

FROM THE LITERATURE

Abstracts of Recent Papers

With thanks to the Editors and Publishers of *Academic Medicine*, *Medical Education*, *Medical Teacher* and *Teaching and Learning in Medicine*, we regularly reproduce selected abstracts of recent papers from these journals that may be of interest to the readers of *Education for Health*.

These journals can be ordered at the following addresses:

Academic Medicine: Association of American Medical Colleges, 2450 N Street, NW, Washington, DC 20037, USA.

Medical Education: Blackwell Publishing Co., PO Box 87, Osney Mead, Oxford OX2 0DT, UK.

Medical Teacher: Taylor and Francis Ltd, Customer services Department, Rankine Road, Basingstoke, Hants RG24 8PR, UK.

Teaching and Learning in Medicine: Lawrence Erlbaum Associates, 365 Broadway, Hillsdale, NJ 07742, USA.

Reasons reviewers reject and accept manuscripts: the strengths and weaknesses in medical education reports. Georges Bordage
Academic Medicine, 76, 889–896, 2001.

Purpose: Scientific journals rely on peer review to maintain the high quality and standards of papers accepted for publication. The purpose of this study was to explore the strengths and weaknesses of medical education reports by analysing the ratings and written comments given by external reviewers.

Method: The author conducted a content analysis of reviewers' comments on 151 research manuscripts submitted to the 1997 and 1998 Research in Medical Education Conference proceedings. The negative comments on 123 manuscripts that received "questionable, probably exclude" or "definitively exclude" overall ratings from at least one reviewer were evaluated. A similar analysis was performed on reviewers' positive comments for 28 manuscripts recommended unanimously for acceptance.

Results: On average, four peers (4.1, SD = 0.97, range = 2–6) reviewed each manuscript. Of those recommended of exclusion, a mean of 2.3 reviewers recommended exclusion and each reviewer wrote a mean of 8.1 (SD = 5.7) reasons. The top ten reasons for rejection were: inappropriate or incomplete statistics; overinterpretation of results; inappropriate or

suboptimal instrumentation; sample too small or biased; text difficult to follow; insufficient problem statement; inaccurate or inconsistent data reported; incomplete, inaccurate, or outdated review of the literature; insufficient data presented; and defective tables or figures. The main strengths noted in accepted manuscripts were the importance or timeliness of the problem studied, excellence of writing, and soundness of study design.

Conclusion: While overstating the results and applying the wrong statistics can be fixed, other problems that the reviewers identified (ignoring the literature, designing poor studies, choosing inappropriate instruments, and writing poor manuscripts) are likely to be fatal flaws warranting rejection.

Community-orientated medical education: extending the boundaries.

Helen C. Cooper, Trevor J. Gibbs & Lyn Brown

Medical Teacher, 23, 295–299, 2001.

Community-orientated medical practice has become an integral part of the more recent undergraduate curricula, newly emerging from the GMC recommendations for medical education in the future. In most of the courses, medical student' community activity focuses around the general practitioner and immediate primary care facilities. As part of an integrated community course at Liverpool, second-year students are asked to spend a period of time outside the confines of primary care in the wider community. This paper describes the course and its evaluation by students. The advantages and disadvantages perceived by the students are described, potential outcomes are identified and future improvements are highlighted.

The benefits of a multiprofessional education programme can be sustained.

Gary Mires, Fiona Williams, Ronald Harden & Peter Howie

Medical Teacher, 23, 300–304, 2001.

Improved understanding by third-year medical students about the professional roles of doctors and midwives in the care of labouring women following a multiprofessional training programme have been previously reported. Following a clinical attachment in the fourth year, the previously observed changes in awareness of professional responsibility were maintained in the same group of medical students and in some areas enhanced. We believe that a short multiprofessional course early in the medical curriculum can change awareness of professional responsibility. Further, we have evidence that these attitude changes were maintained and enhanced following a clinical attachment later in the educational programme. This reinforcement

of multiprofessional experiences may enhance working practice after graduation.

The doctor–patient relationship: from undergraduate assumptions to pre-registration reality. Clare Williams, Peter Cantillon & Mac Cochrane
Medical Education, 35, 743–747, 2001.

Objectives: To describe ways in which the doctor–patient relationship experienced by newly qualified preregistration house officers (PRHOs) differed from their undergraduate expectations.

Design: Qualitative study in which in-depth semistructured interviews were carried out with each PRHO within 406 weeks of the start of their first job.

Setting: Three teaching hospitals, three district general hospitals and four general practices in South-East England.

Participants: 24 newly qualified PRHOs.

Results: A number of differences were identified by PRHOs. These were caused in part by the impact of factors such as the shortage of time, which could lead to emotional "blunting". Some PRHOs were changing their ideas about what constitutes a "good" doctor, and were redefining the meaning of a "professional" relationship. The relationships of PRHOs with patients were also affected by the attitudes of their senior colleagues. For example, where PRHOs tried to maintain a patient-centred relationship, they could be identified by colleagues as working too slowly. PRHOs working in general practice were able to utilize and improve their communication skills with patients, but found it difficult to transfer these skills back into the hospital setting.

Conclusions: Despite receiving substantial undergraduate education on how best to communicate with patients, a variety of factors conspired to prevent hospital-based PRHOs from utilizing this information. Building on these findings, a number of recommendations are made to help improve practice.

Reinforcement of occupational history taking: a success story. Eileen Storey, Sara Thal, Chinwe Johnson, Michael Grey, Heather Madray, Michael Hodgson & Carol Pfeiffer
Teaching and Learning in Medicine, 13(3), 176–182, 2001.

Background: This article describes the results of a retrospective study of 3 classes of medical students who participated in a targeted occupational and environmental health curriculum at the University of Connecticut School of Medicine.

Purpose: We wanted to determine if targeted focused interventions which integrated occupational and environmental health principles into routine

history taking would result in increased scores on the number of questions posed during the Clinical Skills Assessment Program in the 4th year.

Methods: We analysed Clinical Skills Assessment Program questions for 3 graduating medical school classes from 1997 to 1999.

Results: It appears that intense, focused training may increase the occupational and environmental questions which students ask. By revisiting the components of the history during the 3rd year, the final assessment of 4th-year students substantially and significantly increased.

Conclusions: Those who wish to stem the decline in history-taking skills as students enter their clinical years should consider reinforcing these skills using structured programs and practice in areas of the history that are traditionally neglected but recognised as essential gathering comprehensive data on patients.