Flinders University Rural Clinical School, Renmark, SA

Introduction/background:
"We learn by doing and realizing what came of what we did" declared John Dewey (1). Dewey's concept of learning in practice through reflection can create an effective simulation experience which has the potential to build knowledge and improve performance (2, 3). The debriefing which occurs following a simulation exercise is the most integral component of the simulation training, especially when there is integration of the video-playback (4) which took place in this study.

A qualitative research study was undertaken to explore participants' perceptions and experiences of simulation training. Staff from 4 rural hospitals participated in a Clinical Simulation in Maternity (CSiM) workshop. In-depth interviews were conducted at 1 week and 3 months post-workshop with 4 clinical educators, 5 rural general practitioners, 7 midwives and 3 nurses. Data was analysed with NVivo 7 using a thematic analysis approach. The purpose of the study was to explore people's experiences of clinical simulation

Purpose/objectives:
This presentation explores and discusses the theme of "Simulation Debriefing" which was a finding in our study. We consider the value of interprofessional debriefing to practice improvements and teamwork skills.

Issues for exploration/ideas for discussion:
1. Is there enough time and opportunities for interprofessional debriefing in the workplace? Both informally and formally?
2. How could we improve critical thinking and reflective learning in the workplace?
3. Tips for effective debriefing sessions.

If research data are to be presented, please include the following sections:

Results:
This paper presents the findings related to the participants' thoughts about the debriefing sessions following simulation training. Three sub themes were constructed and will be discussed; Self-Reflexivity, Transforming Practice and Space to Reflect.

Discussion:
The opportunity to self-reflect during a simulation debriefing session (reflection-on- action) assisted participants to transfer their learning and become more self-reflexive in the clinical setting. Most participants agreed there was not always enough "space" to reflect in the workplace. The simulation debriefing sessions were in a safe, non threatening environment and raised participants' awareness of the value of being critically reflective and how self-disclosure can inform practice both professionally and interprofessionally.

Conclusions:
Simulation learning creates an environment for critical thinking and reflective learning which promotes future personal development and enhances interprofessional practice beyond the closed doors of the 'debriefing session'.

What are good medical notes and what should we be teaching students?

Dr Martyn Williamson, Tony Egan, Dr Emma Storr, Dr Jim Ross

Department General Practice, Dunedin School of Medicine, University of Otago, Dunedin, New Zealand

Introduction/background:
5th year medical students working with us in the department of general practice, DSM usually record case notes in 3 differing settings:

- On some occasions at the general practice workplace, directly into notes, overseen by the GP tutor
- During simulated GP clinics when the content of the notes is used along with patient feedback to give a guide to performance
- Case reports on 3 patients over the length of the clinical attachment posted on a confidential web site bulletin board for feedback

The variation in these notes in terms of detail recorded, quantity and focus seems large.

We have also observed that thorough notes in the traditional sense do not always equate with good clinical judgement, and may not always contain pertinent information regarding the patient's needs, or key decisions or actions required for a good clinical outcome.

We all write notes differently ourselves, and in clinical practice place differing emphases on content and detail. Our own discussions on what notes are appropriate for a particular clinical situation and trying to write general guidelines for the on line case reports demonstrate considerable variations in opinion of what might be considered ideal.

How students should approach this challenge as they take their first steps of putting theory into practice assumes considerable importance, both in terms of patient safety and protection of the practitioner medico legally.

Purpose/objectives:
The objectives of the PeARL are to discuss some of the questions we have about how as teachers we should be advising clinical students about writing good case notes in order to equip them for the realities of clinical practice, and to gain feedback on our current thinking and directions we have taken, from our peers.

Issues for exploration/ideas for discussion:

- The purpose/s of medical notes (are these explicit, do they vary from time to time and place to place in emphasis?)
- How predictable is the purpose or is it via the 'retrospectoscope'?
- How the context of the clinical situation may influence the content of medical records in practice and as an ideal
- How important a competence is the ability to write good notes for medical students
- How do we match the 'purpose of a set of clinical notes' with an assessment of their quality?
- How well are medical students being taught these skills?

Visions of care and student learning in clinical practice

T. Egan

Department General Practice, Dunedin School of Medicine, University of Otago, Dunedin, New Zealand

Together with my colleague Chrys Jaye, I have been studying the ideas of Jean Lave and Etienne Wenger, particularly the concept of a community of practice (CoP) and its relationship to learning, meaning and identity. It seems to us that communities of practice (or more specifically, "communities of clinical practice") are frequently the site of student learning and can serve as vehicles for influences that operate implicitly rather than explicitly. The concept of a community of clinical practice we proposed (Jaye and Egan 2006) is defined by the group that congregates around an individual patient for the purpose of caring for their health. Membership is defined by relationships and practice consists of a range of activities conducted by members acting individually or in combination.

CoCPs are to be distinguished from formally constituted clinical "teams" which may form all or part of a CoCP, We make the assumption that a functional CoCP works to a "vision of patient care". If the CoCP consists of more than one person (as is often the case) then "a shared vision of care" will be needed in order to optimise patient care.

The questions posed in this PeARLS are:
Do practitioners form visions of care? Are these articulated? In what way?
Do shared visions of care exist? If they do, are they articulated or do they remain implicit?
How can we help students learn about them and their relationship to practice?
Where ambiguities or contradictions exist in the vision of care how can we help students make sense of the care they are party to?

Posters

Building for cultural change: An interprofessional process

Judith Anson, A. Ruth Foxwell

University of Canberra, Canberra, ACT

Introduction/background:
If interprofessional education is to be adopted, we not only need to change how and what is taught, we also have to understand how the physical placement and design of buildings can facilitate or limit interpersonal interactions. Not only can the gulf between buildings prevent effective interactions but also the physical location of staff within a building may restrict interprofessional integration.

Purpose/Objectives:
When building for better interprofessional engagement, plans need to facilitate cultural change and resist creating a more modern version of the status quo. In order to build for the future, the process of designing the space should model interprofessional practice and not simply be a competition for space.

Issues for exploration/ideas for discussion:
This paper explores some of the key elements and processes that were used in the designing and building of an interprofessional allied health building at the University of Canberra.

The finished product is a building strategically located between two existing buildings, seamlessly linking all the disciplines within the School. The final design of the building includes specific purpose rooms that have multiple functions beyond that of a single discipline (eg a physiotherapy area that doubles as a simulated hospital ward, a tutorial space and can be used by health authorities in the event of a pandemic) and office spaces where professional groups are intermingled. The design incorporates light and open public spaces and an interprofessional clinic that serves both the university and public communities.

The challenge was to design a building that i) met the needs of all the user groups, ii) facilitated interprofessional interactions, and iii) remained within budget.

The Canberra experience suggests that certain aspects of governance are fundamental to success. This includes the roles, skills and attributes of key personnel and the formal framework and agreements established prior to the beginning of the project. Upfront formal agreements need to provide rigour with flexibility to ensure a pragmatic and enabling process can ensue over the life of the project. The project coordinator must be able to bridge the vision with the pragmatic, gaining consensus on scope, direction and processes, facilitate communication between the different 'tribes' (the different professional groups, the architects, project manager, university hierarchy and the granting body), hold authority without vested interest, and have the respect and trust of all parties.

Should Australian universities be producing Physician Assistants?

Allan Forde

PA-C, MPAS, Senior Lecturer, James Cook University School of Medicine and Dentistry Townsville QLD

Introduction/background:

Health workforce shortages are a global phenomenon and Australia is no exception. Even with the Australian health workforce growing at close to double the rate of the population and despite an increase in medical schools and student numbers, the shortage of doctors continues to worsen due to factors such as reductions in work hours and the ageing and feminization of the workforce. A 2005 prediction by the Australian Medical Workforce Advisory Committee estimated a shortage of between 800 and 1300 general practitioner graduates alone by 2013. The ageing of the workforce, increasing life expectancy and the mounting burden of chronic disease are major problems facing all developed nations. Compounding these issues in Australia are the difficulties of caring for significant rural, remote, and indigenous populations. Clearly there is a need for change in policy and service delivery models in Australia. Simply increasing the number of doctors will not necessarily lead to increased recruitment or retention in general practice or underserved geographic areas. Many healthcare advocates and organisations have suggested a variety of innovations to facilitate the needed transformation in the existing system. Last year, The National Rural Health Alliance (NRHA) declared: *"We need to redesign the workforce so that services we currently see as 'medical' or 'nursing' are provided by a broader range of professionals than just doctors and nurses. We will get around the unavoidable shortage of doctors and nurses (given the excessive and escalating level of demand) by redesigning and redistributing the way doctoring and nursing are provided."*

Purpose/objectives: Illustrate how the introduction of Physician Assistants (PAs) into Australia, may be one strategy to strengthen the health care team and address medical workforce shortages

Issues for exploration/ideas for discussion:
Review the history of the United States (US) PA profession, policy and education.
Outline the spread of the PA model globally, especially in Commonwealth nations.

Describe the PA pilot trials being run by South Australia Health Department and Queensland Health and the two PA educational programs under development at The University of Queensland and James Cook University.

1. Identify the opponents to the introduction of PAs and present their concerns.
2. Explain why key Australian academic and government healthcare strategists and leaders are supporting the idea and are cautiously optimistic about the future of PAs in Australia.

Increased ICU time increases inter-professional learning and enhances performance of physiotherapy students: An observational study

Bernie Bissett

ACT Health, Physiotherapy Department, The Canberra Hospital, Garran ACT

Introduction/background:
Physiotherapy students undertaking clinical placements in cardiorespiratory areas can be exposed to both ward and intensive care (ICU) environments. Prior to 2008, students at The Canberra Hospital primarily experienced ward environments and only up to 2 days ICU as a 'taste' of this area. This was based on the assumption that students would be overwhelmed by greater ICU exposure and that it was more realistic to expect competence in the ward environment.

In 2008 we challenged these assumptions by dramatically increasing students' time in ICU and hypothesised that this would:

- Increase exposure to a wider variety of patients and broader spectrum of acuity
- Translate into better performance in a ward environment (i.e. broader skills and more honed clinical reasoning)
- Allow for increased opportunities for inter-professional learning

Purpose/objectives:

- To establish whether increased ICU time for physiotherapy students improves performance (as measured academically and observed by supervisors) and facilitates increased opportunities for inter-professional learning.
- To determine whether there are any adverse effects for students of increasing the bias of ICU time within a clinical placement.

Issues for exploration/ideas for discussion:
See below

Results:
21 students from 3 different universities (UC, CSU, Sydney) completed clinical placements of 4 – 5 weeks each
Time in ICU was increased from <10% to 25 – 50%
Emerging themes from students:

- Positive experience
- Broader range of patients
- Increased confidence
- Increased IPL & IPP
- Felt safe and supported
- Supervisor perspective:
- More rapid acquisition of skills
- Increased availability of equipment
- More teaching opportunities
- Improved demonstration of IPP
- Skills translated well to ward environment
- No evidence of students feeling overwhelmed.

Discussion:
The emergent themes from this study reveal that physiotherapy students appear to benefit from increased ICU time during cardiorespiratory clinical placements. It is not yet known how much time is ideal, but this is likely to depend on numerous variables including patient availability and student strengths and weaknesses. One limitation of the ICU environment is that it offers little scope for discharge planning which is an important part of patient assessment and treatment. Thus, while ICU appears extremely valuable, it is important to retain some time in a ward environment to ensure students are fully competent.

Conclusions:
Increased ICU time appears to improve the performance of cardiorespiratory physiotherapy students, whilst also providing more opportunities for interprofessional learning and practice. There do not appear to be any adverse effects for students of increased ICU time.

IPE success in a cancer setting

Jenelle Loeliger, Jane Farrow, Denise Beovich, Anna Boltong

Peter MacCallum Cancer Centre, Nutrition Department, VIC

Introduction/background:
Allied Health (AH) clinicians working in oncology and palliative care face complex cases on a daily basis and close working relationships with other members of the multidisciplinary team are essential. Interprofessional education (IPE) is a novel teaching and learning initiative where students of more than one health profession learn interactively together. Peter Mac was keen to trial a new IPE initiative as there was no formal avenue for collaboration and interactive learning for AH clinicians or students at Peter Mac.

Purpose/objectives:
An IPE session was piloted and evaluated for AH students which aimed to increase student understanding of the role of other AH clinicians in patient care and provide an opportunity for collaboration and interactive learning.

Issues for exploration/ideas for discussion:
Eleven students from six AH disciplines (Dietetics, Occupational Therapy, Pastoral Care, Physiotherapy, Psychology, Social Work) participated in the session, facilitated by four experienced AH clinicians. The session design was structured discussion, small group work and a problem-based learning approach to a patient case requiring multidisciplinary (MD) assessment and intervention. Evaluations were completed by students and facilitators which examined students understanding of the role of other AH clinician's pre/post-session and suggestions for future initiatives.

Results:
Participation in the IPE program increased student understanding of the role of other AH clinicians as demonstrated by category of understanding. The level of 'extensive' understanding was increased from 9% before the session to 73% after the session.

Discussion:
The session provided an opportunity for enhanced communication and collaboration. Students felt it helped prepare them as functional MD team members and would impact positively on their clinical practice and teamwork through more appropriate referrals, increased confidence to collaborate and improved team communication.

Conclusions:
This IPE pilot was evaluated positively by participants and facilitators and has identified potential future initiatives. Recommendations include measuring student understanding/application of skills learnt either at the end of placement and/or graduation and to incorporate multiple disciplines (AH, nursing and medical students) into an IPE package offered to students.

Collaboration or bust

Kath Hoare

In 2006, a Primary Health Care Nursing Entry to Practice Programme was launched in the Manawatu region of New Zealand. This inaugural programme offered newly Registered Nurses a formalised, direct pathway into Primary Health Care practice. The programme is a new and exciting innovation involving the Health Sector, District Health Board and Tertiary Education providers, was the result of two years of collaborative developmental work.

The focus of this paper is on the strengths, challenges and opportunities that this collaboration employed to progress the development and launching of the Primary Health Care Nursing Entry to Practice Programme across a diverse range of clinical practice settings.

While a collaborative approach offers the possibility of utilising experience and expertise from across the health and education sectors, it does also present a number of challenges. The focus of this paper is on those challenges, the lessons learnt, and the strategies that were used to progress the development and implementation of the programme. I welcome the chance to share this experience of interprofessional collaboration.

Impact of simulated patients on teaching counter prescribing and communication skills to undergraduate pharmacy students

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Introduction/background:
Pharmacy practice has evolved from a model that focused on product knowledge and supply, to an emphasis on the patient and the delivery of cognitive services. This prompted new practice standards for counter prescribing, published in 1998, for the supply of schedule 2 (Pharmacy Only) and schedule 3 (Pharmacist Only) medicines, changing the implementation and delivery of this service.

Competent counter prescribing require developed communication skills, knowledge of self-limiting diseases and an understanding of the prescribing, documentation and referral process. It is desirable for students to be practiced in a clinical skill or service at a basic level and possess fundamental communication and problem solving abilities before exposure to clinical placement or their intern year. Novel teaching methods previously unexplored in pharmacy education may be required to educate undergraduate pharmacy students in counter prescribing and communication, ideally in an environment that is safe and reflects the process they will encounter in practice. Developed scenarios incorporating simulated patients can promote skills, knowledge and attitudes necessary for this type of pharmacy practice. Performance based teaching incorporating simulated patients can facilitate the transition between the classroom and clinical practice.

Purpose/objectives:
This research aims to identify the impact of simulated patients on the ability of pharmacy students to learn counter prescribing and communication skills and to understand student views regarding simulated patients and standardised patients in teaching and assessment.

Issues for exploration:
Seventy-four level 3 undergraduate pharmacy students (51 female, 13 male) have been selected for this study. These students will conduct six counter prescribing interventions and observed 24 counter prescribing interventions incorporating a simulated patient over a six week period between March and April 2009. Ability to conduct a counter prescribing intervention and communication ability will be assessed by pharmacist tutors using set assessment criteria. The students perceptions of difficulty and their confidence in dealing with simulated patients during constructed counter prescribing scenarios will also be assessed, in addition to their impressions about the value of simulated patients in teaching and assessment.

Simulated patients are expected to be an effective teaching tool to impart communication and counter prescribing skills to pharmacy students. It is anticipated that the initial high self-reported levels of difficulty and low self-reported levels of confidence in dealing with counter prescribing interventions will improve with exposure to simulated patients. Simulated patients can be an effective teaching tool to teach this type of clinical skill in pharmacy practice courses.

Why mental health needs teeth

Dr Carol McKinstry

This paper outlines the processes a multidisciplinary project team at La Trobe University have taken to improve the oral health of those with mental health issues. Included in the project was the development of educational packages for both health professionals working in mental health and mental health consumers. Reports such as the 'Healthy Horizons Framework' highlight the importance of oral health and the significant issues surrounding mental health. In Australia, poor oral health makes a major contribution to the burden of disease. The *National Oral Health Plan* provides evidence of some improvement in the oral health status of the broader community. However, the plan identifies that the 'gap between the oral health status of the advantaged and the disadvantaged is substantial and increasing'. Mental health clients are identified in this plan as one of the major disadvantaged groups facing significant issues around declining oral health.

Key national and international reports have identified the major issues that impact on improved oral health for mental health clients. These factors include the type of mental illness, client motivation and self esteem, dental phobias, understanding of the importance of oral health, socioeconomic factors, lack of understanding of how to access dental services, and the impact of pharmacology used in psychiatry. Importantly, oral health knowledge and attitudes of health professionals and dental professional's attitudes and knowledge of mental health problems have been identified as major mitigating factors that impede improved oral health outcomes for mental health clients. It has been argued that the impact of poor oral health amongst mental health clients extends well beyond dental issues and is a major contributor to a mental health clients self esteem and social acceptance. Given these factors, the project team consisted of a range of health professionals including dental professionals and half of the members were consumers of mental health services. The input of consumers was considered vital in ensuring the educational material met the needs of all the target audience, particularly those with mental health issues. The project is underpinned by community development and participative approaches that have developed new collaborative networks and strengthened the capacity of health professionals and their clients to achieve better oral health.

Faculty of Health Science collaborative teaching and learning project

Jo Osborne, Glenyse Frost

Faculty of Health Science, University of Tasmania, Launceston, TAS

Introduction/background:
Teaching and learning development funds were awarded to the Faculty of Health Science to support a project exploring possibilities for collaborative curriculum approaches across the Schools of Medicine, Nursing and Midwifery, Human Life Science, Pharmacy, and the Department of Rural Health. The project process employed literature survey, staff interviews and surveys, multidisciplinary focus groups, student feedback and curriculum analysis. Four distinctive collaborative approaches to teaching and learning were identified and have lead to the establishment of cross-disciplinary pilot teaching developments in 2009.

Purpose/objectives:
The project aim was to improve undergraduate teaching and learning by enhancing collaboration between Schools in the Faculty of Health Science.

Issues for exploration/ideas for discussion:
Project outcomes include:

- Pilot collaborative teaching developments for 2009 (under the themes of Quality & Safety; Law & Ethics; and Management of Chronic Illness).
- Proposed governance structure within the Faculty of Health Science to manage risk and support sustained development of collaborative teaching and learning initiatives.
- Lessons for change management, where the consultative project process itself has been significant for the development of a culture of collaboration.

Interprofessional rural mid/med education: A solution to current issues?

Associate Professor Deirdre Whitford, Dr Lois McKellar

Aim:
To highlight the issues currently experienced in the education and placement of midwifery students and medical students in obstetrics and gynaecology resulting from silos in teaching, lack of sharing of teaching resources, and professional stereotyping and conflict, and to explore models of interprofessional teaching for these student groups as a possible solution to current issues.

Method:
To critically review the literature and from the literature to propose an achievable, effective interprofessional education model that prepares students for safe, quality, sustainable, effective and patient centred interprofessional practice in line with current health systems reforms.

Conclusion:
Current education practices for medical student obstetrics and gynaecology education and midwifery student education are not sustainable, equitable, or effective. New models need to be proposed, based on evidence of effectiveness, sustainability and equity.

Implementation of a national interprofessional learning resource – the palliative care curriculum for undergraduates (PCC4U) project

Alison Farrington

Project Coordinator PCC4U, Queensland University of Technology, Kelvin Grove, QLD

Introduction/background:
The PCC4U Project is an Australian Government Department of Health and Ageing initiative that aims to promote the inclusion of palliative care as an integral part of all medical, nursing, and allied health undergraduate training. As part of the project, a range of evidence based palliative care undergraduate curriculum resources intended to promote achievement of four nationally agreed graduate capabilities in palliative care were developed. To embed implementation of the resources

a set of strategies for promoting uptake and optimising outcomes at a student, organisational and systems level were also developed. These strategies focus on the use of the learning resources and emphasise capacity building activities for health professional teaching staff and the wider academic and professional community as key project outcomes.

Purpose/objectives:
This poster will highlight the PCC4U learning resources, the graduate capabilities and the recommended strategies to enhance implementation of the curriculum resources. The display will provide an opportunity for review and discussion of the range of curriculum and capacity building activities currently being implemented to enhance use of the resources and achievement of the graduate capabilities. These activities include individual course improvement projects, workshops, mentoring and the promotion of academic and clinician partnerships and networks.

Issues for exploration/ideas for discussion:
Data collected during the project implementation phase has highlighted factors critical to the development of graduate capabilities in palliative care that have applications for other health specialities, particularly around student engagement and learning support. Issues identified include the decreasing availability of clinical placements, increasing social and cultural diversity of students, and limited use of interprofessional learning opportunities.

An online professional development program for health professionals

Professor Roderic Underwood

Director, Education & Research, Virtual Medical Centre, Osborne Park, WA

The Virtual Medical Centre (VMC), established in 2002, is a leading provider of information online to health professionals. The VMC manages 19 disease sites which are supported by more than 1,100 national and international medical specialists serving on the Editorial Advisory Boards for each site. In addition, the VMC has two educational sites, viz.: Virtual Medical Education and Virtual Nursing Education.

Current site membership includes:

- 6,827 medical specialists
- 3,106 allied health professionals
- 1,304 hospitals
- 4,440 gp's
- 75 universities
- 197 specialist organisations
- 776 pharmacies
- 14,807 consumers.

VMC has taken a number of steps to guarantee the quality of the available information:

1. Medical Directors
   A Medical Director, with relevant specialist knowledge, has been appointed to each of the 'disease' sites. The Medical Director has responsibility for the site content.
2. Editorial Advisory Boards
   An Editorial Advisory Board (EAB) has been established for each of the 'disease' sites. For example, the Cancer EAB includes more than 140 national and international specialists available to comment on health issues relevant to the field of cancer.
3. Health Insite endorsement
4. Health on the Net (HON) accreditation
5. Professional Recognition
   Medical Profession:
   The VMC is endorsed by the RACGP and ACRRM for the purpose of providing continuing medical education for GPs.
   Nursing Profession:
   The VMC is endorsed by the RCNA for the purpose of providing continuing nursing education for nurses.

The CME program has been developed to operate with the live website. Thus, we are able to offer some 600 topics to General Practitioners for professional development purposes.

Currently, more than 350 GPs are enrolled in the CME program studying 156 different topics. The CME program requires each GP to undertake a literature search, a review of relevant clinical trials, a clinical audit, a case study report and a patient information review.

The GP submission is reviewed by the relevant Medical Director or a member of the Editorial Advisory Board.

Participants in the CME program:

- Have the opportunity to select a topic of interest for study purposes;
- Are able to undertake their studies at their own convenience;
- Have access to specialist knowledge in their chosen field.

The VMC is currently adapting the present CME program to suit the educational needs of other health professionals including nurses, pharmacists and allied health workers.

Near-peer learning in clinical education: Where to from here?

Martin Kidd

School of Physiotherapy, Dunedin, New Zealand

Introduction/background:
Peer assisted learning in clinical education, such as near-peer learning (NPL), has been considered an alternative to faculty-led learning in undergraduate health professional curricula. An emphasis on provision of different styles of learning for students, and factors such as increased student numbers, staff shortages, and financial pressures drive such alternatives.

Currently at the University of Otago, School of Physiotherapy, year four students provide clinical guidance to year two students using the NPL model.

Purpose/objectives:
Four year four students not involved in the NPL model conducted a systematic review in 2008 of the peer assisted learning literature to identify evidence for the current NPL model at the School of Physiotherapy, and to suggest directions for further research. The review found that the body of literature in the area of peer learning in undergraduate clinical education varies in quality. The articles tended to have poor methodology, and mixed results with the majority in favour of NPL. No clear parameters have been identified on a gold-standard NPL model. Further research with clear methodology, objective outcome measures and definitive conclusions is needed.

Issues for exploration/ideas for discussion:
- Is NPL anecdotally commonplace in clinical education?
- Has a study been designed elsewhere that is methodologically sound, i.e. has clearly defined goals, strong methodology, objective outcome measures triangulating perception data, and sample selection that avoids bias?
- Is such a study possible in a single clinical setting, or does recruitment need to be multi-centred and sampled to redundancy as the systematic review suggests?
- If a multi-centred study is necessary, can the study be interdisciplinary as well?

A central statewide allocation model for physiotherapy clinical education placements

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Introduction/background:
Provision of high quality clinical education placements for entry level physiotherapy students is vital for the growth and continued development of the physiotherapy profession. It is universally acknowledged that responsibility for provision of student clinical education should be a shared one, with academic facilities (ie Universities) and health facilities acting in a partnership.

Queensland Health has traditionally been the major provider of clinical education placements for pre-entry level physiotherapy students in Queensland. Recent years have seen a progressive decline of participation in student education by QH facilities as increasing student numbers and inadequate resourcing have placed an unsustainable burden on clinicians. With this decline came deterioration in relations between universities and QH.

In 2008, Queensland Health made a substantial commitment to workforce resources with which to progressively build capacity for clinical education placements. One advance arising from this commitment has been the development of a collaborative Clinical Education Placement Working Party

Purpose/objectives:
The main purpose of the Working Party has been "to ensure that Queensland universities' reasonable requirements for student education placements with Queensland Health are met in a fair and efficient way by the QH Departments of Physiotherapy." Objectives of the Working Party are to:

- Improve predictability of student placements for the universities
- Build capacity for student placements within QH facilities
- Improve workforce management of clinical education within QH facilities
- Facilitate communication between QH and the universities in relation to clinical education

An innovative approach to meeting these objectives has been the development of a methodology for central identification, collection and allocation of clinical education placements statewide.

Issues for exploration/ideas for discussion:
This paper will present a conceptual framework on which the Central Statewide Allocation Process has been developed and the implications for physiotherapy clinical education in Queensland for 2009 and beyond. The shift from a competitive model, where each university negotiates directly with individual QH facilities in order to secure clinical placements, to a centralised collaborative sharing of the process of identification and allocation has been successful. The mechanisms by which this has been achieved will be detailed, including a discussion of the cultural shift required by all stakeholders.

The benefits and disadvantages of this central statewide allocation process will be outlined and discussed and application of this model to other health professions involved in clinical education will be presented.

What is the impact of interprofessional education (IPE) on medical student anxiety and learning opportunities in maternity care?

Catherine Whelan, Prof. Maralyn Foureur, Prof. Ian Symonds

Are midwives "The women from hell?"

In-house evaluations provided insight into the expectations of 4th year medical students regarding their pending clinical experiences in Labour Ward, provoking the study question:

"What is the impact of interprofessional education (IPE) on medical student anxiety and learning in maternity care?"

Study design: Comparative study using Before and After surveys to collect data from two groups of students experiencing different models of IPE:

IPE 1 provides a midwife "champion" to introduce students to the birth unit, other staff members and women; and to model exemplary care for women throughout labour and birth.

IPE 2 provides a model of care where students engage opportunistically with any "available and willing" midwife/doctor on duty who is caring for any woman at any stage of her labour and birth in order to meet their learning objectives.
The study hypothesis is that IPE 1 will reduce anxiety and enhances learning opportunities.

Graduate-entry medical students 'immersed' in Indigenous health

Jacqueline McDonnell, Ruvimbo Mudarikwa, Debra Nestel

Gippsland Medical School, Monash University, Faculty of Medicine, Nursing and Health Sciences, Churchill, Victoria

Introduction/background:
In recognition of the Indigenous Health Curriculum Framework (Committee of Deans of Australian Medical Schools), 57 graduate entry medical students from our rural community-orientated medical school attended a week long residential Indigenous Health Placement 1200 kilometres from campus.

Purpose/objectives:
The main objective of the placement was for students to gain knowledge of the relationship between ill health and underlying social and historical factors encountered by Indigenous communities. The long term goals are to produce culturally competent medical practitioners and to reduce health disparities between Indigenous and non-Indigenous Australians.

Issues for exploration/ideas for discussion:
An existing placement program was selected from an external organisation although some staff from our medical school attended. This poster presents the evaluation of the program.

Results:
After the placement, students used a 5-point scale to rate their experiences of the structure and content of the program. Free text comments were also sought.

Students' examination results were used as indicators of program success and a staff member provided field notes on her experiences.

Descriptive statistics summarised ratings while qualitative data was thematically analysed.

Twenty-one students returned evaluation forms (37% response rate). Students rated physical elements of the programme highest (food, travel at the site; mean>4) and educational components lowest (cultural awareness; mean<3). Although all students passed the assignment (reflective essay) many questioned its educational benefit.

While students appreciated the time away from campus, they believed the limited time frame gave only a superficial look at Indigenous health and culture.

Many students would have preferred to visit a local Indigenous community rather than travelling to a distant site. More interactions with Indigenous people would have been appreciated together with a program that incorporated adult learning principles.

Discussion:
Outsourcing this educational program proved challenging. The experience intended to support the development of competency in Indigenous health met with only moderate success.

Challenges included learning methods that contrasted with those currently utilized by students and little acknowledgment of students' prior knowledge. There was minimal advantage taken of opportunities for immersive experiences. A closer alignment with the broader curriculum content would have had greater educational benefits.

Conclusions:
Graduate-entry medical students would benefit from Indigenous health placements that adopt adult learning principles and experiential learning methods. This includes 'hands on' opportunities to explore health and societal issues in context.

The next student cohort will undertake a distributed placement locally with the goal of working closely within our community where we are likely to have greatest impact.

Nursing students' attitudes towards examining each other and patients as part of clinical skills learning

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Introduction/background:

There is a significant body of evidence on the use of peer physical examination (PPE) in early clinical skills and anatomy learning, amongst medical students. Research consistently shows that the majority of students are comfortable with using PPE, when sensitive areas are excluded (breast, genitals & rectal). Students' attitudes are related to their personal characteristics (gender, age, religious faith, ethnicity). There is no data on nursing students' attitudes to PPE.

Method:

All first and third year nursing students were asked to complete a modified ***Examining Fellow Students*** (EFS) questionnaire at the end of 2008. Nursing students learn clinical skills using PPE in all three years of the programme. The EFS asks for students to indicate which of 12 body areas they would not be willing to examine/have examined by a peer of the same/opposite gender. This study also asked students which of the 12 body areas they felt uncomfortable examining on patients. Demographic characteristics were collected.

Purpose/objectives:

Identify and explore:

- Attitudes of nursing students towards PPE
- Levels of comfort towards examination of patients.

Results:

Response: Year 1, 85% (80/94); Year 3, 65% (48/74). Combined years characteristics: male 7%, female 93%; mean age: 21 years (17-44); Religious faith: yes 52%, no 48%; Ethnicity: European 49%, Asian 37%, Maori/Pacific Island 5%, other 10%.

Most students were comfortable with examining non-sensitive body regions of peers (78.2%-100% willingness for same/opposite gender and examiner/examinee role) and patients (92.3-100% willingness for same/opposite gender). In absolute values, year 3 students were more willing to examine peers; this was significant for some body areas. Year 3 students were significantly more comfortable examining patients of either gender compared with Year 1 ($p<0.001$).

Male gender was significantly associated with willingness to examine and be examined by peers ($p=0.001$). Gender was not significant for patient examination. Faith was not associated with peer or patient examination scores. Asian students were significantly less willing to engage in PPE with opposite gender ($p\leq0.007$).

Discussion:

In spite of the male gender findings, this predominantly female population expresses similar attitudes to the more gender-balanced medical student studies. The role of characteristics and attitudes to PPE shows some similarities and differences to other studies. Student characteristics did not play a significant role in determining attitudes to patient examination.

Conclusions:

Non-sensitive area PPE has high acceptability, irrespective of role and is similar to the findings in studies with medical students. Students were more comfortable examining patients, especially for sensitive areas.

The need for innovations in allied health professional practice placements

Dr Carol McKinstry

With increase student enrolments in most university allied health programs to enable sufficient workforce numbers of health professionals in the future, the challenge of finding appropriate professional practice or fieldwork placements has increased. Changes in work practices in both the public health system and private system has also impacted on the ability of facilities to educate students during fieldwork. In professions such as occupational therapy, there are increasing numbers of part-time therapists and therapists working in generic positions who do not offer to have students because of the placement configurations and objectives. An increase in therapists working in private practice has also decreased the availability of therapists to educate students.

Innovation in the fieldwork education models and capacity building is required to meet current and future fieldwork demands. The traditional model of having one student to one therapist is labour intensive and infers an expert-novice approach. Interprofessional practice fieldwork approaches and project management placements are preparing students for future practice while lessening the input from the health professionals educating the students in the field (Fortune, Farnworth & McKinstry, 2007). The is a need for universities to build capacity and support field educators to move to collaborative and interprofessional models of fieldwork (Creighton & McKinstry, 2006). Professional associations, regulation boards and universities need to work together to ensure legal and professional requirements for graduating students are realistic and reflect future practice needs.

Transition from final year medical student to junior doctor

David A Kandiah

University of Queensland, Department of Rheumatology, Royal Brisbane and Women's Hospital, Herston, Queensland

Introduction/background:
One of the most difficult processes for a medical professionals to face, is the transition from being a medical student to graduating and functioning as an Intern and Resident in the following years of their careers..

Students have to make sure that they knowledge base is broad and deep enough to cope with the requirements and responsibilities of being a junior doctor. They also have to learn the basic routines and paperwork required as the most junior member of staff of a functioning medical unit. They have to deal with the patients and their relatives as well as other health professionals and regulatory bodies.

There are many different processes that Medical schools employ to facilitate their students' transitionary processes.

Purpose/objectives:
To explore methods currently in use in a number of medical schools around the world; from experience and the literature.

I have developed four programmes that have had good feedback from Final Year Students that will be demonstrated in this session.

Issues for exploration/ideas for discussion:
As students change from undergraduate to graduate programmes and their personalities and experiences change from that of generation X to generation Y, what are the student expectations and are they realistic? Can we standardise or optimise our methods so that the products of our medical schools all have a certain qualities that we can work from. Research done looking at intern attitudes and base knowledge, from all 13 Australasian medical schools that had produced graduates in 2007, were explored by questionnaire in the one institution. These results help identify positive and changeable methods that may help all Australasian medical graduates start their internship with confidence and clarity on the performance expectations as Interns. Use of other health professionals to facilitate this process will also be discussed, bridging inter-professional training.

Changes to student demographics following the introduction of a graduate entry medical program: Experience from Australia's largest school 1997-2006

Dr Jenny Zhang, Professor David Wilkinson, A/Professor Raymond Peterson, A/Professor Malcolm Parker

School of Medicine, the University of Queensland, Herston, QLD

Introduction:
Over recent years we have become aware that the graduate-entry medical program (GMP) might be acting as a barrier to some students wishing to do medicine. We became concerned that the original intent of the change to a GMP might have been misplaced or become dated. We therefore sought to describe changes in student demographic characteristics over time.

Methods:
Data on student demographics were extracted from the admissions database at the School of Medicine, University of Queensland (UQ). We compared changes in student characteristics through the first decade of the GMP (1997-2006), and also compared undergraduate medical program (UMP) data (1984-1994) with the data from GMP. Student characteristics included age, gender, state of origin, university of first degree, and category of first degree.

Results:
Median age of GMP students was 25 years and that of UMP students 18 years. Age of

students entering the GMP has fallen since its introduction: 52% were aged 20-24 years in 1997, increasing to 70% in 2006 ($P<0.01$). Gender balance was similar in the UMP and GMP (56% and 54% male) overall, but favoured males in the first 2 years of the GMP. Most GMP students (77%) were of Queensland origin, and 60% did their first degree at UQ. In the first graduate entry cohort (1997), 57% of students had a prior degree in a heath profession, but this fell to 22% the next year, and biological sciences have dominated since (50-70%).

Discussion:
Our data indicate that the change from an undergraduate to a postgraduate medical program led to a substantial shift in student demographics, but only for the first year of graduate entry. The introduction of graduate entry led to an influx of older males with a health professional background, but only in the first year. Since then, age has gradually fallen, and gender balance has equalized. Furthermore the academic background of students has shifted substantially to biological science, and the large majority of students are local residents.

Conclusions and implications:
Our data suggest that the introduction of graduate entry has done little to encourage diversity at this medical school. We wonder whether the development of a parallel entry path for graduates, as opposed to a wholesale move to exclusive graduate entry might have been more readily accepted. Others considering whether to develop undergraduate or graduate entry medical programs might find our data helpful in their planning.

Medical student scenario-based resuscitation skills training – are skills retained into internship?

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Background:
Resuscitation training programs have resulted in standardising much of life support training that is occurring in Australian medical schools. There is some research demonstrating that cardiopulmonary resuscitation skills (CPR) are poorly retained by health professionals over time. Medical students at the UWA participate in resuscitation training (basic and intermediate life support) in the final 3 years of the 6 year undergraduate curriculum. Competencies in adult, paediatric and neonatal resuscitation are developed. As part of introducing this curriculum change it is important to evaluate the program process, its impact on skill and knowledge acquisition and its potential effect on knowledge and skill retention.

Purpose:
The aim of this presentation is to describe the process and impact of the Year 5 resuscitation training on medical students' resuscitation skill development and skill retention through to the commencement of internship.

Results:
Results to date show that the processes of the training were positively evaluated by the students with majority of students strongly agreeing the training was well organised, appropriate method of learning and likely to result in increasing their skills in resuscitation. The pre training assessment of resuscitation skills revealed average performance from the majority of students across most skill areas.

The variance between training groups was minimal and Wilcoxon Sign tests (related samples- non parametric statistics) demonstrated significant ($p < 0.05$) improvements 6 weeks after training in all skill areas. This improvement persisted 12 months later (at the beginning of Year 6) for hand compressions ($p=0.041$), ratio ($p=0.004$), call for help ($p=0.000$) and more students passed the pre training assessment in Year 6 ($p=0.000$).

Discussion:
Discussion will focus on appropriate methods of assessment and evaluation for resuscitation skills, and the continuum of training between undergraduate and postgraduate training. The assessment methods and tools used will be presented as will the complete results related to retention of skills at internship. Participants will be encouraged to contribute their own experiences of evaluating simulated resuscitation training.

Utilising online criterion referenced assessment for Health Science students

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Introduction/background:
Criterion referenced assessment (CRA) is currently being implemented in the Faculty of Health Science at the University of Tasmania for all assessment items. Different models of CRA in tertiary education have been proposed, but there has been little discussion regarding the theory of grading by this method, or the use of the online environment for CRA. The ability to allow criteria to be weighted is an important feature of CRA which puts limitations on the grading method. This factor becomes even more important when determining final grades across several assessment items within a university unit. In a university environment it is essential for a CRA program to be able to be implemented online.

Purpose/objectives:
We propose a model for determining intermediate and final grades that is appropriate for the tertiary environment and can be implemented in online assessment tools. The information obtained by this method may be used to map learning outcomes and attributes for students across their whole degree. We describe the implementation of a currently available on-line rubric in MyLO (Blackboard Learning System™ – Vista Enterprise License – 4.2) which is used exclusively at the University of Tasmania. The online rubric was used for grading and feedback for a third year University assessment item in Biomechanics for students in Health Science and Exercise Science degrees and its evaluation by the cohort. Additional development of this tool to allow best practice for criterion referenced assessment is proposed.

Issues for exploration/ideas for discussion:
Feedback from students suggests that the use of a rubric in Biomechanics helped in understanding the assignment requirements, and the anatomical and mechanical learning outcomes associated with the assignment. Students also believed that the rubric assisted them in meeting the assignment objectives. However they did not see the rubric as a particularly useful feedback tool, the rubric was deemed to be most useful as a *feedforward* tool rather than for feedback. The University of Tasmania, along with other Australian tertiary institutions, is moving towards CRA for all assessment. However, the current online environment utilised in many Australian universities is not well placed to incorporate CRA requiring development of new tools and enterprising usage of existing tools. The implementation of CRA online has not been discussed thus far in the implementation of CRA materials.

Going out bush and doing everything: Allied health professionals' experience of working in a transdisciplinary model

Fran Vaughan, Heather Jensen

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Introduction/background:
Many allied health professionals (AHP's) in rural and remote Australia work within a transdisciplinary model of practice, in response to vast distances travelled, limited workforce and in order for AHPs to develop stronger relationships with those particular communities by visiting them more often. The term 'transdisciplinary' in this context describes working in a team with members sharing knowledge, skills, and responsibilities across traditional disciplinary boundaries.

Purpose/objectives:
Two focus groups and a number of semi-structured interviews have been conducted with AHPs in Central Australia with a view to answering the following questions.

Issues for exploration/ideas for discussion:
What does working in a transdisciplinary model mean for AHP's and the service they provide to their clients? Are AHP's being asked to provide services that are outside their competencies? Are people in remote communities getting as good a service as their urban cousins? Are there legal implications? What are the training needs of AHP's working in this model?

Results:
Initial analysis of this data has produced themes around the experiences of AHPs when working with clients and their communities and which include

1. The lack of available resources in remote populations
2. Satisfactions and challenges of working with the community
3. Skills & training required to work in a transdisciplinary way
4. The dilemma between their clients receiving specialist 'best practice' services and providing holistic care within the context of remote communities

Discussion:
These themes will be presented in the poster.

Conclusions:
It is hoped that the results of this study will inform further research and evaluation of this model of service delivery as well as the development of educational programs specifically designed for AHPs working in this way in remote areas.

Self reflections: The PhD experience

Dr Marcus Henning

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Introduction/background:
PhDs are the backbone to scholarship in the University setting and often provide the basis for future research and teaching at this high level of learning. The PhD experience is a highly-charged, challenging, thought-provoking, and rewarding process. It involves considerable self-regulation and motivation, and prudent use of intrapersonal and interpersonal strategies.

Purpose/objectives:
The research objectives aim to consider the student's journey in terms of cognition, affect regulation, and action.

Issues for exploration/ideas for discussion:
The following paper's methodology uses self-dynamic theory as a theoretical framework and a self-reflective approach to consider the present author's journey from the inception of the PhD idea to successful completion.

Results:
The 10 reflections suggest that all these areas are crucial to the process of completion.

Discussion:
The scope of investigation and reflection, thus, presents ideas with regard to how one student successfully attained this qualification and to consider the theoretical and practical ramifications of this student's process.

Teaching bioscience to a novel cohort of enrolled nurses: A personal reflection

Michael Larkin

Australian Catholic University, Watson, ACT

Introduction/background:
Since 2007, the Australian Catholic University (ACU), in conjunction with the Canberra Institute of Technology (CIT), has offered an alternative pathway for enrolled nurses who are seeking to further their education and become registered nurses. The nature of this pathway is a bridging course at CIT which in conjunction with the Certificate IV (Nursing) provides credit for first year subjects at ACU. This has presented unique challenges in delivering science subjects to a diverse cohort of students with a wide variety of ages, experience and educational backgrounds in science and mathematics.

The purposes of this study were to:
- Address the lack of scientific education a proportion of the students arrive at ACU with
- Address the scepticism with which "hardened" enrolled nurses view the biosciences in relation to being a nurse
- Endeavour to deliver practical classes in the absence of science laboratories on the ACU campus in Canberra.

Issues for exploration/ideas for discussion:
- How to develop strategies to present science in a manner that provided interest and a challenge for a cohort of mature-age students, some of whom have not had formal study for 35 years and for others no formal study in science at a high school level
- How to overcome engrained opinions in mature-aged students and desensitise them to science
- How best to develop co-operative partnerships with other tertiary institutions to achieve good learning outcomes for students and a more efficient use of resources.

Results:
Several strategies were employed. The first was to encourage the students to integrate their working experience into the science, and relate the concepts they learn during science classes to their work experiences. An important strategy was to teach material in an informal manner, since this differed from their initial expectations of what university would be like, as well as setting up a better dialogue between teacher and student.

Two other effective learning techniques were peer teaching and eLearning. The students easily integrated themselves into groups that would meet regularly to review and learn material. eLearning enabled the students to access material at home.

The scepticism factor, which was originally thought to be the toughest challenge to solve, proved in fact to be the easiest. As the nurses went on clinical practice, the lessons learnt during science classes became obvious and gave them unique insights into what they were encountering on their clinical practice.

Working with CIT gives significant benefits to the university and to the students. Firstly, by having a fully functioning laboratory within close distance to the university, it negates the need for the university to build its own facility. Secondly, CIT is in close proximity to Calvary Hospital in Canberra which is beneficial for students arriving straight after work.

Conclusions:
Based on evaluation forms and comparison of examination results with another ACU campus teaching the same material, the strategies implemented are not only delivering good student learning, but also resulting in high graduate satisfaction.

Professionalism, pathologists, portfolios and progress

Wendy Pryor[1], Chris Roberts[2]

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Office of Postgraduate Medical Education, University of Sydney, NSW

Background:
The Professionalism of Pathologists has been called in to question. Pathologists have been negatively stereotyped as being laboratory-bound non-communicators remote from clinical practice. The traditional assessment system reinforces this with many demanding formal examinations of knowledge and technical skills.

The Royal College Pathologists Australasia (RCPA) pilot tested a "Learning Diary," a self-regulated portfolio-based assessment tool designed for pathology trainees to evidence their understanding of a broader range of professional roles. This is part of a series of College-led initiatives intended to be proactive in this area and was based on the CanMEDS work form North America.

Summary of work:
Trainees' experience was explored in the context of broadening perceptions of the professional roles of pathologists. Interviews and surveys conducted whilst developing and evaluating the Learning Diary provided text for analysis from a phenomenological perspective.

Summary of results:
A clear articulation of outcomes and standards for the attainment of professionalism has been welcomed by most pathologists. However, a competence-based approach to assessing professionalism has probably generated anxiety and exacerbated the problem. Accordingly, the Learning Diary, in its initial format, was poorly received and is undergoing extensive redevelopment with enhanced resources, a simple interface and an emphasis on formative feedback.

Conclusion:
The next generation of pathologists need to embrace professionalism and an appreciation of their broader roles in safe patient care. Further development is required of an assessment that will support pathology trainees in attaining this whilst identifies problem trainees in a constructive way. This must be implemented in a carefully staged manner to avoid driving trainees to cling more tightly to their microscopes and analysers.

Professionalism and 'just being a diagnostic pathologist'

Wendy Pryor[1], Chris Roberts[2]

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Introduction/background:
Pathologists may have an identity problem with patients and within the medical profession. They may be seen by the general community as romanticised forensic pathologists in television shows like CSI, but according to a recent Australian study of 2,717 patients, 76% did not know that pathologists are doctors. Pathology is unattractive to many medical students because they perceive it as more concerned with autopsies than patient care. Clinicians often have difficulty understanding pathology reports and believe that pathologists choose their career to avoid direct communication. In psychological tests, pathologists score highly for clever thinking and introversion. Pathologists tend to internalise these negative stereotypes and feel misunderstood.

A poor public image has contributed to reduced funding for pathology services and training. Together with suboptimal clinical communication, this has potentially serious implications for safe patient care.

An opportunity to explore these issues arose from data collected during a pilot study conducted by the Royal College Pathologists Australasia (RCPA) of a self-regulated learning tool, a "Learning Diary," designed to address aspects of professional performance. This is part of a series of College-led initiatives designed to change the assessment of pathology trainees.

Methods:
A series of in-depth interviews with pathology trainees and their supervisors was used to explore the implications of professional identities of pathologists from a phenomenological enquiry perspective.

Results:
Pathologists see themselves primarily as diagnostic experts. Whilst they accept the importance of the broader roles, these are likely to be viewed as peripheral, taken for granted, nebulous or experienced with some discomfort. A failure to articulate an explicit curriculum in professionalism, together with an arduous assessment system focusing on knowledge and technical skills, has deflected attention from comprehensive professional development. Negative stereotypes are being cyclically reinforced.

Discussion:
There is vicious cycle of career selection for introverted personalities, an assessment system that hampers professional development, teaching by overloaded supervisors who are products of the same system, poor public image, restricted funding, a workforce shortfall and risk to safe patient care.

Social identity theory describes how members of groups identify with and favour their own so-called "ingroups". If the identity is associated with negative stereotypes, then group members may perform poorly in accordance with the identity.

Conclusions:
Carefully designed strategies are needed to achieve a more positive identity to enhance self-esteem and performance of the pathology ingroup. Evaluation of the Learning Diary as a self-regulated learning approach will be described in a further study.

From strength to strength: Overcoming the challenges of a satellite fast-track Bachelor of Nursing program

Dr Janet Roden, Ms Sandra Campbell, Ms Maree Duddle

Following on from the successful School of Nursing & Midwifery at the University of Tasmania and the St Vincent's & Mater Health Service collaboration, a new School of Nursing & Midwifery campus offering the same fast-track degree opened at Rozelle in 2008 in partnership with Sydney South West Area Health Service.

In this paper we describe the numerous challenges encountered during the establishment of the new campus and how these difficulties were addressed including the creation of a student mentor program, and the introduction of a dedicated Unistart program and weekly information sessions to support students currently undertaking the degree and those new to tertiary education.

'ARS' a tool to improve students' engagement in the bioscience courses

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Introduction/background:
Contemporary learning environments require adaptive learning tools which actively engage students with the course material and with each other. Audience response systems (ARS) or 'clickers', as they are commonly called, offer a management tool for engaging students in the classroom. Although the use of ARS in lecture theatres has been widely documented, our approach demonstrated that they can be used effectively in 'small group' practical/tutorial sessions.

Aim:
An innovative pilot program undertaken at University of South Australia in 2008, and using ARS during our year-long bioscience course practical/tutorial sessions for first-year nursing students, has led to a modified application of this technology with enhanced student learning outcomes and improved student performance in bioscience courses.

Method:
Two approaches were considered; each week in semester one, students used the ARS to respond to 10 questions by selecting one of four multiple choice answers. This has been the tried and tested way in which to use the ARS in education. However, this method did not provide much time for discussion and student engagement. Towards the end of semester 1, due to informal student/staff evaluation, the approach was modified whereby the number of questions asked each week was reduced to three, with each question consisting of up to ten statements with multiple correct answers. Each question was tied with the practical/tutorial sub-themes and students were allocated 20 – 30 minutes to answer each question. With this second approach, students were placed in groups of four and encouraged to discuss the possible answers with their peers, and individual students given the opportunity to choose correct answers. Staff reported a noticeable improvement in students interacting with each other to come up with correct answers.

Outcome:
At the end of the year, students were asked to evaluate the benefits of the second approach to the application of ARS to their interactive learning. The results were overwhelmingly positive, with 90% of the 192 students surveyed agreeing that the ARS improved their learning, 92% agreeing that practicals/tutorials were more interactive, and 94% agreed that the ARS provided instant feedback.

What's Next:
In 2009 the program will be expanded beyond nursing to include the modified application of ARS to other health science programs within the University.

Patient Partner Program (P3), Launceston Clinical School: Community collaboration for medical education

Jenny Barr, Dr Jan Radford, Maria Unwin

Launceston Clinical School

Introduction/background:
The Patient Partner Program (P3) aims to equip medical students with understandings of true patient centred care by offering real and focussed patient learning encounters in the curriculum. P3 offers the strategy, structure and template for addressing contemporary student learning and formative assessment needs with an emphasis on volunteer community based patients in real partnership with the Clinical School.

Previously at ANZAME, our P3 database has been presented, showing the importance of having the capability to implement and manage this underutilised teaching resource – the real community patient in a non-acute setting – in a sustainable way.

P3 has continued to evolve: in the teaching and learning methodology, patient partner management, sustainability measures, formative assessment mechanisms, reflective practice opportunities and the creation of tools to assist new staff learning or implementing the P3 teaching approach.

Purpose/objectives:
This poster/exhibition will demonstrate all these aspects of P3 by:

- Using a laptop to show the P3 Database and DVD -a web based system demonstrated and video of a P3 consultation.
- Marketing / recruiting documentation
- Theoretical underpinnings and reflective piece outlines
- Training resource package for new users
- Consent / referral documentation
- RICS – linked assessment tool / formative assessment tracking
- Program evaluation findings to date

Issues for exploration/ideas for discussion:

- How can medical schools ensure patients are properly engaged and managed to ensure a sustainable program?
- What Faculty support is required to implement such a patient centred approach to health care education?
- P3 can help develop doctors competent in engaging patients in health care delivery.
- The relevance of the P3 Database to a broad scope of medical teaching contexts.

Patient experiences as partners in teaching clinical skills at the Launceston Clinical School

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Introduction/background:
The ever increasing voice of the patient is driving a shift towards patient centred care and patient partnership in health care delivery. To have patients involved in regular teaching and learning, proper engagement and management is vital to ensure a sustainable program.

Real patients are often considered 'too hard' to handle for reasons of logistics, consent, cost, perceived vulnerability and perceptions of not being interesting or 'hot' enough for students searching or clocking up 'diseases' in their clinical repertoire.

However, plenty of evidence indicates that medical educators and curricula need to move away from the exclusive traditional hospital model to focus on community based care and chronic illness management in teaching and assessing students. Real partnerships with community patients can ensure students experience managed and focussed clinical encounters in their undergraduate years.

The existence of the Launceston Clinical School's Patient Partner Program (P3), since 2005, allows for the unique opportunity to investigate the role in education of real volunteer patients from the community, their motivation for participating, any possible benefits and their perceived impact on student learning. This poster will highlight what patients in the educational setting have to say.

Purpose/objectives:
To investigate this patient perspective in teaching / learning partnerships, our Patient Partners took part in a survey (no= 31) and focus groups (no= 16) and both quantitative and qualitative data obtained.

Issues for exploration/ideas for discussion:
Do patients consider participation in P3 a partnership in student learning?

What do they consider their role to be?

What impact does this teaching / learning partnership have on the Patient Partners?

Results:
Data is currently under analysis and will be displayed in the poster.

Discussion:
The privilege of hearing patient's views about partnership in learning offers an exciting contribution for greater consideration of such curricula and ethos; that is, a true patient centred care focus ensuring the development of doctors who are competent in engaging patients in health care delivery.

Conclusions:
This research activity proved to be a rich experience for our P3 team, providing clear insights into the benefits of patient engagement for students' learning. Key features of these findings will be presented, showing how valuing the patients' perspective in health education can contribute to and lead to further development of curricula and formative assessment procedures.

Development of a p-drugs student formulary for medical students

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Introduction/background:
The large number of therapeutic agents developed over the past 30 years has complicated the learning of drug therapy for medical students. Others have tried to create a core list of drugs for medical students, but sacrifice practicality with inappropriately long lists of drugs. The Australian Medicine Handbook (AMH) advocates the concept of P-drug list (personal list of preferred drugs) to increase confidence in the use of the limited number of drugs clinicians regularly prescribe.

Purpose/objectives:
- To remedy the lack of clinical pharmacology and therapeutic teaching in an integrated medical course
- To enhance prescribing skills and reduce medication errors on graduation.
- To develop a template student P drug formulary for Australia
- To implement the use of the formulary at a new graduate entry medical school
- To assess the feasibility of using the formulary to learn drug therapy.

Issues for exploration/ideas for discussion:
Is this a valuable way to learn the principles of clinical pharmacology within a clinical context?

Results:
The formulary was developed from other student formularies from the UK and USA and then "Australianising" with the aid of the AMH, the Therapeutic Guidelines and data from the PBS prescribing literature. The resulting list of 120 drugs has a single preferred drug from each pharmacological class used in common disease states. Drugs are listed by disease, generic name into 3 categories; commonly used, less commonly used and rarely used or specialist drugs. Students are assessed for knowledge of each drug by completing a template of 13 key questions and have to "prescribe" the drug in a sample of the National Hospital Medication Chart.

To date 78% of 74 students have engaged with the P-formulary tool averaging 3 drug templates per student.

A satisfactory or excellent mark has been achieved in 82% of the templates. The feedback from students includes the following positive comments: easy to use: good format: limited amount of space in the template forces the student to select essential information; it's a Personal learning tool and allows alternative medications choices. Some improvements suggested by students have been: introduce it earlier in the course, integrate it with some of the on line learning modules and have regular quizzes related to drug therapy.

Discussion:
Currently this programme is being conducted by two senior clinical academics.
This method seems to be achievable because it requires minimal direct contact with the student.

Conclusions:
Although results up to now are encouraging it needs further outcomes evaluation.
If successful the programme is easily exportable to other medical schools in Australia and other countries.

ECG Who Am I?

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Introduction/background:
Acquisition of skill in the accurate reading of ECGs is an important task for medical students and it maintains its importance throughout many medical careers. The teaching of ECG interpretive skills is a key objective in medical education.

Educationally there is evidence that information is best retained when the learner is enjoying and engaged in the learning process. Learning methods which are non threatening and congenial have been shown to achieve better outcomes and to aid students in constructing deeper meaning or schema for action.

Purpose/objectives:
Our aim was to develop and evaluate an educational tool that would promote systematic ECG interpretive skills within an engaging learning environment.

Issues for exploration/ideas for discussion:
"ECG Who Am I?" combines a well known game with ECG interpretation. This intervention, based on sound constructivist educational principles, utilizes a party like atmosphere to engage learners. The method relies on participants interpreting ECGs through the eyes of their peers, with each group member being given an ECG fixed to a party hat which they wear on their head and therefore can't see.

Results:
From March 2007 to December 2008 we have run six "ECG Who Am I?" activities. There have been 2 for medical students (n=26), 2 for junior medical officers (n=41) and 2 for general practice registrars (n=44). Ninety-two participants have completed a self-report evaluation (response rate 81%) which asked them to rate their agreement with five statements.

Nearly all participants agreed that the activity was informative, enjoyable and encouraged further learning about ECGs. Most participants (76%) agreed that the activity made them feel more confident reading ECGs. The qualitative data indicated that the educational principles underpinning the intervention were supported by the students' opinions about its usefulness as a learning tool.

Discussion:
This learning tool has been rated as informative, enjoyable and encouraging of further learning. Most participants report increased confidence in reading ECGs following the activity. Qualitative responses suggested that the non-confrontational, congenial format was conducive to learning.

Conclusions:
ECG Who Am I? is an innovative peer-to-peer learning activity which our survey suggests has high acceptability for both students and recent medical graduates. "ECG Who am I" is a fun and useful way of developing expertise in ECG reading and the authors invite other educators to use and critique the method.

Junior doctors and evidence-based medicine: A look at practice and competence using a unique multi-modal approach

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Introduction/background:
The Australian Curriculum Framework for Junior Doctors includes evidence-based practice as a key component of knowledge, skill and behavioural requirements for JMOs, but little is known about how and to what standards JMOs practice evidence-based medicine. In a project funded by the Medical Training Review Panel we used a combination of three outcome measures to investigate how prevocational doctors in New South Wales practice EBM: a self-assessment questionnaire, a modified version of a validated EBM competency test (dubbed the 'mini-Fresno') and weblog analysis of participant access and use of NSW Health's Clinical Information Access Program (CIAP), which provides access for all health care practitioners to clinical information and resources to support evidence-based practice at the point of care.

Purpose/objectives:
- To evaluate both perceived and actual competence of junior doctors in EBM
- To determine trends in access and use of CIAP EBM resources by junior doctors
- To identify any associations between self-assessment, competency and web-log outcome measures
- To identify any associations between EBM performance and demographic factors
- To identify strategies for the enhancement of EBM practice by junior doctors

Data collection is now complete and results of the multivariate analysis and overall study findings will be presented.

Issues for exploration/ideas for discussion:
- How does EBM education influence EBM practice by junior doctors?
- How can we enhance evidence-based practice amongst junior doctors?
- How do EBM educational needs and EBM practice change over time?

Performance-based assessment in dentistry

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Introduction/background:
The impact of subjectivity on the assessment of pre-clinical procedures has been an issue in Operative Dentistry for years. In 2008 a major educational research project was conducted at the UWA Dental School to investigate the reliability of both traditional (tutors providing formative or summative feedback to students) and alternative methods, such as peer assessment and self assessment. These different methods will be discussed and how they fulfil the criteria for an effective assessment i.e. reliability, validity, standardisation and educational effectiveness.

Purpose/objectives:
To investigate the reliability of both traditional (tutors providing formative or summative feedback to students) and alternative methods, such as peer assessment and self assessment

Results:
Using a checklist with criteria, no significant differences were found in intra rater reliability although there were differences in inter rater reliability.

Using the global method of assessment, great disparity in comments from tutors were found. Even when coming to the same conclusion, the justification varied among tutors. The conclusion was that this is not a reliable and effective method of assessing preparations in pre-clinical Operative Dentistry.

Great differences were found in the quality and quantity of written feedback to students. This is a new skill for tutors and training is essential.

Student self-assessment, using an analytical method, provided 74% agreement between assessor and student. 18% of students over-rated themselves and 8% of students under-rated themselves. None of the evaluation methods studied provided consistent assessment and unbiased feedback.

Discussion and Conclusion:
More research is needed to evaluate the effect of extensive tutor training on assessment. However, the availability of the same sessional tutors in Operative Dentistry often vary from semester to semester and constantly training new tutors may prove to be a time-consuming process. Alternatively, consideration should be given to the introduction of advanced computer technology simulation units as a reliable and consistent method of assessment.

Building a multi-level bridge in medical education and training: Linking recognition of current competence, workplace learning and assessment in the NSW Hospital Skills Program

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Introduction/background:
The Hospital Skills Program (HSP) is designed to recognise and support the knowledge, skills and other attributes of non specialist doctors in hospital and community settings within NSW. Curriculum has been designed for 7 clinical streams (Emergency Department, Mental Health, Aged Care, Surgery, Medicine, Paediatrics and Obstetrics and Gynaecology) in addition to a core curriculum (which focuses on patient safety, professionalism, communication and other core medical capabilities).

The goal of the HSP is to improve patient care and safety by enhancing medical education and training for non specialist doctors (e.g. Career Medical Officers, Multi-skilled Medical Officers).

Assessment is an integral component of any curriculum and will strongly influence the motivation and learning activities of learners. Assessment also involves substantial tasks and responsibilities for clinical assessors and workplace supervisors. Using processes of workplace appraisal, formative and summative assessments the HSP recognises and collects evidence about the current clinical competence in addition to supporting the achievement of further clinical capabilities of non specialist doctors.

Purpose/objectives:
The purpose/objectives of this workshop are to:
1. Report developments in linking recognition of current clinical competence, workplace. learning and work-based assessment in the design and implementation of the HSP in NSW
2. Invite discussion and comments on these developments.

Issues for exploration/ideas for discussion:
- Exploring models of work-based assessment in post-graduate medical education and training and how we selected the particular model used for the HSP.
- Selecting assessment methods that are matched to purpose and assess HSP learner capabilities across the clinical and service management, communication and professionalism domains
- Supporting the effective implementation of work-based assessment through strategies such as ensuring that participants fully informed of assessment processes, methods and policies, providing opportunities for staff training and designing appropriate administrative assistance and support.

Online and engaged – A communication tool for pharmacy students

Nicola Shapland

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Introduction:
Observation and experiential learning are necessary to maximise learning of communication skills. The current Net Generation of students also expect the adoption of current technology in their courses.

A Communication Tool that offers a blended learning approach would meet current student expectations, and enhance students' communication skills development.

Purpose:
The purpose of this study was to develop a distinctive online communication tool to enhance the learning experience of pharmacy students as part of a Communications Course. The tool comprised digitised video vignettes using simulated patient-pharmacist interactions that demonstrated both poor and good communication scenarios for five core communication skills: Non verbal communication; Appropriate language; Questioning and listening; Experiencing empathy and; Clarifying effectively.

Issues for exploration:
- How to optimise the use of the tool to best engage with students in the learning process
- How to appropriately assess effectiveness of the tool as a stand alone and/or as part of comprehensive communications course
- How to maximise use of the tool both at home and in the class room

Results:
Results from the student survey of 19 Graduate Diploma students exposed to the Communication Tool during the 2008/2009 Summer Semester Course prior to entering the Masters of Pharmacy program at Griffith University showed that the tool was very well received and highly regarded.

- 72% strongly agreed/agreed that the tool was well designed and easy to navigate
- 93% strongly agreed/agreed that the tool was well integrated and complemented their whole learning experience within the course
- 86% strongly agreed/agreed that the tool assisted their development in communicating more successfully in a pharmacy practice setting
- 29% viewed each clip 1-3 times in their own time
- 29% viewed each clip 4- 6 times in their own time
- 43% did not view any clips in their own time
- The most useful video clip was "Questioning and Listening"

Discussion:
The Communication Tool was an effective means of engaging pharmacy students and developing their core communication skills. The majority of students were highly satisfied with the tool as a teaching and learning aid, believing it assisted their communication skills development.

Interestingly, although the tool provided flexible access, 43% chose not to engage with this aspect.

Conclusions:
The Communication Tool provided a distinctive teaching tool that met student expectations, and achieved improved learning outcomes.

Student survey results also indicated that more examples and scenarios were warranted for the future.

Educational support for paediatric pre-intern (Print) students

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Introduction:
An integral component of the University of Sydney Graduate Medical Program is a unique eight weeks pre-intern (PrInt) term designed to equip final year medical students with relevant clinical skills and decrease anxiety during transition from medical student to intern. Our aim was to institute and evaluate a skill-based learning program for the PrInt students based at The Children's Hospital at Westmead (CHW), Sydney, along with a resident out-of-hours work survey to inform future PrInt student education.

Method:
A program was designed for PrInt students to include a small group, interactive tutorial and an observed clinical exercise (OCE) for each of three topics: 1) Fluid Management 2) Pain Management 3) Growth assessment. Students were evaluated for their level of confidence in specific clinical tasks prior to the program, after the tutorial but prior to the OCE and following completion of the program. The students were asked to evaluate the program. CHW medical residents kept a daily diary of tasks undertaken outside of routine working hours.

Results:
PrInt students highly valued this structured learning programme, 12 of 14 students (88%) rating it as 'excellent / very good'. For each topic students' confidence rating increased after the tutorial and again after the OCE. Improvement in confidence was most marked for skills for which students rated themselves pre-teaching as having poor confidence, (pain management and calculation of rehydration fluids). Competence in skills was confirmed by the OCE. Out-of-hours junior doctors at CHW were most commonly called to write up intravenous fluid orders, review patients with asthma and rewrite medication charts.

Conclusion:
PrInt students value a structured teaching programme incorporating observed assessment of clinical skills with direct formative feedback and gained in confidence and competence with important and common tasks. Our junior doctors' survey will inform future programs for PrInt students.

Pattern recognition is a clinical reasoning process in musculoskeletal physiotherapy

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Introduction/background:
Pattern recognition as a non-analytical reasoning process has been reported in the medical and allied health literature as an alternative to the analytical process of hypothetico-deductive reasoning (Patel & Groen, 1986). It has great potential as an efficient reasoning strategy, however its use by clinicians without sufficient domain specific knowledge or experience may be associated with negative effects on clinical outcomes (Norman, 2005). Our understanding of pattern recognition has largely been based on low fidelity 'paper case' experiments in medicine that limit the normal data collection process.

Purpose/objectives:
The study aimed to identify pattern recognition in musculoskeletal physiotherapy using high fidelity case methods and investigate its relationship with accuracy and efficiency. A single case study was utilised with multiple participants. A real clinical case with a diagnosis of high grade lumbar spine spondylolisthesis was simulated using a trained actor. Two participant groups (ten experts and nine novices) were included to explore the common understanding that pattern recognition is an experience based reasoning process.

Results:
The use of pattern recognition was identified and found to be more likely to produce an accurate diagnosis than analytical reasoning strategies during a physiotherapy history. However its use was not a guarantee of success with only three of the four experts using this strategy nominating the correct diagnosis. Participants using pattern recognition spent more time conducting the history than those using analytical reasoning.

Discussion:
The results confirm the use of pattern recognition in musculoskeletal physiotherapy and support a relationship between pattern recognition and diagnostic accuracy. The analysis of efficiency was limited by the lack of physical examination or treatment components.

Conclusions:
This is the first study to investigate the presence and accuracy of pattern recognition in musculoskeletal physiotherapy using high fidelity methods. The demonstrated association between pattern recognition and accuracy supports the findings of the low fidelity medical research studies (Coderre et al, 2003).

Issues for exploration/ideas for discussion:
Pattern recognition is a clinical reasoning process used by experienced physiotherapists and the evidence indicates it is associated with greater accuracy. Little is known of the development of clinical patterns leading to accurate diagnostic outcomes. Can this be effectively researched?

Given the difficulty finding clinical education placements in undergraduate and post-graduate courses in physiotherapy presently, innovative thought is required to meet the challenges. This raises the question of whether recognition of clinical patterns can be facilitated through classroom educational activities.

Nursing endorsement courses and the Primary Clinical Care Manual improving health outcomes in rural and remote communities

Cheryl Papworth, Donna Palmer

I believe the collaborative approach to the nursing endorsement courses and in particular the primary clinical care manual is in keeping with the upcoming conference.

Both are excellent examples of the benefits of collaboration of health professionals to improve access and quality of care to rural and remote communities.

Nursing endorsement programs and authorisation courses in Queensland

The philosophy and approach of the Office of Rural and Remote Health – Workforce Unit nursing programs is reflected in the nursing team mission statement, *"Making a difference to rural and remote health outcomes through partnerships in education and training."*

To *make the difference* through the development and provision of nursing courses acknowledging the expanded role of the registered nurse, especially those who are working in rural and remote settings. Preparation for the expanded role requires educational processes that centre on the needs of the student, safety of the consumer and demonstrates a deep understanding of the context of the practice.

The concepts of partnership and *collaborative practice* are quintessential elements in the development, implementation and evaluation of our nursing program courses.

Collaborative practice is the term used to describe the practice relationship between Registered Nurses, Medical Practitioners, Indigenous Health Workers and other health professionals who will use the Primary Clinical Care M as a guide to practice. The collaborative practice relationship incorporates the dual notions of collaboration and delegation. The defining characteristics of the collaborative practice relationship are:

- mutual respect and acknowledgment of each profession's role, scope of practice and unique contribution to health outcomes
- clearly stated protocols and guidelines for clinical decision-making which comply with relevant legislation and are supported by the health facility and the health organisation
- clearly defined levels of accountability with an acceptance that joint clinical decision-making is an integral component of collaborative practice
- a belief that the best health outcomes are achieved when well prepared health professionals work in collaboration and partnership in both the practice and educational setting

Nowhere is this more evident than in the three courses that prepare registered nurses for endorsement with the Queensland Nursing Council to practice under the relevant drug therapy protocols (DTP's).

The role of the registered nurse holding a DTP endorsement is characterised by a significant degree of autonomy, well-developed assessment and comprehensive patient care skills applied in a collaborative practice environment.

The Primary Clinical Care Manual (PCCM) is the result of a successful partnership between Queensland Health staff and staff of the Royal Flying Doctor Service (Queensland Section) and is reviewed every two years. The PCCM is the principal clinical reference and policy document for Indigenous health workers, registered nurses, medical officers and other health professionals working in rural and remote Queensland.

The PCCM provides clear and concise clinical care guidelines and health management protocols in accordance with the Health (Drugs and Poisons) Regulation 1996. The interventions in the PCCM are based on the best available evidence and information on best practice from experienced health professionals and clinical specialists.

By definition, health management protocols contained within the PCCM must be developed or adopted by an interdisciplinary health team and as a minimum that team must consist of a medical practitioner, registered nurse and pharmacist, and may include other identified professional personnel as considered appropriate by the employing authority.

The content is not an exhaustive list of situations that may confront Registered Nurses and Indigenous Health Workers, but rather, those they most commonly encounter.

Towards a sustainable clinical education model for paediatric physiotherapy: Building capacity for physiotherapy students at the Children's Health Service District in Qld

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Introduction/Background:
It is well recognised nationally that clinical education for entry level Allied Health students faces building pressure from increasing clinical demands, growing student numbers and reducing educational funding. The way forward is unclear with systematic review of physiotherapy clinical education literature concluding that "No model is more effective than another". How does a busy physiotherapy department lead the change to build sustainable capacity and support the next generation of therapists? What model of clinical education best supports the local needs, what steps are involved in its formation and are they transferable to other therapy departments?

Purpose/objectives:
To analyse the efficacy of an innovative pilot model of clinical education and describe the lessons learnt to facilitate elements of adaptation among physiotherapy departments and possibly across Allied Health disciplines. This model aims to incorporate strategies to unload busy clinicians and build capacity for students while supporting their learning curve of skills attainment within the context of a diverse paediatric health district with clinical units ranging from tertiary hospital based teams to community based elements and specialist state wide services.

Methods:
A mixed action research design used features of qualitative semi-structured interviews, focus groups and observational analysis combined with quantitative time/motion study tools and survey data. Innovative models for assessing student attainment of competencies eg the MiniCEX, an assessment tool of clinical skills validated in medicine, are investigated. Participants include members of the Paediatric physiotherapy services in the Children's Health Service District of Queensland based at Royal Children's Hospital (RCH) in Brisbane, and other key stakeholders such as students, parents and patients.

Results:
The results of the pilot are still being gathered in collaboration with university educators in Queensland and the project is due to report in August 2009.

Peer Student Observer Feedback sheets: Are they an effective learning tool in enhancing early undergraduate small group learning in clinical skills tutorials?

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Introduction/background:
Peer feedback has been reported to be perceived very positively by medical students and has been well recognised as having potential benefit in medical education and assessment. Students gain insight into evaluating their own level of understanding within a subject and student participation is encouraged in the processes of learning. There is a need to explore students' perceptions of the usefulness of peer feedback systems.

Purpose/objectives:
Peer Student Observer Feedback Sheets were devised with the aim of enhancing higher order learning in the area of clinical skills. Students' perceptions of the effectiveness of this tool in enhancing small group learning in clinical skills practical sessions were explored.

Issues for exploration/ideas for discussion:
Copies were distributed to various small student groups at every Year 1 and 2 clinical skills practical session (n=25 sessions per student) throughout the academic year. The effectiveness of this tool in assisting both learning during the sessions and preparation for the end of the year OSCE was evaluated. Students were also asked to evaluate how they felt about peer feedback in general.

Results:
The results supported the usefulness of Peer Student Observer Feedback Sheets in helping early undergraduate medical students become part of their own teaching and learning in clinical skills. Nearly 78% of Year 1 and 74% of Year 2 students at the end of the academic year, found the sheets partially to extremely useful in learning although only 49% and 52% respectively found them useful in preparing for the OSCE. The major benefits of the sheets were seen to be the provision of opportunities for self-reflection on students' own skills and constructive discussion of their strength and weaknesses. Those who did not find them useful reported that too much time was spent writing and that peer feedback was less reliable than tutor feedback.

Discussion:
Peer Student Observer Feedback sheets were perceived to be useful as a tool in clinical skills teaching by early undergraduate medical students although they were less useful in assisting preparation for an OSCE. Some modifications of these sheets were suggested by the students and will be implemented the following year.

Conclusion:
Peer Student Observer Feedback sheets will be implemented as a tool in clinical skills learning for future Year 1 and 2 medical students at the University of Adelaide. Further investigation is required to determine the impact of this tool on actual student performance, especially low performing students.

Interprofessional education – who needs it? We can work on a team!

Susan Morrison

The use of the word 'team player' has become so ubiquitous, that most people report that they are team players. Where and how people learn to work on teams… and successfully, are hard to determine.

Support for team skills is given importance by universities when they list it as a generic attribute their students will possess upon graduation. A university's generic attributes are knowledge, skills and attitudes not connected to discipline-specific knowledge that are necessary for a new graduate to begin in the workplace. Literature on teaming in university for class work is abundant and found in all curricula such as business, education, allied health and medicine. However, few universities explicitly teach teaming skills even though courses require team assignments. Literature on team assignments within the university curriculum highlights many positive and negative issues for both the instructor and the student. Yet, business is firm on the need for team skills to be an explicitly taught skill.

In recent years, there have been directives from governments, organisations and universities to implement interprofessional education so not to perpetuate the 'silo' mentality created when students and instructors teach and learn within their specific discipline. Unfortunately, confusion of terms and definitions gets in the way of the teaching structure. Interprofessional education has two important elements: learning together and most importantly, from each other. Thus, many universities refer to large classes where students from different disciplines sit in a large auditorium as interprofessional education. However, if students from different curriculums are not learning from each other, it is merely a cross-disciplinary class. Literature has shown that without the interaction of learning from each other, a prior attitudes toward other professions is perpetuated. There are numerous research articles, which talk to the beneficial elements of interprofessional education. However, the implementation has continued to be a problem as reported in the literature.

It is the purpose of this paper, to discuss a model of team learning for students that provide explicit steps in teaching team skills. The need for this is that within the allied health and medicine field, our students will be working with each other in the professional arena. Opportunities for interprofessional education are happening, if slowly, but much can be done with the status quo to insure students are successful team members so that when opportunities are created within their learning process, they will have the basis for interprofessional work.

Student-led tutorials to teach and practise OSCE skills to medical students

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Introduction/background:
OSCE (objective structured clinical examination) is quickly becoming the standard method of examining medical students. In addition to acquiring clinical knowledge and skills, a student must also know and understand the OSCE exam format to satisfactorily pass. Unfortunately due to time restraints and other issues, there are very few chances to practise and learn the OSCE exam format during formal class time. Therefore, a group of students working together with teaching staff from the University started a peer program where older students (5th and 6th year) taught newer students (3rd year). Starting in 2008 lunch time sessions were organised in rooms suitable for OSCE examinations. Student tutors were arranged and advised to run the tutorial like an OSCE session (practice OSCE exams were provided for by University Staff), not only allowing younger students to become familiar with the format but also learning course content as well.

Purpose/objectives:
This session aims to:

- Introduce a method of giving an opportunity to students to teach and learn OSCE skills
- Discuss the effectiveness of student led OSCE practice tutorials
- Discuss ways to further enhance this program

Issues for exploration/ideas for discussion:

- Is further support required for the student tutors?
- Is this a sufficient method to learn OSCE exams in addition to formal teaching? Or are more senior teaching staff required?

Results and discussion
At the end of the year, the program was evaluated via focus group interviews. A total of 5 focus group interviews, involving 9 tutors and 16 students were conducted. The interviews were transcribed and data analysed through thematic analysis.

The program was well received by tutors and students. Students found that the OSCE practice program very helpful not only in assisting them in their examination preparation but also in their learning of clinical skills. They found the program assisted them in understanding OSCE exam better and reduced their anxiety related to the exam. Tutors found the experience helpful in assisting their professional development as well as learning clinical and teaching skills through the process.

Conclusions:
A well supported peer-to-peer OSCE practice program provides significant advantages to students and tutors. This program should be continued with student and university support.

Constructivist classroom project

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Introduction/background:
Traditional methods of university learning and teaching based largely around didactic lectures are frequently criticised for their surface approach to learning, inability to cater for different learning styles and ineffectiveness in the development of the ability to apply learned knowledge to real life problems (Shreeve, 2008; Struyen, Dochy, Janssens & Gielen, 2008). This is of particular concern to the practice based disciplines such as nursing, where the ability to think critically and problem solve are essential for safe practice. The medical/surgical teaching team at Charles Sturt University's School of Nursing and Midwifery decided to develop and implement a new approach to teaching and learning that is consistent with the philosophy and principles of constructivism. The basic premise of constructivist theory is that knowledge cannot simply be transferred from one person to another. Instead, students must construct new knowledge based on knowledge that they have already acquired through previous experience, in combination with the use of supportive resources.

Purpose/objectives:
The main purpose of this project was to replace traditional didactic lectures with self-directed enquiry and case based learning. In doing this, the team aimed to increase student satisfaction and engagement with the subject content. The project also aimed foster active participation in the learning process in order to increase student confidence in the problem solving and decision making processes.

In order to meet these aims and objectives, students were provided with authentic case scenarios during tutorial sessions which were then followed through to simulation in the clinical laboratories. This was supplemented with other self-directed and group work activities that were designed to maintain student interest. Many flexible learning tools were developed to support diverse learning styles during the transition to the new approach to teaching. These included a Clinical Skills DVD and a CD-ROM containing selected lectures on core theoretical concepts.

Issues for exploration/ideas for discussion:
- The development of authentic assessment tasks that adequately reflect the new approach to teaching and learning
- The advantages of implementing such an approach to distance education cohorts in order to promote greater equity between these students and their internal counterparts.
- The change in the role of lecturer from expert to facilitator or guide and its impact upon the relationship between staff and students.
- The intended method of data collection and analysis.
- Informal feed back to date.

Health-related screening: A decade of teaching and learning with undergraduate medical students

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Introduction/background:
For most clinicians, principles underpinning health-related screening have traditionally been poorly understood, and even more poorly applied in day-to-day clinical settings. Despite screening activities spanning many areas of primary, secondary and tertiary clinical practice, teaching and learning about screening for prevention and early detection of disease has tended to be addressed in public health contexts, separated from clinical learning environments and divorced from ethics teaching.

We describe 10 years' experience of teaching and learning with undergraduate medical students, where health-related screening initiatives and controversies have been variously considered in the clinical context both of Obstetrics and Gynaecology and of Primary Care, underpinned by an ethical framework for screening and informed by public health principles. In our experience, the understanding and explanation of risk, the wise use of finite financial and human resources, and assumed principles of equity and social justice in a publically-funded health system, provoke especially rich debate about areas of clinical practice not often explored.

Purpose/objectives:
With a new curriculum planned for 2010, opportunity now exists to integrate population health and personal health learning and teaching in ways not previously possible. In this session, we aim to facilitate discussion about effective ways to fully engage students in an integration of theory and practice that is sufficiently robust to underpin their future clinical practice with a sound appreciation of the advantages and disadvantages of screening, ethical considerations, the need for ongoing evaluation of both individual and public health care practices, and effective resource management.

Issues for exploration/ideas for discussion:
We aim to present draft teaching plans for health related screening in this new environment, facilitate discussion as above and explore ideas for assessment and evaluation of teaching and learning about screening in clinical contexts.

A three year longitudinal study of reflective journals from an undergraduate radiation therapy program

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Introduction/background:
Personal reflective journals have been incorporated as a component of the Radiation Therapy (RT) program at the University of Newcastle for over 15 years. The journals are completed by students as part of their professional placement course. To evaluate the journals and provide feedback the Newcastle Reflective Analysis Tool (NRAT)was developed. The NRAT is a two phase system allowing both narrow and broad classification of reflective writing.

Purpose/objectives:
The purpose of this study is to:
1. Identify evidence of reflection in the students personal journals
2. Assess if there are any changes in the evidence of reflection as the students progress through the program

Issues for exploration/ideas for discussion:
Have any other institutions audited or evaluated their student's personal reflective journals?
Are short form guided inventories currently being used in any settings?
The use of the NRAT in the radiation therapy community

Results:
The sample included 96 long form journals across the three years of the program, the level of agreement achieved between four coders ranged from Kappa 0.53 – 0.63 for six narrow levels of reflection and Kappa 0.65-0.93 for three broader levels of reflection.

The results indicated that a large proportion of the students were reflecting to a low degree with few reaching the higher levels of critical reflection. There was no statistically significant difference detected by all four coders that the levels of reflection within the long form journals changed as the students progressed through the program.

Discussion:
These result indicate the need to introduce interventions to foster students reflective writing ability within the RT program. As a result of these findings the Newcastle Reflective Inventories (NRI) have been developed. The NRIs are short form guided inventories aimed at assisting students with their reflective writing development.

Conclusions:
These specifically designed inventories will be included in the RT professional placement course from 2009 onwards.

How are workload and location related to educational outcomes?

Dr Sue Goldman

University of Tasmania, Elwood, Vic

Introduction/background:
Previous research on general practice vocational training between 1999 and 2001 examined trainee self-assessments and reports of satisfaction with training experiences.1-4 However, in these studies, workload was not examined in relation to the important factor of the location of trainees.

Purpose/objectives:
The study examined whether trainees' workload and location affect their assessments of themselves and their educational experiences, and whether workload and location interact.

Results:
Trainees answered a series of questions on five domains of general practice and the management of different patient groups. Urban trainees saw themselves as slightly more capable in communicating with patients, and managing people with dermatological problems ($p<.05$). Rural and remote trainees saw themselves as substantially more capable in the care of indigenous people ($p<.05$) and those from rural and remote communities ($p<.001$). Only a significant effect for locality emerged in a multivariate analysis, indicating that locality acted independently of the workload and the numbers of patients seen by trainees.

The analysis also included trainee satisfaction with a range of questions about learning experiences, resources, supervisors, educational releases, locations of training posts and the level of remuneration. No interaction emerged between workload and locality. However, there was a significant effect for locality. Rural and remote trainees were markedly more satisfied with the locations of training posts ($p<.01$). Urban trainees were more satisfied with opportunities to meet with other trainees than their rural and remote counterparts ($p<.05$).

Discussion:
Only few differences in particular areas emerged between urban, and rural and remote trainees. It is possible that rural and remote trainees viewed themselves as more capable in the care of groups of patients with whom they have more contact. The marked differences between urban, and rural and remote trainees in their satisfaction with the location of training posts were also to be expected. Compared to their rural counterparts, urban trainees reported a higher level of satisfaction with opportunities to meet with peers. This, to some extent was anticipated, as rural and remote trainees might have less contact with peers.

Conclusions:
Although the system for training delivery has altered, the curriculum for general practice vocational training has remained consistent. Workload did not emerge in this analysis as acting independently of the location of trainees, but it remains important in general practice vocational training. It is noteworthy that the analysis of location reflected only a few areas of difference in training experiences between urban, and rural and remote trainees. The findings suggest that additional opportunities to meet with peers would enhance the experiences and learning environments of rural and remote trainees.

Surveillance or promoting reflection: Professional supervision in 'the risk society'

Liz Beddoe

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Introduction/background:
Supervision is an expanding professional practice internationally in health and social care. This is clearly related to the increasing regulation of health and social care professions and the explicit linking of supervision to notions of 'quality' and 'accountability'. A current study explores the links between the revitalisation of supervision and the impact of 'the risk society'. This linkage was signalled in the 1990s when a resurgence of interest in supervision began. The term 'the risk society' is used to describe a society that is organised in response to risk (Beck, 1992) and preoccupied with safety, (Giddens, 1999). The extension and development of clinical supervision practice within the health professions is very much underpinned by the risk-averse cultures in contemporary society.

The current preoccupation with oversight of practice has arguably strengthened the mandate for supervision; but does this threaten its integrity as learning-focused activity? How can supervision practice resist micro-management and surveillance and contribute to effective practice?

Purpose/objectives:
The aims of this presentation is to describe the impact of 'the risk society' and its attendant focus on risk identification, risk minimization and compliance on the significant practice of professional supervision in health and social care. Findings will contribute to an enhanced conceptual framework for supervision to assist supervisors and their supervisees to retain their commitment to a supervision practice grounded in critical and reflective learning.

Issues for exploration/ideas for discussion:
Key questions posed include:

- in this environment, how is supervision distinguished from other professional activities, especially from line management and clinical oversight;
- in the light of potential overlapping purposes and roles within supervision in health organisations, how do supervisors maintain focus on the key functions of supervision when organisational imperatives might concentrate attention on micro-management and surveillance of professionals; and
- how do supervisors address the considerable pressure on health professionals to redirect attention from person-centred practice toward compliance in 'the risk society' ?

Mapping the medical curriculum: A snapshot of the mapping exercise at the University of Tasmania

Ellen Ennerver

Medical Education Unit, University of Tasmania, Hobart, TAS

Introduction/background:
Curriculum mapping provides evidence that the teaching and learning events in a curriculum are meeting the standards of accrediting bodies, the aims of the medical school and the needs of the learners. The University of Tasmania has undertaken a curriculum mapping exercise for its new 5-Year MBBS program to help establish that its curriculum is meeting expected standards, aims and needs. The process has an added attraction: it also provides baseline information for review and remodelling elements of the curriculum and allows for succession planning and curriculum renewal.

Purpose/objectives:
This poster aims to give a "snapshot" of the mapping undertaken by the University of Tasmania. The approach taken to mapping at this institution differs somewhat from those undertaken elsewhere, in that it is coding entries numerically in spreadsheet format initially and using basic search capability only in its initial phases, with an emphasis on teaching event collection and a cascading tree structure for uncovering learning objectives. This reflects a bias towards a pragmatic and utilitarian use of the mapping exercise and reflects a concern for mapping identified learning outcome structures.

Issues for exploration/ideas for discussion:
Some other medical schools are currently undertaking similar exercises and this poster will provide a vehicle for the exchange of ideas and approaches to mapping. For those unfamiliar with the mapping process, it will provide a brief introduction to its purposes and use. For those interested in curriculum renewal, it will illustrate the mechanisms for the quality control of curriculum changes and will encourage critical reflection on the means by which we match the intended to the delivered curriculum.

Motivation to learn amongst medical students during the transition to learning in a clinical environment

Dr Clinton Mitchell, A/Prof. Phillippa Poole

Medical Programme Directorate, The University of Auckland, Auckland

Introduction/background:

Those who believe intelligence is a fixed trait align their learning towards achieving favourable judgments of that trait (performance orientation). Learners who believe intelligence is a malleable quality position themselves toward developing that quality (mastery orientation).

Controlled motivation (like performance orientation) relies upon students' own beliefs about what is expected of them. In contrast, autonomous motivation (like mastery orientation) is focussed upon what students find interesting and important, and is associated with better educational outcomes (Sobral, 2004).

A positive association exists between the presence of autonomous motivation and the students' rating of the quality of the educational experience with respect to its value (Sobral, 2004). Mastery-oriented students were more likely to demonstrate the adept skills required for lifelong learning (Perrot et al., 2001). If a learning task occurs under significant time restraint it is likely to reinforce performance orientation, and can convert mastery-oriented students into a performance mode (McLean, 2001).

Medical students are especially motivated to learn when they perceive that the learning will help them perform tasks, or enable them to manage obstacles that they are likely to come across in their day-to-day life (Misch, 2002).

After two relatively competitive and structured years, Auckland medical students spend an increasing amount of time in their third year in clinical settings. It is hypothesised that this exposure will change the orientation of these students from performance to mastery approaches.

We are conducting a project looking at the motivation and goal orientation of medical students in their third year of medical school. Volunteer students will complete questionnaires at the beginning and end of the year. A small number will also be individually interviewed at various times throughout the year to add qualitative data to any trends observed.

Initial baseline data will be further analysed to determine if pre-existing differences are present amongst the student cohort with respect to gender or prior undergraduate student experience.

Purpose/objectives:

The purpose of this PeArLS is to:

- present the outline of the planned project, and any preliminary results available.
- discover whether similar ideas have been explored elsewhere in Australasia.

Issues for exploration/ideas for discussion:

- Motivation in medical students – does it matter?
- Is this an issue for other health professional groups?
- What is the optimum timing and method for such a study within a programme?
- How do the multiple 'high-stakes' assessments in programmes affect motivation?
- Can medical curricula and assessments feasibly be designed to ensure a mastery approach?

Achieving continuity in longitudinal medical education programs

Linda Sweet

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Introduction/background:
Continuity is a key component of effective longitudinal clinical education programs that aim to meet the needs of the learner, the health system and society. Ogur et al (2007) established a longitudinal clerkship following a "learning in practice" model that promotes professional values by students following patients and providing continuity of care. This was valued not only by the student, but also by patients and clinicians. This model differs from other longitudinal models such as the Flinders Parallel Rural Community Curriculum as the student becomes the patient's 'doctor' and the student is alerted by pager whenever the patient presents for health care. The primary focus in the Cambridge model is continuity with patients, resulting in a patient centred and student centred curriculum.

Flinders University School of Medicine has commenced a new longitudinal community based medical education program in an outer metropolitan region of southern Adelaide. Continuity of care is the philosophy being promoted and this is being achieved by the students recruiting and following through a minimum of 10 medical and/or surgical patients and 3 women's health patients throughout the year in addition to the sessional experiences.

Ogur et al's (2007) program has been successful as they facilitated the longitudinal follow-up by implementing an electronic information program that notified students when their assigned, or continuity patients registered anywhere in the clinical care system. Such an intricate system is not currently available in South Australia.

Purpose/objectives:
To explore the ideas and experiences of peers in how best to achieve continuity in longitudinal community based medical education programs.

Issues for exploration/ideas for discussion:
- How prescriptive should we be in directing the students' cohort of continuity patients and their diagnoses?
- How do we manage the logistics of timetabling experiences with the need for following through continuity patients?
- How do we best facilitate continued contact between the student and the continuity patient in a safe and educationally valuably manner?
- How do we foster an interdisciplinary environment through the continuity of care program?

The LIME Network: Ensuring quality and effectiveness in teaching and learning of Indigenous health in medical education and curricula

Odette Mazel, Erin Nicholls

LIME Network Project Manager, Onemda VicHealth Koori Health Unit, School of Population Health, The University of Melbourne, Parkville, VIC

Introduction/background:
The LIME Network is a Medical Deans Australia and New Zealand Project and is hosted by Onemda VicHealth Koori Health Unit within the School of Population Health at The University of Melbourne.

Purpose/objectives:
The aim of the LIME Network is to be a dynamic network dedicated to ensuring the quality and effectiveness of teaching and learning of Indigenous health in medical education and curricula, as well as best practice in the recruitment and retention of Indigenous medical students.

Issues for exploration/ideas for discussion:
The LIME Network Project seeks to establish a continuing national presence that encourages and supports collaboration within and between medical schools in Australian and New Zealand to support the development, delivery and evaluation of quality Indigenous health content in medical education with the aid of the CDAMS Indigenous Health Curriculum Framework and the Critical Reflection Tool (CRT). It also seeks to build multi-disciplinary and multi-sectoral linkages and to provide quality review, professional development, capacity-building and advocacy functions.

Review of undergraduate nursing students' changing perceptions towards science at different stages of their degree

Hemant Mehta

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Introduction:
Scientific knowledge empowers nurses to embrace new technologies and to understand physiological and pathological changes in their clients. The modern health system is complex, requiring the professional nurse to possess a high level of scientific knowledge and skill to provide quality, evidence-based care. Many of the diverse students drawn to nursing as a caring profession initially fear learning science and have problems developing effective study techniques.

Objectives:
The purpose of this study was to investigate whether and how nursing students' perceptions of science changed during their undergraduate studies. Three successive first year (2005-2007) and related second year (2006-2008) nursing cohorts (340-364 students each year) at a Sydney university were invited to participate in a mixed-methods study using a questionnaire and focus group discussions.

Ideas for discussion:
- Why do students' perceptions change?
- Will awareness of changing student perceptions towards science during their undergraduate studies provide insight into the processes of cognitive development and the achievement of mastery?
- What are the best strategies to promote positive perceptions of science?

Results:
Within a year, significant numbers of students increasingly appreciated the value of science. Comparison of first and second year student responses revealed a significant reduction in the percentage of students who did not value science much (24.6% 2.4%) and an increase in those who highly valued science (25.7% α52.6%). There was a reduction in the second year students' perception of science being "boring" (2.8% down to 1.9%) and "difficult" (from 23.4% to 17.7%) compared to their perceptions before commencing the BN, and a change towards science being "interesting and relevant" and "important for medical advances". While there was a significant difference in perception of science as "difficult" between first and second year students (Yr 1: 21.3%; Yr 2: 17.7%; $p<0.01$), only a few (< 1.5%) believed that science was "easy". More than 61% of first year students reported that the science units integrated with nursing and clinical units "quite well", with a significant increase in the response "extremely well" by the second year. An overwhelming majority (> 90%) of first and second year students felt that science was relevant and a valuable part of nursing.

Discussion and conclusion:
Students became more accepting of science through practical experience and cognitive skill acquisition, and perhaps because of their intellectual maturation during the university years. The awareness of students' growing acceptance and valuing of science is encouraging and reinforces the academic certainty that science is essential for the underpinning and understanding of nursing concepts and practices.

If a blended delivery approach to support clinical tutors is developed, what would that support comprise?

Dr Peter Gallagher

In order to function as effectively as possible as a clinical tutor, clinicians require educational support. The most usual form that support takes is face-to-face small group tutorials facilitated by a member of the university academic staff.

However, the competing demands made of clinicians' time makes it difficult for many of them to attend this form of classroom based workshop.

In addition, current and planned increases in the range and volume of student attachments (clinical placements) to locations geographically distant to the main university campuses, compound the challenge of providing educational support to those clinicians who teach medical students.

A solution to this perennial problem may partly lie in a change of approach to the way in which educational support is offered to clinical tutors. Thus to enhance the quality of student learning a different and parallel approach to the educational needs of clinical tutors in the form of a blended delivery (Harrison, 2003) approach should be developed.

Such a blended approach will complement, and in some instances replace, face-to face support of clinical tutors. This will be achieved primarily by incorporating electronic access to existing resources and by developing bespoke teaching and learning materials using appropriate information technologies.

In 2009, and before embarking upon any extensive and potentially expensive development of blended resources, a small scale project to: Develop, make use of, and evaluate a mixed-media resource for clinical tutors alongside whom medical students learn is being undertaken at the University of Otago . This paper will briefly report of the first phase of that project and seek from delegates their response to the following question:

"If a blended delivery approach to support those clinicians who teach medical students is developed, what would that support comprise?"

A community-based practice program in a rural medical school: Benefits and challenges

Ruvimbo Mudarikwa, Jacqueline McDonnell, Debra Nestel

Gippsland Medical School, Monash University, Churchill, VIC

Introduction/background:
Community-based education is a means of achieving 'local' educational relevance. The educational experience consists of learning activities that are intimately engaged with the 'community' which becomes the 'learning' environment. Community-based rural medical education may contribute to the solution of inequity in health service delivery by producing doctors equipped and willing to work in rural communities. Gippsland Medical School (GMS) was established to graduate doctors of the highest calibre that are prepared to work in a changing healthcare system. One component of the curriculum is the Community Based Practice (CBP) program in which students are assigned to a community agency for twelve days over sixteen weeks. The objective of the CBP program is to provide students with an opportunity to develop an interprofessional perspective on the application of social equity, justice and models health interventions in the community. Students are expected to develop an understanding of the agency, formulate and conduct a research project within the setting.

Purpose/objectives/research question:
To what extent was the goal of the CBP program met?

Issues for exploration/ideas for discussion:
What are the benefits and challenges of a community-based program?

Results:
Twenty-nine students returned questionnaires (51% response rate). Twelve community 'partners' were interviewed by telephone (63% response rate). The benefits of the program identified by students and 'partners' were:

- Broadened students' understanding of health professional roles in the community
- Opportunity for students to learn from role models
- Improved student-'client' communication skills
- Insight into the social context of health and 'real life experience'
- The research project added value to the community agency

Challenges of the CBP program included:
- Formulating and conducting a research project within the setting
- Limited exposure to range of agency activities
- Time constraints on partner's involvement with students
- Limited contextualisation of lecture materials at agencies

Discussion:
The placement enabled students to meet the principal goal of the CBP program. The understanding of social aspects of health is likely to promote 'holistic' practice. The communication skills acquired and professional role models encountered contribute to the students' personal and professional development.

Recommendations to GMS faculty include:
- Clearer distinctions between the project and placement experience
- Further contextualisation of population health and social concepts from lectures
- Review placement structure and duration

Conclusions:
The CBP program contributes to the development of graduates committed to the health of populations. Our challenge will be to maintain this commitment in subsequent years of the curriculum.

A student-facilitated group exercise programme for individuals with type II Diabetes Mellitus living in the community

Jenny Conroy, Chris Higgs

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Introduction/background:
Diabetes Mellitus is one of the highest causes of disability and premature mortality in New Zealand, with one in twenty adults (5%) having a diagnosis of diabetes in 2006/7 (Ministry of Health (MOH), 2008; World Health Organisation (WHO), 2008). By 2030, the prevalence of diabetes is estimated to increase by 150%. The New Zealand Health Strategy (King, 2000) has identified priority areas for funding to ensure health services are targeting those groups most at need in order to reduce health inequalities in the general population. Physical inactivity in people with diabetes has been identified as one of the leading causes of poor health and reduced function.

Physiotherapists are trained to provide individualised physical activity programmes to enhance health and optimise quality of life for people with chronic conditions. In spite of these skills, most physiotherapists work in tertiary settings or in private practice and few physiotherapists work in community or home based settings with people who have chronic diseases.

In 2008, an individualised group exercise programme for community-dwelling people with type II diabetes was introduced as part of the training of undergraduate physiotherapists.

Purpose/objectives:
To determine the interaction between community-dwelling individuals and undergraduate physiotherapy students, and the role this relationship has on facilitating student learning and the understanding of community health problems.

Issues for exploration/ideas for discussion:
Student evaluations showed that the programme challenged student perceptions of what it is like to live with diabetes. They found it difficult to adapt exercise programmes to suit individual participants due to their lower exercise capacity and physical limitations. Students found it challenging to find varied ways to motivate participants, and often found that their communication skills improved by working within this setting.

The diabetes exercise programme is continuing during 2009. A series of focus groups will be held during May to determine the effectiveness, utility and acceptability of the programme amongst participants. Focus groups consisting of students will be held to further develop the ideas expressed above to inform future planning of community interaction within the undergraduate physiotherapy programme. If students can be exposed to the problems that individuals with chronic diseases have living and coping in the community, it is hoped that it will encourage students to pursue a community-based pathway for employment on graduation.

Higher degree postgraduate research supervision – important issues from a student's perspective

Patrina Caldwell

Introduction:
The quality of the supervision received by postgraduate research students is likely to impact on student satisfaction, learning and candidature progress. Yet the quality of supervision is variable, with many students being dissatisfied with the supervision they receive.

Objectives:
This study aims to identify and rank important postgraduate research supervision issues from the student's perspective. It forms part of a body of work used to improving postgraduate research student supervision.

Methods:
Ten postgraduate research students working at two hospital clinical school sites participated in focus group discussions on important research supervision issues. The Delphi method was used to rank issues identified.

Results:
Issues were broadly grouped into those that occurred before, during and after completion of the postgraduate research higher degree. Student and supervisor factors were also explored.

- Before the research higher degree begins
  - Supervisor factors
    - Motive for supervision
    - Experience with supervision
    - Expectations of supervision
    - Roles and responsibilities
  - Student factors
    - Motive for undertaking PhD
    - Experience with research
    - Expectations of student
    - Roles and responsibilities
  - Project factors
- The research higher degree process
  - Supervisor factors
    - Input in direction of project
    - Giving and receiving feedback
    - Time/deadlines
    - Writing/authorship
  - Student factors
    - Input in direction of project
    - Giving and receiving feedback
    - Time/deadlines
    - Writing/authorship
  - Relationship between supervisor and student
    - Two way communication
    - relationship
- After the research higher degree

Conclusions:
Improved communication and clarification of supervisor and student expectations, roles and responsibilities both before commencing and during the candidature is likely to enhance the quality of the postgraduate research experience.

Investigating emerging technologies in medical teaching and learning

Catherine Studdert[1], Dr Robyn Smyth[2], Dr Graeme Horton[1]

[1] University of Newcastle, University Drive, Callaghan NSW
[2] University of New England, Armidale NSW

Introduction/background:
The authors have investigated emerging technologies, specifically e-Portfolio & Pod/Vodcasting in the context of developing an undergraduate medical program delivered between two institutions across multiple sites. These innovative methods of teaching and learning are technologically and pedagogically progressive, based on a student-centred approach and have the potential to enhance student education and adapt to their needs whilst learning in both clinical and non-clinical settings, as well as in rural and urban locations.

Purpose/objectives:
- The Poster presentation will outline ways in which these emerging technologies can be used to effectively capture and record student learning; track and assess students' professional experience, competencies and development; and enable students to monitor their progress and reflect on their experiences.
- The Poster format will illustrate our investigative process, which was shaped by the unique and complex requirements of our program: from initial identification of the
- need for these technologies, through to a trial phase, implementation and continuation.
- The authors invite observers to share their experiences with us.

Key Findings:
The authors have identified the strengths of these technologies in meeting the learning needs of students in the medical program, and in exploring a range of available products (tools, functionalities and capabilities), have considered the logistics and challenges involved in implementation.

e-Portfolios are an electronic repository, for recording, storing and tracking a student's work, assessment items, supervisor and peer feedback, multi-media files and evidence of clinical experience, skill acquisition and competencies. They have the potential to promote reflective learning and planning, and create a record to support students' professional careers and life long learning.

Different platforms of e-Portfolio allow for varying degrees of a user-friendly interface, portability upon graduation, curriculum mapping capability, reporting and verification features. Important considerations include privacy, confidential content storage, protocols and mentoring, resistance to use by students and/or academic staff, interoperability across systems and universities, equity of access, licencing, hosting, maintenance, support, customisation, adaptability to technological advancement and implementation timeframe.

e-Portfolios have the potential to incorporate Pod/Vodcasts, which are audio/video recordings available as digital files, and may be used to record evidence of students' clinical experience. Use of Pod/Vodcasting within e-Portfolios requires consideration of issues including copyright, privacy, quality control, professional development and misuse of electronically available data.

Our investigations have led us to adopt and plan for a program of action research based on a conceptual framework reflective of Buzzetto-More and Alade's (2008) Pentagonal e-Portfolio model.

Is science an island?

Kathy Robinson

ACU National, North Sydney, NSW

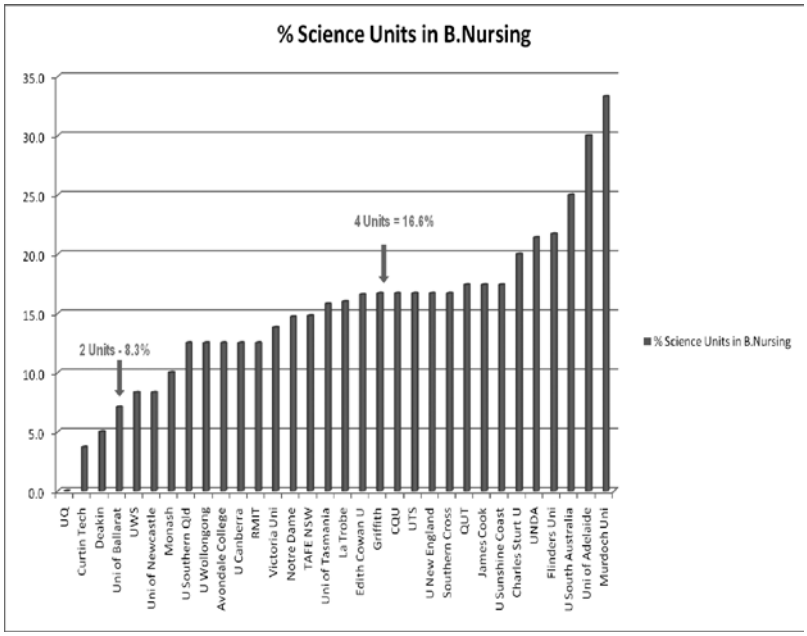
Introduction/background:
Over the past decades there has been an ongoing desultory debate about the role of science in nursing degree programs with protagonists for two distinct models emerging: those touting a "Caring" model that underplays the need for science in nursing and others supporting a "Knowledge" model that emphasises the importance of science in client care and evidence based practice. Tensions caused by attitudes and perceptions regarding science have persisted and now become amplified in the debate regarding interprofessional units.

Purpose/objectives:
This study examines the position of science in Australian undergraduate nursing curricula in 2009.

Issues for exploration/ideas for discussion:
- Is science an island? Should science be part of the mainland?
- Where does science fit within the context of some of the current moves towards collaborative/interprofessional approaches?
- Will Interprofessionalism stand the test of time?
- Why does the "one size fits all approach" seem to be returning with regard to basic science education?

Results:
In most Australian nursing courses the industry standard appears to be 4 units of clearly recognisable science though the range is from no obvious "stand alone" science at the University of Queensland to a science rich program with 12 units of science at Murdoch University. At several institutions the nursing curriculum is in upheaval – with trends towards both amalgamation and separation of science. There is a growing tendency to devalue biological sciences, accompanying a move in nursing philosophy from cure to care.

Fig 1 Dedicated science units in undergraduate nursing programs at Australian universities and colleges



Discussion:
The decline in the visible science content of a number of BN programs is of concern, particularly in the light of the government having declared science a national priority area and also since it visibly counters the notion as proposed by Obama in his inaugural address "Let us restore science to its rightful place" If science, as an underpinning skeleton for the BN degree is reduced or removed what will remain apart from an amorphous mass? Do we want to risk a generation of graduates who are scientifically illiterate?

Conclusions:
While the "blended" model may initially appear attractive there is the possibility that, once the bubbles subside, there may be insufficient material of substance remaining so the question I pose is "Will science need a bridge or a transplant?"

Video-reflective learning for acute resuscitation training: Outcomes from 3rd year and final year students

Dr Kwang Chien Yee[1], Juliana Ahmad[2]

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University of Tasmania, Hobart, Tasmania

Introduction/background:
Acute resuscitation is an important skill which students must acquire prior to internship. Multiple skills are required in order to perform acute resuscitation well. These include technical and non-technical skills, such as team work and communication. Acute resuscitation skills can be well taught through simulation training. The use of video reflective learning during simulation for acute resuscitation among students with different clinical exposure, however, has not been widely evaluated. This project is developed by a medical student as part of her advanced study. This project aims to design an acute resuscitation training module, incorporating video-reflective learning. We present the results of this project here.

Issues for exploration/ideas for discussion:
This presentation aims to engage participants to discuss the following questions:

- What technical and non-technical skills are required for acute resuscitation? How do students best acquire these skills?
- What is the role of simulation training in assisting students to acquire these skills?
- What is the role of video reflective learning in acute resuscitation training?
- What are the impacts of clinical exposure on video reflective learning?

Results and discussion:
We analysed six sessions of acute resuscitation training, involving 60 students. We found that students were more likely to be self-critical of their own technical skills than non-technical skills. We also found that students tended to provide feedback to their peers regarding technical skills. With guidance from tutors, however, students were able to understand the important role of non-technical skills in acute resuscitation scenario.

Simulation performance post-video-reflective learning showed improvement in both technical and non-technical skills. Greater improvement seems to be related to non-technical skills, especially leadership and team work skills. Clinical exposure during medical student years does not seem to affect the value of video reflective learning during acute resuscitation simulation. More importantly, students with less clinical exposure seem to be more willing to adopt principles of leadership and team work into post-reflective simulation. Most students, however, believe that video reflective learning is an important part of acute resuscitation training, regardless of their clinical seniority.

Conclusions:
Video reflective learning method during acute resuscitation simulation training improves technical and non-technical skills of students. Non-technical skills, such as leadership and team work skills, might be shaped by clinical experience of students and they might be harder to change. Non-technical skills training for clinical practice must be provided to students early in their journey as a medical student.

A holistic conceptual model to discuss student-to-internship transition

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[2] University of Tasmania, Hobart, Tasmania

Introduction/background:
The student to internship transition period represents a difficult time due to the abrupt increase in responsibility of patient care. While student to internship transition programs exist, the transition process itself is poorly understood. More importantly, there is a lack of conceptual model to discuss issues related to student-to-internship transition. .

Issues for exploration/ideas for discussion:
This presentation aims to discuss our research data from the following perspectives:

- What are the issues related to student-to-internship transition?
- How could we understand the transition process better?
- Could we develop a conceptual model to better understand the transition process?

Methodology:
The project deploys a learner-centred, self-reflective ethnographic method for data collection. Interns were shadowed by medical students on after hours shifts. The learner then undertook self-reflection of the shift in order to better understand the student to internship transition process.

Results and discussion:
Through the analysis of our data, we would like to propose a five step transition model. The five step transition model links the knowledge and skills acquisition and application to emotional growth of each individual through the transition process. The conceptual model is presented in Figure 1. The presentation will discuss the conceptual model in detail.

Conclusions:
Our conceptual model has important implications regarding student-to-internship transition educational program. Educational programs can provide knowledge and skills, but will not ensure the achievement of final transition. Educational programs should therefore aim to provide skills and support for students to achieve the final three steps of transition.

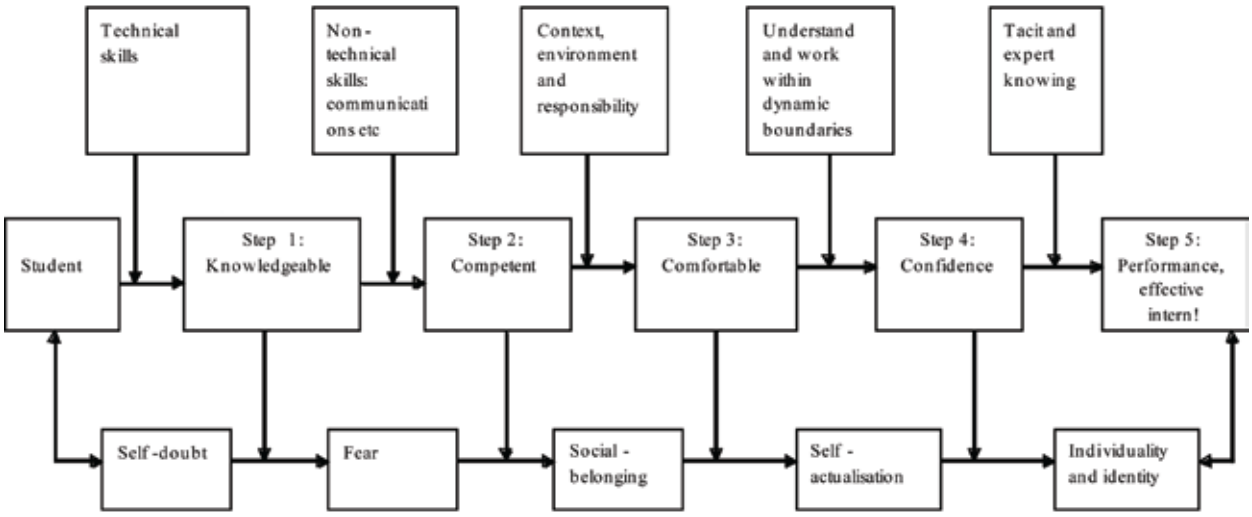

Figure 1: A holistic conceptual model for student-to-internship transition.

Education of medical students using a community event – The medical team at rural rugby championship

A/Prof. Martin Jones

The region of Shoalhaven in NSW has many sporting groups and it was with the Junior Rugby Group at the Shoalhaven Rugby Club that a novel way of educating a group of medical students, junior medical doctors and nursing staff became available. A championship for under 12 through to under 18 year-old rugby players from country NSW, allowed the medical team to be involved in the planning and provision of on-site medical treatment for the two day weekend. Hundreds of players and their relatives and friends were concentrated in the rugby complex for the championship. The weekend provided an insight into the treatment of injuries both on and off the field and how to co-ordinate care with the local ambulance service, local hospital and also to provide information for the injured players local medical officers (on return to their homes all over rural NSW).

Utility and validity of Mini-CEX in a graduate entry medical program

Suzanne Wilson, Gary Rogers, Simon Broadley

School of Medicine, Gold Coast Campus, Griffith University QLD

Introduction/background:
Assessment of clinical skills is seen as an essential component of any clinical program. Observed structured clinical examinations (OSCE) have done much to standardise this process and have been widely adopted. However, this type of clinical assessment often does not involve 'real' patients, occurs in a somewhat artificial examination setting and may not truly reflect a students performance 'on the wards'.

The Mini-clinical evaluation exercise (Mini-CEX) has been developed as a practical clinical assessment tool that can be used in a variety of settings. Its reliability characteristics in post-graduate and undergraduate settings have been demonstrated but its validity in terms of comparability to currently standard methods of assessment (OSCE) has not been studied in an undergraduate setting.

The Griffith Medical Program is a 4 year post-graduate course, in which the final 2 years are mainly based around clinical placements, including 9 rotations through various discipline areas. We have utilised the Mini-CEX assessment process in these rotations with students being required to complete 2 Mini-CEX assessments in 8 rotations. Students also undertake an 18 station OSCE towards the end of the course.

Purpose:
To study the reliability and validity of Mini-CEX assessments used in the clinical years of the Griffith Medical Program through comparison with the same students' result in the final OSCE.

Results:
Reliability of Mini-CEX, assessed using Cronbach's alpha, was 0.607 compared with 0.739 for the OSCE. The Pearson's correlation coefficient for Mini-CEX against OSCE performance was significant ($p = 0.015$) but the correlation was modest 0.291.

Discussion:
We encountered a range of issues in implementing this method of assessment. In general, the process is understood by clinicians and students alike. However, there are issues around the use of a primarily formative tool as part of summative assessment. There are concerns amongst students relating to the variability of both the process and the applicable standards of the Mini-CEX.

Mini-CEX is less reliable than OSCE and this can in part be explained by the greater variability in terms of tasks, raters, times and locations. The level of correlation between Mini-CEX and OSCE is not high and this may reflect random variation in both assessment tools, but may also reflect the fact that they are measuring different things.

Conclusions:
Mini-CEX is a useful and valid tool for assessing student clinical performance and implementation is both feasible and practical in an undergraduate setting.

Development of a clinical curriculum map

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Introduction/background:
Defining what the curriculum is for a Medical Program is a near impossible task particularly for the clinical years, because of both scale and complexity. The amount of expected knowledge in new medical graduates is large and the modes of learning are varied in the standard apprenticeship models. However, defining learning objectives for both individual components and for a program as a whole is desirable in terms of articulation of expectations to students, alignment of teaching experiences and setting of assessment.

We have therefore set about a strategy of asking locally based clinicians to list the commonest presenting symptoms and diagnoses that they see, as well as the principles and clinical skills that they find most important for their clinical practice.

Purpose/objectives:
At Griffith Medical School (a new school) we have undertaken a program-wide attempt at defining a curriculum map with specific learning objectives for each component of the program. This has been developed within a fully relational framework to allow students to be aware of the complex relationships of some topics across the curriculum. We have chosen a fairly traditional overarching structure of clinical placements based around core discipline areas, but the same principles could be applied to more integrated models.

Here we outline the procedures used to define a curriculum map and highlight some of the difficulties and technical challenges faced.

Results:
Responses were received from 108 clinicians covering 44 discipline areas.

A total of 950 learning items was defined and categorised as either a 'presenting complaint', a 'medical condition', a 'medical principle', a 'clinical skill/procedure' or a 'drug treatment'. For each of these a specific learning objective was outlined. Learning items were also further categorised according to theme and clinical rotations. This was done using a relational database such that learning items can appear at numerous stages in the curriculum.

Assessment items have been mapped to this curriculum framework.

Discussion:
Use of a curriculum map has greatly aided the communication of learning objectives to students for the clinical years of the program. It has also provided a framework connecting the clinical experiences of each rotation with relevant learning resources. Finally, the ability to map assessment material directly to the curriculum map allows for easy blue-printing of assessment.

Conclusions:
A curriculum map can greatly aid learning for students and assists program coordinators in planning curriculum content and assessment.

A regional network approach to interprofessional clinical education

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[2] Faculty of Health Sciences, LaTrobe University, Bundoora, VIC
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Introduction/background:
Interprofessional clinical education is gathering momentum in Australian tertiary, government and health and community services sectors. In Victoria, the Department of Human Services has released a new round of funding to support further development and roll-out of innovative clinical education models that incorporate an interprofessional approach to student learning. Building on a successful past project and established working relationship, a partnership team from a major university and an outer metropolitan health service is collaborating on a regional network project. The project extend s and refines an existing approach to interprofessional clinical education for application with additional professions, universities and agencies across a regional network. The intention is to develop a model that could be applied statewide.

Purpose/objectives:
The project – *Interprofessional Clinical Education – a regional network approach* – aims to:

- further refine and roll-out across different organisations within a geographic region the IPCE model of professional placement learning developed in the DHS funded project "Learning Together to Work Together".
- incorporate interprofessional clinical education (IPCE) into the professional placements curriculum for entry-level allied health and other available health care students within a geographic region.
- develop workforce ready graduates who are person centred, interprofessional and evidence based in their approach to service delivery.

The main objective is to implement and evaluate a model that could be applied with a broad cross-section of health professional students during their clinical education/professional placements at a range of agencies in a geographic region. This includes engaging allied health, medical and nursing students across health and community services agencies in an outer metropolitan/rural fringe area.

This presentation will discuss project progress to date and provide detail of the preliminary findings and experiences.

Issues for exploration/ideas for discussion:

- What are the challenges and enabling factors to bringing together students and clinical educators from multiple disciplines, universities and health/community service organisations to participate in such a program?
- To enable advancement of such a program what policy/practice advice would the group recommend to:
  - Government;
  - University; and
  - Health/community service stakeholders?

An evaluation framework for a School of Medicine and Dentistry

Gill Kelly, Tarun Sen Gupta, Richard Murray

James Cook University, School of Medicine & Dentistry, Townsville, QLD

Introduction/background:
The School of Medicine at James Cook University is a relatively new school with its first enrolment in 2000. Since then, four cohorts have graduated. Feedback has been sought from the students about their teaching and learning experiences but there has not been a systematic approach to evaluation across the School, with just a few tutors actively evaluating their subject with minimal feedback of the results. As well as student feedback, we also need to gauge the opinions of academic and support staff, adjunct staff, the teaching hospitals and communities we utilise for teaching and learning purposes. As an expanding regional medical school, with increasing student numbers, new facilities and increasing demands on the resources available, an evaluation framework is necessary to coordinate what is in progress and what are priority areas for action.
To this end, we seek ideas from our colleagues as to what works for them and what lessons have been learnt so we can develop ideas for our own framework.

Purpose/objectives:
It is now an exciting period of growth for us, with increasing student numbers and new courses, so it is important we are working effectively and efficiently as a provider of public service personnel. This can only be proven through evaluation and the creation of an evaluation framework, which incorporates all aspects of the School from teaching and learning to staff development, resource allocation to research.

Issues for exploration/ideas for discussion:
What works? Are other medical / health education units implementing a program evaluation? Where are there areas for improvement in evaluation? How do we avoid survey overload and create meaningful information that guides the School in the right direction during these times of growth and demand?

Orientation to the acute care workplace: Experiences of transition enrolled nurses

Jasmine Waterworth, Penny Fenn-Smith

Clinical Nurse Preceptor, Education and Training Office, Royal Hobart Hospital, Hobart

Introduction/background:
The Royal Hobart Hospital is a tertiary health care facility located in Tasmania. The Education and Training Office at the Royal Hobart Hospital provides a program to assist graduate enrolled nurses in their transition to acute care practice, titled "Enrolled Nurse Transition." Currently participants undergo a generic hospital orientation and induction, followed by orientation to their respective ward environment. Currently there is no existing generic structure to the ward orientation; the experiences and effectiveness of ward orientation relies solely on each wards staff and educator's ability to provide supernumery days, preceptor support, orientation manuals and assistance etc.

Purpose/objectives:
To conduct an analysis and present findings about the experiences of transition enrolled nurses during their orientation to the ward, with the intention of identifying issues and concerns and thus areas for potential improvement.

Identifying the possible benefits of formulating a generic ward orientation program to be used across the hospital, whilst allowing for ward specific orientation requirements to be met.

Issues for exploration/ideas for discussion:
Potential issues in implementing a more structured approach hospital wide for enrolled nurse transition participant's orientation will be explored. These issues will be provided by the Transition Enrolled Nurses in the form of feedback, either evaluation forms or verbal feedback. Recurring themes will be chosen from this evidence and discussed.

Potential solutions to the identified issues will also be explored applying the relevant theoretical literature.

Content versus process in Problem Based Learning (PBL): Evaluation of a first year graduate entry medical program

Barbara Dungey, Associate Professor William Hart, Amelié Dinsdale, Associate Professor Robyn Hill, Professor Debra Nestel

Gippsland Medical School, Faculty of Medicine, Nursing and Health Sciences, Monash University, Churchill, VIC

Introduction:
Gippsland Medical School (GMS) uses a traditional approach to PBL in which small groups (8) are presented with written scenarios, identify problems, brainstorm possible solutions, write learning objectives and then research independently. Students share and discuss their research in a second tutorial. Tutorials are student-led however a tutor is present, guiding and challenging as necessary.

Purpose:
- Evaluate effectiveness of PBL as an educational method.
- Explore the impact of PBL on knowledge acquisition.
- Explore students and tutors competence in the PBL process.

Methods:
Tutors and students completed written evaluation forms after every tutorial. Focus group interviews were conducted with population specific respondent groups. Data was entered to SPSS 15.0 and descriptive statistics computed. Transcripts of interviews were thematically analysed.

Issues for exploration:
- To what extent do new medical students focus on content aspects of PBL?
- In what ways and when should process aspects of PBL be emphasised?

Results:
Rating forms
Ratings suggest PBL scenarios are realistic, learning objectives are largely met, PBL process is followed and satisfaction with performance. Suggestions were made for improving some cases although most were considered suitable. Conversely, free text comments suggested PBL process was not followed as intended.

Interviews
PBL scenario content was considered highly valuable especially as it related to other curriculum activities. Some students and tutors identified that PBL process was not being followed. Effective tutors were perceived as those who suggested research questions, focused students on key issues, asked probing questions and shared clinical experiences.

Discussion:
Overall, results suggest students and tutors value content aspects of PBL over process. Written evaluations indicated high levels of satisfaction with PBL tutorials while interviews suggested some students and tutors focused on content knowledge in scenarios; short cutting to objective writing rather than working through the process.

When novices are learning they often over focus on what they consider to be most important. Our students value and are anxious about acquiring knowledge and therefore focus attention on content. Without a structure to revisit the PBL process systematically, it is unlikely that students (and tutors) will develop these skills.

Recommendations:
Develop PBL skills by:
- Improving the introduction of the PBL process
- Acknowledging that it is common to focus on one aspect of a task at the expense of another
- Allocating time within tutorials to reflect on and discuss process
- Rewarding students and tutors for developing effective process skills

Academic medicine and possibilities for revitalisation: Observations from one Australian university

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Introduction/background:
There are ongoing challenges faced in attracting clinicians to teaching and to careers in academic medicine. There is also a noticeable lack of female academics and junior doctors in the field [(1-3)]. Compounding these issues are the difficulties faced by clinical academics to do justice to clinical, research and teaching commitments within the current service intense clinical environment. These concerns have highlighted a need to more formally explore the profile of academic medicine and possibilities for its revitalisation.

Purpose/objectives:
The purpose of our study was to explore the issues surrounding clinical teaching capacity, the profile of academic medicine, and possibilities for renewal at one Australian university.

Methodology:
Data was collected through 23 interviews and 2 focus groups with purposefully sampled informants across the faculty. Interview and focus group data was analysed using Framework Analysis [(4)]. Three researchers carried out an independent analysis of recurrent themes and subthemes in the data, and then jointly developed a framework which documented the key themes emerging from the data.

Results:
Interview participants (n=23) included heads of clinical schools, heads of academic disciplines, medical program coordinators, senior academics, and junior clinicians who teach. Focus groups were carried out across 2 clinical school sites and involved a mix of clinical academics, medical education coordinators, and administrative staff. Themes emerging from the qualitative analysis included participant conceptions and concerns regarding clinical teaching capacity and academic medicine; their perceptions regarding enablers or barriers to teaching generally and to pursing a career in academic medicine; models of capacity building; and possibilities for revitalisation.

Discussion and Conclusions:
Our analysis highlighted a number of issues that have to be addressed in renewing the profile of academic medicine. Based on these findings we have developed a set of recommendations regarding achieving diversity and gender balance, increasing the capacity to teach, and revitalising the profile of academic medicine.

Issues for exploration/ideas for discussion:
- What challenges are other medical schools facing with regards to clinical teaching capacity and academic medicine?
- What do we need to do to revitalise the profile of academic medicine?

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8241